dose, adjuvant has been reintroduced, and the recommended schedule for the vaccination of children has been changed.

In Israel a similar improvement in the efficacy of pertussis vaccine has been noted,⁷ but with fewer accompanying changes. In that country the improvement dates from 1968, when the inclusion of agglutinin 3 in their vaccine was ensured. The earlier vaccine, which gave unsatisfactory protection, did, however, contain adjuvant and it also achieved a mouse-protective potency of four international units per human dose.⁸ Moreover, the vaccination schedule in Israel has not been altered.

The one feature common to the improvements in British and Israeli vaccines is that their manufacturers now make deliberate attempts to ensure that their products contain enough agglutinin 3. But ought our hopes for the wellbeing of vaccinated children to be based merely on the good-will of present well-informed staff, adequate though this proves to be at present? Or should we formulate requirements which would ensure that present knowledge is not forgotten?

To conclude: though there is evidence that for some years before 1967 the pertussis vaccine of Glaxo Laboratories was less effective than that of Wellcome Laboratories, there is ample reason to believe that this does not apply to vaccine made during the last six years. There is also further evidence that effective pertussis vaccines are those that contain sufficient agglutinin 3.—I am, etc.,

NOEL W. PRESTON

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- ¹ Preston, N. W., *British Medical Journal*, 1963, 2, 724.
- ² Preston, N. W., *British Medical Journal*, 1965, 2, 11.
- ³ Preston, N. W., *British Medical Journal*, 1965, 2, 1001.
- ⁴ Abbott, J. D., Preston, N. W., and Mackay, R. I., *British Medical Journal*, 1971, 1, 86.
- ⁵ Preston, N. W., and Stanbridge, T. N., *British Medical Journal*, 1972, 3, 448.
- ⁶ Perkins, F. T., *British Medical Journal*, 1969, 4, 429.
- ⁷ Shmilovitz, M., Preston, N. W., Zaltser, H., and Cahana, A., *Israel Journal of Medical Sciences*, 1972, 8, 1936.
- ⁸ Singer, E. D., 1973. Personal communication.

Discrimination against Rhodesian Nurses

SIR,—In Personal View (28 April, p. 238) Professor Levy says that regulations governing the entry of Rhodesian students into the U.K. have recently come into effect and are manifestly discriminatory against the young Rhodesian girl who seeks to train as a nurse in the U.K. It would even appear that the discrimination is maximal against the less well-educated girl who wishes to train for the S.E.N. diploma rather than for the S.R.N. The raised educational standards demanded by the new regulations apply exclusively to applicants from Rhodesia.

Personally I have no sympathy with the present rebel Rhodesian regime and I would approve any whole-hearted action our Government might take against it. When, however, the action involves petty discrimination against trainee nurses, then surely it is time our nursing institutions and the B.M.A. united to protest that the professions of nursing and medicine have a long tradition of international co-operation and have in the past striven to rise above national disputes. Our British institutions

should protest against the new discriminatory measures.

World opinion is hardly likely to view our new regulations as evidence of our Government's firm determination to deal with the Rhodesian problem, but our colleagues abroad will note the profession's silent acquiescence as evidence that we care less about our international obligations than we did.—I am, etc.,

PETER DIGGORY

London W.1.

Resources and Needs in Africa

SIR,—In your leading article (5 May, p. 255) you commented with editorial sympathy on the first International Congress on Basic Medical Sciences in Africa, held at Lusaka in March.

Will you allow me, in the name of the trustees of the Commonwealth Foundation, to mention that the presence of many of the distinguished Commonwealth African delegates at this meeting was made possible by a Foundation grant of £4,250? This does not in the slightest detract from the imaginative and far-sighted planning of Professor Ezeilo and his colleagues, with whom the writer had the privilege of discussing plans for the conference as far back as November 1971. The main point is that you have commended the value of this meeting—a judgement which will certainly not be lost on our trustees.—I am, etc.,

JOHN CHADWICK

Director,
The Commonwealth Foundation

London S.W.1

Prescribing Mandrax

SIR,—I was interested to read the letters of Drs. G. C. Mathers and R. W. Green (28 April, p. 243) and of Dr. H. J. S. Matthew (12 May, p. 367) commenting on my letter published earlier in the *B.M.J.*, (7 April, p. 54).

I would like to stress that I did not write my letter to extol the virtues of Mandrax (methaqualone and diphenhydramine). My complaint was of a communication I had received from the senior medical officer. I can assure Dr. Mathers that I am aware of the additive qualities of Mandrax, and if he will refer to my letter again he will note that only a little over 1% of my patients had been prescribed this drug, and all the recipients were of a mature age. I cannot ever remember prescribing the drug to a youngster—in fact I find it unusual for a teenager to come to me with a sleep problem, and when they do it is usually amitriptyline which they receive.

I completely reject the advice of Dr. Green that I should accept the S.M.O.'s communication "in the manner intended." I considered that the letter was unnecessary, and it is my interpretation, devoid of paranoia, that the "manner intended" could have had but one object, and that was to intimidate me, and I think that intimidation should be resisted. I should imagine that the S.M.O. has powers that he can exercise over erring doctors, and I am very pleased that he should have such power, but he should abandon his tactics of attempted intimidation.

I have before me the last published details of suicidal poisoning in England and Wales during the year 1971 which have been ex-

tracted by the General Register Office.¹ The list of drugs is a very formidable one and, as one would expect, deaths due to barbiturates outweigh those due to any other listed drug; contrary to Dr. Green's and Dr. Matthew's assertion there were six listed deaths attributable to Mogadon (nitrazepam).

Though as I stated earlier the intention of my letter was to draw attention to a letter I received from the S.M.O. and not to discuss the virtues or otherwise of drugs, I would like, if I may, to comment on Dr. Matthew's letter. Dr. Matthew suggests that a voluntary ban on Mandrax could help to prevent thefts from chemist's shops. Why did he not follow his suggestion to its logical conclusion and suggest a ban on barbiturates as well? It is not my experience to find that Mandrax is a drug that my patients become addicted to. There is not a demand for increasing dosage by those to whom the drug is prescribed. A half to one tablet at night are the requirements of my patients, and I could count on the fingers of one hand those who require two tablets at night. I am in no position to know the most popular drug of addiction apart from alcohol—and I'll wager that most of us have a tippie at this—but my guess would be that barbiturates would far outweigh all other prescribable drugs put together, and as to the cause of death by drug overdosage there were 286 deaths from Tuinal (quinalbarbitone and amylobarbitone) alone in 1971, and 43 from Mandrax.¹

That the S.M.O. should "politely draw" my attention to those of my patients to whom I prescribe Mandrax is what irritates me, besides the implied threat already mentioned. I regard it as an impertinence that a remote Ministry official should write and tell me what I'm prescribing for my patients. I do not prescribe sleeping tablets willy-nilly; it often happens that patients with a sleeping problem do not require hypnotics at all. I wish to remain master of my own house, and be free to practise as I see fit. If I err, then let officialdom act.

The day has drawn to a close and bedtime has arrived. Rather than risk taking half a Mandrax to soothe me off to sleep I'm going to have a nice stiff whisky instead. Good health and good night.—I am, etc.,

C. G. BROWN

Slough, Bucks

¹ General Register Office, *Pharmaceutical Journal*, 1973, 210, 77.

Behçet's Syndrome and Oral Fibrinolytic Therapy

SIR,—We were interested to read the paper of Drs. T. Chajek and M. Fainaru (31 March, p. 782) and, by reference to a similar case, would like to support their observation that impaired fibrinolysis is an important factor in the pathogenesis of Behçet's syndrome.

We have under our care a male patient now aged 32. For eight years he has had recurrent attacks of deep venous thrombosis and one episode of pulmonary embolism. During this time he has also suffered from recurrent mouth ulcers, scrotal ulcers, erythema-nodosum-like lesions, and superficial phlebitis. When referred to us he had lower inferior vena caval obstruction but there was no proteinuria, suggesting that the renal veins were not affected. For a few years he had been treated with intravenous heparin and oral anticoagulants. Though this had