which a loud bruit became audible. Her recovery was complete. The case was reported in greater detail by Enoch and Williams.1

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Additives to intravenous fluids

Sir,—I should be grateful for the opportunity to clarify a potentially confusing recommendation in the report of the DHSS Working Party on the Addition of Drugs to Intravenous Infusion Fluids1 and one that has been compounded in your leading article on the subject (31 July, p 239). The article states that fusicin acid is said to be too toxic or irritant to be given by intermittent infusion and should therefore be given by continuous intravenous infusion.

In our experience, and that of others,1 it is not desirable nor necessary that the infusion be continuous throughout the period of treatment. The data sheet dosage recommendation for fusicinic acid (diethanolamine fusidate)2 states that the powder should be dissolved in the buffer provided, diluted to 250-500 ml with the infusion fluid, and infused slowly over a period of not less than two to four hours. This dosage can be given three to four times daily. The intention of this recommendation is that the drug should be administered intermittently over a 24-hour period, albeit in three or four slow infusions. Provided these instructions are followed and the infusion is made into a wide-bore vein the incidence of local irritant effects on the vein is small.

The method of administering intravenous diethanolamine fusidate clearly falls within an area midway between the categories devised by the working party. It is a pity that the working party did not follow the precedent of the editors of the Prescribers' Journal and Drug and Therapeutics Bulletin in asking for the views of the manufacturers concerned before publishing their report.

B T MARSH
Medical Director, Leo Laboratories Ltd
Hayes, Middx.

3 Copperman, I. J., British Journal of Clinical Practice, 1972, 26, 83.

Anginal pain in a phantom limb

Sir,—The patient whom Dr C V Deenadayalan records (24 July, p 238) with anginal pain in a phantom left arm recalls two similarly affected patients, reported 33 years ago by the late Dr Wallace Jones and myself,1 in whom anaesthesia of the brachial plexus to the phantom caused in one patient abolition of the phantom component of the cardiac pain and in the other delay in its appearance and a reversal of its site of onset and spread.

These are amongst a number of data leading to a hypothesis on the mechanism of visceral pain which I postulated in 1944 in my Lettessonian lectures.2 I have seen four additional cases of cardiac pain in a phantom left upper limb in which my earlier observations were repeated, with identical findings.

COHEN OF BIRKENHEAD
Liverpool

2 Cohen, H., Transactions of the Medical Society of London, 1944, 64, 65.

Toxicity of paracetamol in children

SIR,—Paracetamol (acetaminophen) is not an exception to the wide variety of household products and drugs that find their way into the stomachs of young children. In 1975 138 (18½%) of the 775 calls about the treatment of paracetamol poisoning received at the London Centre of the National Poisons Information Service concerned children. Follow-up of these cases has failed to reveal any significant toxicity, and this experience is shared by others interested in this subject.1

This finding is not unexpected, as paracetamol has a wide toxic to therapeutic ratio, and in general the amounts taken were small. Children would appear to find the large tablets of paracetamol difficult to swallow, and the quantities of paracetamol contained in the proprietary paediatric elixirs are too small to cause liver damage. The case reported by Dr P S Glascott (24 July, p 235) is typical in that despite the child having consumed a "full bottle" of the plasma paracetamol levels were well below those associated with liver damage.2

Since paracetamol poisoning in children is usually mild, our experience with antidotes such as cysteamine3 or methionine4 is limited. There is no reason to suppose that the toxic effects of cysteamine and other observations led to damage.3 Since paracetamol poisoning in children is usually mild, our experience with antidotes such as cysteamine or methionine is limited. There is no reason to suppose that the toxic effects of cysteamine and other observations led to damage.

Since paracetamol poisoning in children is usually mild, our experience with antidotes such as cysteamine or methionine is limited. There is no reason to suppose that the toxic effects of cysteamine and other observations led to damage.

The geriatric ward and the patient

Sir,—I am disappointed that Dr Kathleen Hurley's impression (7 August, p 371) that the most elderly patients find geriatric wards "grim and dreadful." This might have been true many years ago, but the British Geriatrics Society and the DHSS have been increasingly concerned regarding the type of care provided in the geriatric wards. In fact, many geriatric units up and down the country are already providing a high standard of care, and after adequate treatment (including rehabilitation)
many patients are being discharged to the community to lead a healthier and happier life. Geriatrics has already been established as a separate specialty. The skills needed by doctors, nurses, and remedial staff over the past 25 years are extremely valuable not only to provide a high standard of care to the patients in the geriatric wards but also to enable many people to remain in their own homes.

On many occasions elderly patients have told me that if admission to hospital is required for treatment they would prefer a geriatric ward as they find the staff in the general wards are too busy with the younger patients, the pace being faster, and they have little time and skill to deal with the special problems of the elderly. Recently I was asked by a doctor to see his father at home (the patient is in his eighties and the doctor is also his general practitioner) to advise him regarding management. The patient had multiple pathology including Parkinsonism and had difficulty in walking, incontinence, etc. After a short period of rehabilitation in the geriatric ward the patient made very good progress and at present he is enjoying an independent and as near to normal a life as possible. If Dr Hurly would make an effort to visit an active geriatric unit anywhere in the country and would observe what is being done there for these patients, I am sure his impression would change, which is bound to benefit his elderly patients.

N K CHAKRAVORTY
St Luke's Hospital, Huddersfield

SIR,—As a general practitioner in Hull for many years my experience is quite different from that of Dr Kathleen Hurly (7 August, p 371). A number of my patients who have gained admission to hospital have returned from one of our local geriatric units full of praise for the care and treatment given and the happy atmosphere of the ward. My own father was a patient in such a unit for 10 weeks and I cannot speak too highly of the teamwork of the consultant and all the staff. He was treated the same as the other patients, all of whom in my opinion greatly benefited by being looked after in a quiet and professional way by the care of elderly patients, which cannot be the case on a general ward.

Perhaps we are unusually fortunate here on Humberside, but I personally feel that excellent geriatric units such as we have here are the only satisfactory answer to the increasing problem of the elderly sick.

GERALD P OXBROROUGH
Hull

New look at malaria

SIR,—I wish to refer to Dr S L Henderson Smith's letter (5 June, p 1402), in which he questions the humanity of WHO in campaigning to eradicate malaria in African countries instead of concentrating on family planning.

In support of Dr Helen Kingston's statement (26 June, p 1593) that family planning work is being undertaken in African countries by several organisations and individuals I would direct attention to the pamphlet Family Planning in Five Continents issued by the International Planned Parenthood Federation in November 1975, in which it is shown that increasing numbers of governments of countries in Africa are now committed to unilateral programmes of the United Nations funds for population activities and are members of the IPPF.

With reference to the population increase a recent article in the *Chronicle of Tropical Medicine* entitled "The epidemiology of infertility," based on the report of a WHO scientific group, states that "so much public attention has been directed in recent years to the problem of rapidly increasing populations in many of the developing countries (the so-called population explosion) that few people are aware of the existence of the opposite problem in others: a relatively static or actually declining population..." In parts of Gabon, Cameroon, the Central African Republic, and Zaire the proportion of women 50 years of age and older who have never borne children ranges from 20% to 40%.

Among younger women the higher percentages have been noted. A similar situation has been reported from East Africa, the Sudan, and elsewhere in the continent."

As the IPPF report shows, Africa has the lowest life expectancy of all continents (47.3 years compared with an overall figure of 55.2 years), while the birth rate is 2.6%, compared with the overall rate of 1.9%.

Another article in the *WHO Chronicle* on the impact of malaria on economic development gives some of the findings of a 22-month study in Paraguay sponsored by the Pan American Health Organisation. I wish to mention two salient ones—namely: (1) that both factors can diminish or negate the good effect of measures taken to improve economic opportunity; and (2) that diseases such as malaria may affect the labour force by incapacitating the individual worker or by reducing his efficiency when he is able to work. In addition to the foregoing I would reiterate the statement in your leading article (1 May, p 1050) that the disappearance of malaria will "throw into relief the malaria export-import problem, which at the moment menaces the rest of the world." Dr Henderson Smith's new look is myopic.

A F TURBOKU-METZGER
Mitcham, Surrey

Alcoholism: wet hostels

SIR,—At a recent meeting of many disciplines dealing with alcoholism the notion of wet hostels for alcoholics was considered. These hostels, in some countries, provide shelter, food, and alcohol until the person dies, which one could construe as encouraging the alcoholic to die as quickly as possible.

As a result of this I devised a questionnaire which was circulated to 80 doctors in the north-east of England. Thirty-one replied to the questionnaire. It was interesting to note that 11 out of the 31 doctors who replied thought that to provide alcoholics with easily available alcohol and shelter was an appropriate solution, while the remainder rejected this. It is also interesting to note that 10 doctors wished that, in the event of themselves becoming alcoholic, they themselves would be provided with alcohol and shelter.

I personally am alarmed that so many doctors seemed to have such a hopeless view of alcoholism and, furthermore, fear that it reflects a change in the caring, benevolent attitude which we are used to accompanying medical endeavour. I feel this result is not only a harbinger of uncaring solutions to social problems but also reflects demoralisation in the medical profession.

Those who wish for a more detailed copy of the results are welcome to contact me.

A FREED
Parkwood House Alcohol and Drug Addiction Unit, St Nicholas Hospital, Newcastle upon Tyne

Sedatives for alcoholics

SIR,—I am becoming increasingly concerned about the way that the sedative drug chlorpromazine (Heminevrin) is being used by general practitioners in the management of alcoholism. I fairly frequently come across patients who are being prescribed Heminevrin three times a day as "medical treatment" for alcohol problems. My own personal view is that it is undesirable for people with alcoholism to substitute the use of another central nervous system sedative for alcohol, and my experience has been that this really does nothing to advance solution of the many problems which arise in connection with alcoholism.

My experience with inpatients in the setting of a small special unit for alcoholics is that Heminevrin can be extremely useful during the period when a withdrawal syndrome is likely to occur, but that it can be reduced and stopped within about 10 days normally. It is also my experience in this setting that sedative drugs such as hypnotics are quite unnecessary and tend to perpetuate the alcoholic's continued demand for substitute drug therapy. To me a demand of this nature indicates that the treatment programme is being unsuccessful and that the patient is failing to accept the situation which he has to deal with.

It is like to draw attention to the problems likely to be produced by the prescription of drugs other than alcohol to alcoholics, which in effect sets the seal of medical approval on a drug-taking behaviour. The main effect of this in my view is to allow the alcoholic to escape the realities of his situation for a time, but it does nothing to provide a stable recovery.

A R FOSTER
Exe Vale Hospital, Exeter

Seizures and metolazone

SIR,—In the short report of muscle cramps, collapse, and seizures in two patients taking metolazone by Dr M X Fitzgerald and Dr N J Brennan (5 June, p 1381), the symptoms are attributed to a serious adverse reaction to metolazone. In particular, the symptoms in the second case were tentatively ascribed to hypomagnesaemia.

A review of the standard texts on the subject of hypomagnesaemia inclines to the opinion that this condition occurs after prolonged parenteral feeding, malabsorption, alcoholism,