then be stopped. The serum creatinine concentrations should be measured each month during the treatment. If an early relapse occurs the patient will need another course, but after that the choices are to give a single 400-mg dose every night to prevent further relapse; to stop the drug and wait; or to recommend surgery. With our present knowledge it seems better to choose surgery for the young, fit patient whose ulcer relapses often, for a lifetime of taking a drug whose hazards remain unknown is undesirable. For the old and unfit, on the other hand, the best options are recurrent courses for the patient who relapses occasionally and regular night-time dosage for the frequent sufferer. When an ulcer recurs after vagotomy there is an obvious potential for cimetidine, though reports are so far lacking. It is likely to be valuable in cases in which further surgery is undesirable or impossible.

Gastric ulcers present more difficult problems. As now, they should all be examined by endoscopy with cytology and biopsy to ensure that they are benign before any treatment is undertaken. If benign, the same policy as for duodenal ulcers applies, for, though the superiority of cimetidine over carbenoxolone has not been established, it seems likely at least to be as good, and (so far) less hazardous than the liquorice-based drug with its aldosterone-like effects on sodium and potassium balances. Cimetidine will also be called on as a temporary measure in anyone suffering from the Zollinger-Ellison syndrome, but so far it does not seem justified as an emergency aid in the management of upper gastrointestinal bleeding, except when the source is known to be erosions in a patient who is very ill.

All in all, cimetidine is a powerful new addition to the therapeutic armament that doctors deploy. Now that it has been released for routine clinical use by the Medicines Commission we need to think carefully about the ways it may be put to the service of our patients.

7 Bonfils, S, Mignon, M, and Accary, J-F, La Nouvelle Presse Medicale, 1974, 30, 1883.
8 Richardson, C T, and Fordtran, J S, Gastroenterology, 1975, 68, 973.

Safe paediatric prescribing

Given that the adult dose of a drug is known, rules have been devised for calculating the dose required for an infant or child from the age, weight, and surface area. These rules have so many exceptions that they are best avoided, and it is far better to learn the correct dose of each drug in each age group. While the prescriber may rely on memory for familiar drugs he also needs a more comprehensive source of drug dosage than the British National Formulary or MIMS for safe paediatric prescription. Two sources may be recommended: the comprehensive and familiar Paediatric Vade Mecum edited by Wood and colleagues from Birmingham, now in its eighth edition,1 and the modest Alder Hey Book of Children’s Doses from Liverpool.2 Both list over 160 drugs with doses related to age and weight. No doctor should feel inhibited from consulting such a reference source in prescribing for children.

Having the correct drug reference does not avert all prescribing tragedies. In spite of metrification and decimalisation being almost universal, disasters still occur because minims are prescribed and interpreted as millilitres3 or the decimal point has been misplaced.4 Great care is needed and calculations must be checked and rechecked, particularly with the many potent drugs now available. Incomplete or illegible prescriptions are an additional hazard which may make it less possible for a pharmacist to spot a mistake. One practice particularly to be deprecated is that of ordering a drug dosage by volume without designating the content by weight. This applies not only to intravenous agents such as potassium chloride but to well-tried drugs such as the oral hypnotic chloral hydrate. A prescription of 5 ml of chloral hydrate would give 200 mg of chloral hydrate to the patient if chloral elixir paediatric BNF were dispensed, but there are 1000 mg of chloral hydrate in chloral syrup BPC. The difference could have a disastrous effect if repeated doses were given.

Edinburgh and medicine

The St Andrew’s Day Symposium of the Royal College of Physicians of Edinburgh this year is the last of the events linked to the 250th Anniversary Celebrations of the Faculty of Medicine. In 1726, under the influence of Leiden and of the two Edinburgh royal colleges, was initiated the first faculty of medicine in Britain to provide a full medical course with appropriate examinations. In part this resulted from the farsightedness of Lord Provost George Drummond, who, dismayed by the falling fortunes of the City of Edinburgh after the Act of Union in 1707, saw that a medical school, attracting students from far and wide, would strengthen the city’s influence in world affairs. Simultaneously, the ambition of John Monro, Deacon of Surgeons, for his son, Alexander, led to the latter’s being trained for a professorship, to which he was appointed by the city council in 1720. Six years later the city’s college had its faculty of medicine, and the Royal Infirmary followed soon after.

The influence on world medicine of medical students who trained in Edinburgh has been immense. They can be numbered among the founders of the University of London, University College Medical School, the Middlesex Hospital Medical School, the modern St Bartholomew’s Hospital Medical School, and the Royal Society of Medicine. In America Edinburgh graduates founded Philadelphia Medical School and King’s College Medical School (Columbia), and influenced the medical schools in South Carolina, Maryland, and Virginia—not to mention McGill, Dalhousie, Sydney, and Otago. Indeed, had not James Lind (who graduated in Edinburgh) shown how to prevent scurvy at sea, it is doubtful whether Captain Arthur Phillip, convinced by the experience of Captain Cook, would have reached Australia or whether it would have become a British possession.

Not surprisingly, then, the Royal Scottish Museum, which is in close proximity to the University’s Old College, chose this year to arrange for the first time an ambitious exhibition of nearly 600 medical treasures. Displayed to the public under the title of “Edinburgh and Medicine,” the exhibits range from