alone. Four weeks later she was discharged from hospital taking 62 IU daily. The chloroquine dose was gradually reduced, and she remained responsive to subcutaneous insulin.

The rarity of true subcutaneous insulin resistance has been emphasised.[3] The patient reported on by Blazar *et al* had accelerated insulin degradation in subcutaneous fat but also showed severe resistance to intravenous insulin.[2] There is evidence that, in addition to its action on hepatocyte receptors and receptor mediated degradation, chloroquine also inhibits lysosomal degradation in human skeletal muscle[4] and fibroblasts[5] and that it inhibits adipocyte insulin degradation in vivo.[6] Chloroquine's action may help to explain the pathogenesis of this rare syndrome as well as being useful in its management.

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SIR,—Dr G D Smith and colleagues (21 February, p 465) conclude that chloroquine may have a role in reducing postprandial hyperglycaemia in non-insulin dependent diabetic patients by decreasing insulin degradation. This potentially exciting finding needs to be qualified as, firstly, the pathophysiology of non-insulin dependent diabetes is heterogenous and increased exposure of peripheral tissues to insulin in some patients may exacerbate insulin resistance,[1] and, secondly, the use of changes in plasma C peptide and insulin concentrations to measure insulin secretion and hepatic extraction, particularly in the non-steady state after ingestion of oral glucose, is questionable because of the large individual variability in C peptide and insulin concentrations.[2]

There are now non-invasive techniques for assessing these variables. We suggest that such techniques should be used to assess the mechanisms of action, and consequently the role, of chloroquine in improving glucose tolerance in patients with non-insulin dependent diabetes mellitus.

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Alcohol and violence

SIR,—The management of patients who claim to have been assaulted is an accepted part of the workload of every accident and emergency department. Increased violence is now expected every weekend, over the New Year in Scotland, and after football matches throughout Britain.

Our department enjoys a suburban setting and has perhaps been shielded from the violence witnessed by some inner city departments. Nevertheless, analysis of the number of patients who have been assaulted coming into the department over the past year shows an increase of large scale violent incidents. Between 2% and 5% of our patients who have been injured in accidents claim to have been assaulted (the true figure is probably higher), but around New Year the incidence increased dramatically.

Between midnight and 8 am on New Year's Day we saw 59 patients. Of these, 45 had sustained recent injury, and 24 (53%) of these claimed to have been assaulted, five having received human bites. All of the injured patients were intoxicated. Excessive alcohol consumption also precipitated the attendance of three of the "medical" cases (an epileptic, a diabetic, and a haemophiliac). Throughout the night the department was full of policemen and drunken people supporting their injured friends.

Some departments may accept this problem and others may as yet have no experience of it. Certainly, most senior doctors and senior policemen do not learn about it until the next day, and the general public views the subsequently published statistics with distant apprehension. The link with alcohol, so obvious to those of junior rank, who usually treat the patients, is rarely emphasised.

The only effective influence on alcohol consumption is cost. As Sir George Godber (24 January, p 245) pointed out, if the government really is concerned about public law and order it could show its conviction and be guaranteed success by increasing the tax on alcohol. Perhaps the budget surplus could then be used to finance the health service.

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Effect of dietary cholesterol on plasma cholesterol concentration

SIR,—The report by Ms Jacqueline Edington and coworkers (7 February, p 333) is a fine example of the degree of precision that can be obtained in nutritional studies even in free living populations. An important conclusion is that reducing dietary cholesterol offers little benefit if the diet is already low in saturated fats. This implies that people need not avoid cholesterol rich foods, such as eggs, provided they have reduced their intake of saturated fats and increased that of polyunsaturated fats. This is one possible interpretation of the data.

A close examination of the results suggests that the conclusion on which they have made those interpretations can be questioned. Their study compared, in a crossover design, the effects on the serum cholesterol concentration of adding either seven eggs weekly (high cholesterol) or two eggs weekly (low cholesterol) to a prudent diet. Each crossover period lasted four weeks. The authors concluded that the serum cholesterol concentration was lowered significantly with the low cholesterol diet for the first four weeks but not at the end of the eight week study. The total cholesterol concentrations for the entire group were as follows: basic diet 5·70 mmol/l; high cholesterol period 5·57 mmol/l after four weeks and 5·57 mmol/l after eight weeks; low cholesterol period 5·43 mmol/l after four weeks and 5·46 mmol/l after eight weeks. These data are remarkably consistent, but only the difference between the two four week dietary periods is significant. Clearly, however, the difference at eight weeks was virtually the same as at four weeks and may not have reached significance because the overall differences were small.

The important questions are, firstly, whether the difference observed is important in relation to the whole community and, secondly, whether that difference can be ignored, as suggested by the authors. The actual difference was a 2·5% reduction in the serum cholesterol concentration. On the basis of most published prospective data and data on cholesterol lowering intervention, this fall in serum cholesterol concentration would be reflected in at least a 5% reduction in new clinical coronary artery disease events—in my view, a substantial benefit. Their interpretation can also be challenged on the grounds that not all individuals would make the necessary effort to lower saturated fat and increase the polyunsaturated to saturated fat ratio in their diets. The authors are correct in drawing attention to the effect of the interaction between dietary cholesterol and dietary fatty acids on the serum cholesterol concentration. An equivalent intake of cholesterol raises the serum cholesterol concentration more in those who have a high intake of saturated fatty acids than in those with a lower intake. Therefore, if the dietary modification of fatty acid intake were less the benefit of lowering cholesterol intake would be greater than that achieved in this study. This benefit might well apply to individuals in the community who would prefer to reduce their consumption of cholesterol rich foods than to make major cuts in their intake of saturated fat. Though I agree with the authors that the best public health approach is to emphasise a reduction in the intake of saturated fatty acids, they may have understated the additional value of also lowering cholesterol intake for the whole community.

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Better reporting of adverse drug reactions

SIR,—Dr Frank Wells, medical director of the Association of the British Pharmaceutical Industry (14 March, p 704), raises important issues concerning the reporting of adverse drug reactions and will be discussed by the Committee on Safety of Medicines at the earliest opportunity.

As Dr Wells states, the Department of Health and Social Security (and indeed the Committee on Safety of Medicines) has always insisted that the reporting doctor should remain anonymous when details of adverse drug reactions are passed to pharmaceutical companies. He did not state the reason for this policy—namely, the concern that the reporting doctor would be subject to harassment by the company. This concern is also shared by the director of the association, Dr J P Griffin, who stated at a public meeting last year: "I wish I had no worries about the kind of correspondence that goes from companies to doctors. I agree that probably nine out of every 10, or perhaps 99 out of every 100, adverse drug reaction follow up letters are acceptable, but, within the last three months, I have had complaints from physicians, giving me letters that have been sent to them from member companies which have been harassing them. Harassment does occur. We are fooling ourselves if we believe that it does not."[1]

The spontaneous reporting of adverse drug reactions ultimately depends on mutual trust between the reporting doctor and the recipient of