and would not wish to change the opinions expressed in the paper.

In our study of phenazine decanoate (17 March, p. 633) 78 chronic schizophrenic patients aged under 65 attending St. Olave's Hospital constituted all those with the defined characteristics in the catchment area known to be on the drug. Eight of them could not, for various reasons, be adequately managed on phenazine decanoate alone and did not enter the trial. During a 15-month period six of the 34 patients receiving active phenazine decanoate relapsed (including one who dropped out and relapsed). Assuming that a similar number among the 36 on placebo would have relapsed had they been receiving active medication, it can be estimated that 20 patients out of 78 (26%) could not be managed adequately on phenazine decanoate alone. This estimate takes no account of the unknown number of patients who may have begun phenazine injections but for various reasons did not continue and were therefore not included in our original group.

So far as Drs. Daniel and Schiff's remarks on the dose level are concerned, it should be pointed out that our patients received a minimum level of 25 mg monthly. The dose could have been adjusted at the monthly visits if the clinicians in charge of the patients had wished. In fact, most relapses were fairly sudden. There was no evidence in the case-notes describing the previous routine visits of any prodromal deterioration which might have given a clue that an increase in dosage was necessary. Our results suggest that the drug is effective in low doses.

In view of the hazards of long-term phenothiazine treatment, which have not yet been fully explored so far as injected phenazine is concerned, we would suggest that these drugs must be used in a cautious and balanced way. Our papers indicate their value in preventing relapse in many patients, but they also indicate that not all patients are likely to benefit and that some patients may require continued maintenance medication at all. We are, etc.,

S. R. HIRSCH J. P. LEFF J. K. WING
Institute of Psychiatry, London S.E.5

Meningococcal Meningitis

Sir,—The article by Dr. J. Stevenson which dealt with bacterial meningitis (19 May, p. 411) was timely. Though Dr. Stevenson notes that meningococcal infection is still the main cause of pyogenic meningitis, he states that its position is now less dominant than it once was vis-à-vis the other two main causes—Streptococcus pneumoniae and Haemophilus influenzae. I have recently drawn attention1 to a recrudescence of meningococcal meningitis since 1967 which is apparent in the statistics of mortality, notifications, and hospital discharges as well as in the number of isolations reported by the Public Health Laboratory Service which he quotes. The latest information indicates that this trend is continuing and may indeed be accelerating. The number of notifications of acute meningitis specified as meningococcal in the December quarter of 1972 was 189 and the provisional figure for the March quarter of 1973 is 360. These compare with 115 and 185 notifications respectively in the corresponding quarter of the year before. In 1971 the estimated total number of hospital discharges3 ascribed to meningococcal infection passed the 1,000 mark for the first time since 1964. The number of isolations reported by the P.H.L.S. rose from 519 in 1971 to 601 in 1972, and the latest cumulative total for this year stood at 395 as compared with only 280 at the corresponding time last year.4

Dr. Stevenson refers to the hazard of delay in reaching the correct diagnosis in the home or in hospital. It may be that a greater awareness of the trend revealed by these statistics will help clinicians to be on their guard.—I am, etc.,

PETER M. LAMBERT
Office of Population Censuses and Surveys, Medical Statistics Division, London W.C.1

Treatment of Bacterial Meningitis

Sir,—Dr. J. Stevenson (19 May, p. 411) suggests cephaloridine as an alternative treatment in cloxacillin-resistant neonatal staphylococcal meningitis. This is an unexpected suggestion and I would be interested in the evidence on which it is based. According to Garrod and O'Grady5 there is always cross-resistance between methicillin, cloxacillin and cephalexin and staphylococci proved to be resistant to either of these penicillins may be assumed to be resistant to cephaloridine.

Is there any evidence that the in vivo activity of cephaloridine in high dosage of a resistant staphylococci is different from its activity in sensitivity tests in vitro?—I am, etc.,

J. S. CARGILL
Department of Bacteriology, Royal Infirmary, Glasgow

Prescribing Mandrax

Sir,—As my main interest in the last 30 years has been continually learning and teaching the skilled selective use of physical treatments of psychiatric patients, I hope I may comment on the proper clinical use of Mandrax and methaqualone in view of some of the things said about them in your columns, such as Dr. P. R. Smith's letter (2 June, p. 152) regarding that his committee had been told, and seems to believe that “addiction could be rapid and that withdrawal symptoms are just as bad as heroin.” He asks for a voluntary ban on its use in as many parts of the country as possible. I have used various forms of continuous sleep treatment since 1940 on several thousand patients, and recently patients have been kept under narcotics for two or more months while inpatient at密碼, with the idea that the addiction therapy can also be given; the longest course of narcosis has been over four months. Large amounts of phenothiazines have been used, but sedatives have to be given as well. We have been able to falling back on the last 500 or more patients on the use of Mandrax or methaqualone in preference to other sedatives such as barbiturates, chloral, Mogaden (nitrazepam) etc. as it seems to produce less withdrawal symptoms and tend to induce the barbiturates and it works well. At present I have 10 patients on this regimen at a nursing home, if any “committed” doctor would like to try it, up on a clinical realities; and there are hundreds and hundreds of clinical records to consult at St. Thomas's and Belmont Hospitals.6

I have also used Mandrax as a sedative for many years and find it often preferable to the barbiturates as regards addiction, and more effective as a sedative than Mogaden. No addiction (the taking of rapidly increasing doses and a severe withdrawal syndrome) has been seen except in the young, in psychopaths, or in very ill depressed people, who needed more antidepressants and not increasing sedation. If one uses Mandrax or Mogaden, one should give only one tablet if possible, or fall back on a relatively mild additional antidepressants given at the same time (amitriptyline or trimipramine 50-150 mg) to stop early waking; one should not just increase sedatives. One can also start with Mogaden, and use Mandrax only if the former does not work, in preference often to the barbiturates.

And, please Sir, no more suggested drug but more B.M.J. on clinical realities, selective clinical use of drugs, and fewer articles on non-clinically useful double-blind sample results.—I am, etc.,

WILLIAM SARGANT
London W.1


Eclampsia and Social Change in the Tropics

Sir,—I suggest that Dr. J. Jenkinson (26 May, p. 487) may be able to correlate the ability of Zambians to speak English with increased social status and prosperity on the one hand and a tendency to be older and heavier at the time of their first pregnancy and to gain more weight during pregnancy on the other.

In the U.K. the incidence and severity of pre-eclampsia in primigravidae increase with increasing age, weight, and weight gain during pregnancy. This is also the case in Yorubas in Western Nigeria,7 but they are younger, lighter, and gain much less weight during pregnancy than in the U.K. and the incidence and severity of hypertension during pregnancy are correspondingly less. However, the blood pressure frequently rises剧 during the last 3 months of pregnancy combined incidence of hypertension in pregnancy and labour is very similar. The incidence of eclampsia in Yorubas is probably greater than in the U.K. because of the rapid gain in weight which can develop during labour. On the other hand, the risk for the baby is greater in the U.K. because
severe pre-ecplampsia may occur early enough to retard fetal growth. It is therefore important to distinguish between pre-ecplampsia and ecplampsia in such comparisons.

The relatively small percentage of Yoruba primigravidae who are over 25 years of age tend to be overweight and to show a higher than average incidence of pre-ecplampsia during pregnancy of the type seen in Europe. These women are usually in non-manual occupations. There is good evidence that hypertension is common in Yoruba women in middle life.—I am, etc.,

DUGALD BAIRD
M.R.C. Medical Sociology Unit,
Centre for Social Studies, Aberdeen

with opiate antagonists.

who, the advantages treated “subclinical” tributory SIR,—In their During appropriate. it is effective in the treatment of pentozine poisoning in horses, addiction potential), and produces no psychotomimetic effects.5 Naloxone, when available, should be regarded as the treatment of choice in all opiate poisonings, and in view of its proved qualities I hope that it will soon be made available for general use in Britain.—I am, etc.,

L. E. J. EVANS
Royal Victoria Infirmary,
Newcastle upon Tyne

Subclnical Brucellosis

SIR,—To advise in a short article on brucellosis (31 March, p. 791) that the term “subclnical” should be used without hesitation does not mean that it should be used rarely or even reluctantly—provided there is no doubt— but I apologize to Dr. R. J. Henderson (5 May, p. 306) if I failed to express myself clearly. I would, however, like many clnicians to agree that in practice subclnical brucellosis is always a perfectly obvious state. Continuing ill health in brucellosis is not always immediately apparent and thus a paragraph on subclinical brucellosis later in the same article is partly an apology for some of my imperfections.

The term “subclnical” should not be used merely because antibody tests remain positive after recovery, and neither does it seem fair if during an earlier acute illness, however mild, the diagnosis was not considered. During Dr. Henderson’s 1966-7 inquiry many persons, among them 50 veterinary surgeons, were visited and interviewed and their histories were recorded. If these subjects were not also examined, for a few the description “subclnical” may not have been appropriate. Seven of 70 veterinary surgeons in a comparable survey in south-west Wales had spenomagly, an abnormal clinical sign, and in one who was symptom-free liver biopsy showed cirrhosis with heavy iron deposition in association with recent vaccination. Brucellosis was possibly a contributory factor, in which case the deceptive term “subclnical” would hardly apply. But for the great majority of veterinary surgeons who, despite the laboratory findings, are well, why another label?—I am, etc.,

EIRIAN WILLIAMS
Pembroke County War Memorial Hospital, Haverfordwest

Poisoning by Dry-cleaning Fluid

SIR,—We recently treated a small child who had drunk dry-cleaning fluid in a launderette. Apparently this liquid was left in a beaker on a low table so that customers could remove spots before general cleaning. The main supply was kept nearby in a lemonade bottle. I do not know how widespread this practice is, but it is manifestly an extremely dangerous one in areas where there are liable to be many people with young children.—I am, etc.,

CYNTHIA M. ILLINGWORTH
Children’s Hospital
Sheffield

Doctors and Overpopulation

SIR,—I would like to make a personal comment on the thoughtful letter from Dr. F. Difford (12 May, p. 369). Perhaps for the benefit of those less familiar with the Doctors and Overpopulation Group I can include a summary of our aims? These are: (1)—To exhort the Government to admit that a population problem exists in this country. (2)—To press for a large extension of family planning services, emphasizing that such facilities must be provided free of charge within the framework of the N.H.S. (3)—To endeavor that the abortion law remains liberal and that more facilities be available under the N.H.S. (4)—To see that the facilities for male and female sterilization be massively increased and made available under the N.H.S. (5)—To urge a reappraisal of the laws and policies that govern the employment of women in society with a view to bringing about a significant improvement in their position. (6)—To be in the vanguard of a nation-wide campaign of population education.

Dr. Difford objects to the third of these and partakes in the concept of population control. Everybody I am sure agrees that prevention is infinitely preferable to the termination of an unwanted pregnancy. It is for this reason that we regard an efficient contraceptive service backed up by education as of the greatest importance. However, even the best contraceptives when used otherwise occur in abortions this and human fallibility, it would seem that in the foreseeable future there is likely to be a need for termination of pregnancy.—I am, etc.,

GEORGE MORRIS
Secretary
Doctors and Overpopulation Group

Londen N.10

Clinical Work in Public Health

SIR,—The Public Health Committee would wish it to be generally known that in April of this year they established a working party “to review as a matter of urgency, and in depth, the role, organization, training, grading structure, and future functions of those doctors currently undertaking clinical work in the public health field who will all be transferred to the new regional health services.” The members of this party, in addition to myself, are: Dr. Catherine Atkins (a principal medical officer), Dr. David Baldwin (a consultant in public health medicine on the upper salary range), Dr. Rosemary Graham (a principal medical officer), Dr. Mariana Jenkins (a principal medical officer on the upper salary range), Dr. R. May (a consultant paediatrician), Dr. Maud Menzies (a principal medical officer), Dr. A. Reeves (a general practitioner) and Dr. H. G. Robinson (a deputy medical officer for health).

The working party concluded that it should first identify the range of work carried out by clinical public health doctors at the present time and move from there to a consideration of the future. The major part of this operation will be to produce concepts or concepts of the longer-term future of this group of doctors. In the light of the collective experience of the members it has already made considerable headway with these tasks, but it recognizes that there may be other individuals with special experience who may wish to draw attention to facets of the matter which they believe might not otherwise occur to members of the working party. If this is so, then my colleagues and I would be delighted to receive such observations, which should be sent to B.M.A. House, Tavistock Square, London, WC1H 9JP.—I am, etc.,

C. D. L. LYCETT
Chairman, Public Health Committee
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Distinction Awards

SIR,—The decision of the Annual Representative Meeting calling for renegotiation of the distinction awards (Br Med J, 16 June, p. 117) gives the profession an opportunity to take a fresh look at methods of remunerating consultants in the light of the attack on private practice. The growth of private practice is an indicator of unmet needs in the National Health Service and we would do well to consider how the privileges sought by private patients can be offered to all. Patients seek private arrangements to obtain more time, privacy, and consideration that a consultant can offer in a busy outpatient