Scotland’s Drink Problem

Addiction to alcohol is one of the largest and most neglected health problems of our time. It is particularly severe in Scotland, so that any attempt to tackle it there deserves a sympathetic hearing.

Last year the Departmental Committee on Liquor Licensing (chairman, Lord Erroll of Hale) reported on licensing questions in England and Wales, and its main proposals were criticized in these columns as untimely and hazardous. Now the Departmental Committee on Scottish Licensing Law (chairman, Dr. C. Clayson) has issued its report for Scotland. Like the Erroll Committee’s report, it has many recommendations that lack medical implications, but some of those that might affect the public health deserve critical scrutiny and are indeed disappointing. For this report also recommends some relaxation of the present restrictions on access of the public to places where alcoholic drinks are sold.

As the report points out, hospital admissions for alcoholism in Scotland according to recent figures were seven times as high for men and five times as high for women as south of the Border, while recorded death rates for alcoholism were six times as high for men and twice as high for women. Convictions for public drunkenness are over 2·5 times as high in Scotland, and death rates for hepatic cirrhosis about 1·5 times as high. No one of these indicators is free from scientific objection, but taken together the evidence overwhelmingly indicates that alcoholism constitutes a considerably more serious problem north of the Border than in the South.

It is in this context that the report’s proposals must be judged, for it recommends several relaxations in the licensing law to the end that they might “help to promote civilized drinking and break down the attitude that regards the consumption of liquor as an end in itself.” The introduction of a separate type of certificate is recommended for suitable premises which sell light refreshments such as soft drinks, tea, coffee, and snacks so that they could also sell alcoholic drinks. There would be no restriction on the access of children to premises of this kind, though under a minimum age limit they would not be allowed to buy alcoholic drinks. That age the report recommends should be retained at 18. A further recommendation is that so-called “children’s certificates” should be issued. “Where the conditions are right (report’s italics) we see no reason why a child should not be present in a bar in a hotel, a restaurant or even a public house in the company of his family,” it says. And in pursuance of this aim holders of such certificates would be allowed to admit children to any part of their premises thought to be suitable, “including parts used mainly or exclusively for the sale and consumption of excisable liquor, namely, bars.” It should be left entirely to local judgement to decide which premises are suitable for the admission of children under 14, states the report.

Such proposals must raise the question whether corner cafes are to become places where drinks can be on sale throughout the day. Would the number of “refreshment house” certificates be limited in any given area? Further, to allow young children into places where alcohol is being drunk may be an encouragement to “civilized drinking,” but to many people there would seem to be risks that ought not to be run. Though statistics in this field are notoriously difficult to interpret, it is worth noting that the annual convictions for drunkenness in Scotland of persons aged 14 to 18 rose between 1966 and 1971 from 273 to 445. Consequently, if the report’s recommendations are put into effect, there is no doubt that another of its proposals should be taken up seriously, and that is the introduction of a system of monitoring to measure the incidence of the misuse of alcohol.

Prognosis in Cystic Fibrosis

Cystis fibrosis of the pancreas is one of the commonest lethal genetically determined diseases in north-western and central Europe or among people coming from there. Estimates of its frequency vary from 1 in 2,300 to 1 in 3,000 live births. It appears to be rare in African and Far Eastern races.

It was first clearly separated from coeliac disease by G. Fanconi and his colleagues in Zurich in 1936 and by Dorothy Andersen in New York in 1938. In both studies the identification of the disease was based on an examination at necropsy of the gross and histological changes in the lungs and pancreas. The mortality in the early years after its recognition was high and the likelihood of survival beyond childhood was small. But the prognosis has steadily improved, mainly owing to the establishment of special clinics, the introduction of more effective antibiotics, the use of the mist-tent and inhalation therapy, and an appreciation of the importance of physiotherapy. Yet it remains one of the most distressing and disabling conditions affecting children and adolescents and imposes the most exacting demands on patient and parents.

To determine an accurate prognosis in individual cases presents problems. Statistical probabilities are of little help to the worried parent. Comparison between the results in older series and present-day ones are useless, for treatment has improved and ascertainment is more complete, so that many mild or even symptomless cases with diagnostic levels of sweat sodium are now included which would have been missed previously. Another factor impeding comparisons between old and recent series is that mass screening of the newborn is now done in some areas. This means that improved results are likely to be due to the early start of treatment rather than any alteration in the treatment itself.

Consequently, attempts have been made to construct a prognostic scoring system that can be applied to each individual patient and also be used to assess progress. A standard scheme of evaluation of patients was introduced by H. Shwachman and L. l. Kulczycki and modified by C. M. Doershuk and colleagues for use at all ages. A simplified scheme was suggested by E. M. Cooperman and colleagues. Recently Lynn Taussig and colleagues have produced a scoring system based on pulmonary function tests (FEV1 and vital capacity), chest radiographs, chest symptoms such as acute infective episodes, pneumothorax, haemoptysis, sputum production, and cough, with the addition of scores for physical examination of the lungs and the presence of cor
pulmonale. A further group of scores includes appetite, weight loss, exercise tolerance, and attitude to the disease. Hepatic fibrosis or portal hypertension were not included in the scoring system, perhaps because of their relative rarity, though severe hepatic disease undoubtedly influences the outlook in some cases.

It is not clear whether this system has advantages over previous ones, particularly since it relies heavily on pulmonary function tests, which are not easy to perform accurately in young children. Moreover, some criteria such as changes in chest radiographs and physical examination of the chest are difficult to standardize, while a certain diagnosis of cor pulmonale in its early stages is difficult to make in cystic fibrosis.\(^1\)\(^2\) There is not yet, nor is there likely to be, a completely satisfactory prognostic scoring system for cystic fibrosis, particularly since the disease is peculiarly subject to unexpected fluctuations in its course. Consequently, though a physician will be helped by his own attempts to evaluate his cases in a standardized manner, he cannot usually give a precise prognosis in terms of months or years. Patient and parents are unlikely to be helped by being offered a numerical score instead of hope.\(^3\)


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**Single-dose Treatment of Gonorrhoea**

Many patients suffering from gonorrhoea fail to come back to a venereal disease clinic after their first visit. This immediate default rate may be as high as 30%.\(^1\)\(^2\) If treatment has not been completed, some patients may believe themselves cured while still harbouring gonococci. Though relapse is usually obvious in men, symptoms of uncomplicated gonorrhoea are often minimal in women. To lessen the risks from default many venereologists prefer to give treatment in a single dose.

The treatment of gonorrhoea has recently been reviewed by S. K. Sim.\(^2\) Penicillin has for many years been the favoured antibiotic because of its effectiveness and lack of toxicity. The emergence of strains of gonococci which are relatively insensitive to it has necessitated the use of larger doses of up to 2-4 to 4-8 meagunits, but these have the painful disadvantage to the patient of a large volume of injected material. About 30% of strains of gonococci now isolated in London need concentrations of 0-125 μg penicillin per ml or more for their inhibition in vitro, and such strains often show diminished sensitivity to other antibiotics. Slow-release of oral penicillin preparations should not be used to treat gonorrhoea, but good results have been obtained with a single dose of 1-2 meagunits of procaine penicillin if it is given in conjunction with 2 g probenecid to enhance the blood level by delaying excretion. P. Rodin and A. Seth\(^3\) had only two failures in 105 men so treated. R. J. C. Cobbold and his colleagues,\(^4\) who treated 264 men with the same dose of penicillin but with 1 g probenecid, had 11 failures within one week of treatment. Penicillin-insensitive strains of gonococci are prevalent in the Far East, but T. F. Keys and his colleagues\(^5\) have reported 98% cure rates in U.S. naval personnel who were given a single injection of 2-4 meagunits of procaine penicillin an hour after 1 g probenecid by mouth. In this study 73%, of 242 strains of gonococci succumbed to a minimum inhibitory concentration of 0-25 to 1 μg penicillin/ml. These findings show that probenecid has given penicillin a second wind in its race against the adaption of the gonococcus to it.

Many patients prefer pills to needles, though their physicians may prefer the greater certainty to absorption when antibiotics are injected rather than given by mouth. Encouraging results have been obtained by giving ampicillin with probenecid. This also lessens the risk of serious reactions to penicillin and obviates those due to procaine, which can be very alarming. Willcox and his colleagues\(^6\) gave a single dose of 2 g ampicillin plus 1 g probenecid; they had five failures during the first week among 94 men treated in London and 2 among 91 treated in Swanssea. Amoxycillin gives higher serum levels than comparable doses of ampicillin. C. D. Alergent\(^7\) had 12.6% failures among 136 patients followed up after a single dose of 1 g. When 1 g probenecid was given as well, the failure rate was reduced to 5.8% in 136 patients followed up. Only one failure was seen in 95 patients given 1-2 meagunits of procaine penicillin plus 1 g amoxycillin by mouth.

In previous trials of cotrimoxazole, treatment given over a five-day period has been found effective against the gonococcus. A. S. Wigfield and his colleagues\(^8\) tried giving six tablets as a single dose, but abandoned this when they had seven failures in 25 patients. The same dose of cotrimoxazole plus a single injection of 1-25 meagunits of Triplopen (benethamine penicillin, procaine penicillin, and benzyl penicillin) gave only three failures in 104 men. They suggest that this combined treatment may be of value in infections due to less sensitive strains of gonococci. Single doses of 2 to 4 g of spectinomycin dihydrochloride have been reported to give 90 to 95% cure rates by B. A. Smithurst.\(^9\) L. Z. Oller and his colleagues\(^10\) gave 50 men a single dose of 400 mg doxycycline and had only one failure in the 44 who were followed up. This drug has the advantages of rapid absorption and prolonged serum levels, but it produced a high incidence of nausea and vomiting in the patients who took it on an empty stomach. The single failure in treatment was in a patient who vomited 10 minutes after taking it.

These recent reports show that a choice of effective single-dose treatments for uncomplicated gonorrhoea is available. Of these, 2 g ampicillin with 1 g probenecid or 1-2 to 2-4 meagunits of procaine penicillin plus 2 g probenecid have been widely used and give acceptable cure rates. But not all patients will be cured, and careful clinical and bacteriological follow-up is essential to detect the small number of failures. It should also be remembered that these antibiotics are not effective against non-specific urethritis. This is becoming increasingly common and is often contracted at the same