Points

Code of practice for the Mental Health Act 1983

Dr T J CROW (Division of Psychiatry, Clinical Research Centre, Harrow, Middlesex HA1 3UJ) writes: Dr J R Hamilton (10 May, p 1219) and Professor R E Kendell (p 1249) deserve the gratitude of the psychiatric profession for their incisive analysis of the Mental Health Commission's proposed code of practice and its implications for treatment and research. The irony of the situation is that the members of the commission responsible for this brontosaurus of legislative pedantry undoubtedly see themselves as protectors of psychiatric patients and guardians of their civil liberties. Yet the consequences of their deliberations if translated into law would be to restrict treatment possibilities and curtail future progress in understanding the nature of the diseases from which these patients suffer. The comments of Judge L Brandeis in the case of Olmstead versus United States (1928) may be relevant: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficial. Men born to freedom are naturally alert to repel invasion of their liberty by evil minded rulers. The greater dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding."

Happiness is: iron

Mr DAVID P TAGGART (Department of Peripheral Vascular Surgery, Royal Infirmary, Glasgow G31 2ER) writes: In response to my criticisms (17 May, p 1334) of his leading article (12 April, p 969) Dr D P Addy states that "the evidence about iron and infection is equivocal and many believe that iron deficiency may be associated with increased susceptibility." He goes on to cite a study in which iron administration to infants was not associated with adverse effects[1] and again recommends iron supplements for all iron deficient children. This response is misleading. The confusion in published reports exists because of attempts by authors to attribute in vitro impairment of leucocyte bactericidal activity and cell mediated immunity simply to iron deficiency in children who were also malnourished.[2] The adverse effects of protein energy malnutrition on the immune response are well recognised.[3] In their extensive review of the relation of iron and host resistance Pearson and Robinson emphasise that most of the clinical studies purporting to incriminate iron deficiency as a predisposing factor of susceptibility to infection are invalidated by their inclusion of patients with "multiple nutritional defects, pre-existing infection and environmental deprivation."[4] There are many well conducted animal studies illustrating the detrimental effects of iron depletion in septic animals[5,6] and the available clinical evidence in humans would support this.[7-9] Although Reeves and Yip showed no adverse effects in the provision of iron supplements to children,[1] their subjects were all non-anaemic "healthy infants." In 1868 Trousseau described the pernicious effects of iron administration in patients with tuberculosis and predicted that his observations would be ignored.[10] The continued failure of many practitioners to appreciate that a low plasma iron value may simply reflect the physiological response to infection,[6] with consequent prescription of iron supplements, has proved him correct.

1 Reeves JD, Yip R. Lack of adverse side effects of iron ferrous sulphate therapy in 1 year old infants. *Pediatrics* 1985;75: 352-5.
2 Srikantia SG, Prasad JS, Bhaskaram C, Krishnamachari K. Anaemia and the immune response. *Lancet* 1976;i:1307-9.
3 McFarlane H, Reddy S, Adcock KJ, Adeshina H, Cooke AR, Akene J. Immunity, transferrin and survival in kwashiorkor. *Br Med J* 1970;iv:268-70.
4 Pearson HA, Robinson JE. The role of iron in host resistance. *Adv Pediatr* 1976;23:1-33.
5 Kochan I. The role of iron in bacterial infections, with special consideration of host-tubercle bacillus interactions. *Curr Top Microbiol Immunol* 1973;60:1-30.
6 Beisel WR. Iron developments in infectious processes. *Med Clin North Am* 1976;60:831-49.
7 Weinberg ED. Metal starvation of pathogens by hosts. *Bioscience* 1975;25:314-8.
8 Hunter RL, Bennett B, Towns M, Vogler WR. Transferrin in disease II: Defects in the regulation of transferrin saturation with iron contribute to susceptibility to infection. *Am J Clin Pathol* 1984;81:748-53.
9 Murray MJ, Murray AB, Murray MB, Murray CJ. The adverse effects of iron repletion on the course of certain infections. *Br Med J* 1978;ii:1113-5.
10 Trousseau A. *Lectures on clinical medicine*. London: New Sydenham Society, 1872.

Drugs in developing countries

Dr C J BURNS-COX (Department of General Medicine, Frenchay Hospital, Bristol BS16 1LE) writes: The old fashioned maternalistic key proposals of Mrs Banotti (17th May, p 1347)—that EEC countries should not export drugs that they have not themselves licensed—suggest that we should do what the governments of independent countries should do for themselves. The acceptance of her proposals will merely delay the time when these governments legislate to control dangerous and extravagant drug imports and their advertising. China, Mozambique, Bangladesh, and Sri Lanka have already done this.[1] It is the job of wealthy nations to advise, encourage, and publicise the evil behaviour of international companies but not to interfere with free trade and the development of legislation. In the long run we will show ourselves to be most naive and insulting to Third World countries if we go along with Mrs Banotti.

1 Melrose D. *Bitter pills*. London: Oxfam, 1983.

JANE YEO (Henley on Thames RG9 1SG) writes: Just as the European Parliament is to debate the recommendation that drugs not licensed in the European Community should not be exported to developing countries (Dr Tessa Richards, 24 May, p 1347) it was disturbing to read that the US Senate had voted to repeal the law which proscribes the export of prescription drugs before they are approved by the Federal Drug Administration.[1] Not selling for export drugs which are not accepted for sale in their country of origin seems to be the only way in which Third World countries can be helped to protect themselves against defective drugs.

While working in west Africa some years ago, I often saw the desperate consequences of drugs produced by unlicensed "mushroom" companies and sold in vast quantities to ignorant or corrupt regimes before the company involved disappeared from sight. The proposed change in US law is a threat to those poor and smaller countries which have no drug control mechanisms and rely on labels, price, and the good faith of metropolitan countries in selecting their drug sources. The possible effects are twofold: firstly, the appearance in the Third World countries of standard drugs from "mushroom" companies based in the US, and, secondly, the use of Third World populations as guinea pigs for the testing of drugs which could not be performed on the US population itself.

1 Tran M. Drugs could be exported before being declared safe. *Guardian* 1986 May 16:8:(col 1).

Antiviral treatment in chronic injection with hepatitis B virus

Dr M A VICKERS (Guy's Hospital, London SE1 9RT) writes: Doctors Graeme Alexander and Roger Williams overstate the extent of the problems in the UK (5 April, p 915). They state that 1-2% of the population is positive for the hepatitis B surface antigen and about one third of these develop chronic active hepatitis. This gives chronic active hepatitis a similar prevalence to diabetes or thyrotoxicosis, which is obviously untrue. Probably the best estimates come from surveys of screened blood donors, which yield a prevalence of 0·1-0·4% for new donors[1] (Regional Transfusion Centres, Tooting and Edgware, personal communication). The authors do not quote a source for their claim but I suspect that their figure is for those who have antibodies against this antigen.

1 Sherlock S. *Diseases of the liver and biliary system*. London: Blackwells, 1981:254.

Occurrence of polymyalgia rheumatica in rheumatoid arthritis

Dr M A CASSON (Manchester M20 9QT) writes: I have been following with interest the correspondence about difficulties in differentiating polymyalgia rheumatica from other rheumatic conditions (29 March, p 867; 24 May, p 1394). Alexander *et al* showed the value of comparing paired plasma and serum viscosities.[1] They showed that in polymyalgia rheumatica only the plasma viscosity was raised, while in rheumatoid arthritis both plasma and serum viscosities were raised. Raised serum viscosity reflects raised globulin concentrations, seen in chronic inflammatory conditions, whereas a raised plasma viscosity may be due to a rise of either fibrinogen or globulin values. In their study, a raised serum viscosity successfully predicted those patients who would develop chronic arthritis.

1 Alexander GJM, Blake DR, Holman RL, Bacon PA. Predictive value of paired plasma and serum viscosity in early rheumatic conditions. *Br Med J* 1981;282:1198.

IPPNW

Dr D S JOSEPHS (Biddenham, Bedford MK40 4AD) writes: In his otherwise fair report of the sixth congress of International Physicians for the Prevention of Nuclear War Scrutator (7 June, p 1536) comments that "a majority of the organisation's 150 000 doctor members are from Russia." This fails to tally with IPPNW's own records, which include 60 000 Russians (and 37 000 Americans). Your readers may be reassured to know that IPPNW's funds come from its 50 affiliates, East, West, and Third World, levied strictly pro rata to their individual memberships, boosted by additional contributions, mainly from Western sources.

Two centuries of medical benevolence

Dr ANTHONY BATTY SHAW (Norfolk and Norwich Hospital, Norwich NR1 3SR) writes: In my account of the Norfolk and Norwich Benevolent Medical Society (19 April, p 1066) and in the monograph on which it was based there were two small errors, to which P G Gordon-Smith, secretary of the Royal Medical Benevolent Fund, has drawn my attention and which I would like to correct.

On the basis of information given me by one of Mr Gordon-Smith's predecessors I stated that when the Essex and Hertfordshire Benevolent Medical Society was dissolved in 1951 its funds were transferred to the Royal Medical Benevolent Fund. In fact its assets were transferred to an Essex and Hertfordshire Benevolent Medical Society Fund, separately registered with the Charity Commissioners, and it is this fund that is administered and managed by the Royal Medical Benevolent Fund, its designated trustee.

Secondly, Mr Gordon-Smith has informed me that the Essex and Hertfordshire Benevolent Society was founded in October 1786, six months after the Norwich society, and not, as I had assumed, before it. My reasons for believing that the Essex and Hertfordshire Society had been formed earlier than the Norwich society in the same year were that the Norwich records stated that its medical benevolent society was the second in the country to be formed and in 20 years of collecting information on medical societies I had been unable to trace any other earlier society. There must, therefore, have been another benevolent society, no longer in existence, founded earlier than the Norwich society and I would be grateful if any of your readers could tell me of it.

These two points do not affect the claims that the Norfolk and Norwich Benevolent Medical Society is the oldest existing medical benevolent society and that the seven societies listed in the article are the oldest surviving medical benevolent societies in the UK.