Since its introduction in 1943 over 6×10^9 Clinitest tablets have been distributed throughout the world. This demonstrates how universally acceptable this test has proved to be for diabetics—when used as directed.

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¹ Thompson, D G, *et al*, *British Medical Journal*, 1979, **1**, 859.

² Taylor, W O G, *Transactions of the Ophthalmological Society of the United Kingdom*, 1972, **92**, 95.

³ Thompson, D G, Howarth, F, and Levy, I S, *Lancet*, 1978, **1**, 44.

Choline chloride in the treatment of ataxia

SIR,—We note with interest that the initial encouraging report of the treatment of cerebellar ataxia¹ with choline chloride has been followed by reports which place the response to such therapy in better perspective (14 July, p 133; 8 September, p 613).

We have recently completed a double blind crossover trial (to be reported in full later) of oral choline chloride in the treatment of ataxia in three groups of patients: eight patients with typical Friedreich's ataxia, six with sporadic cerebellar degeneration, and six with atypical spinocerebellar degeneration with cerebellar ataxia and lower limb spasticity. The choline was administered for a period of six weeks before and after crossover and the response was assessed by numerical ataxia score. Patients were randomly allocated to three treatment groups—those receiving placebo, choline 12 g/day, and choline 6 g/day.

Preliminary results indicate a noticeable improvement in upper limb co-ordination in approximately 50% of patients in each diagnostic group receiving either 6 or 12 g/day of choline. Improvement in gait was noted in only two cases (one with cerebellar degeneration, one with "spastic" ataxia). Most of the patients who demonstrated an improved numerical ataxia score were noted to have some degree of useful functional improvement in upper limb co-ordination, but in the majority this was of a minor degree. Only one patient, who experienced recurrent vomiting, stopped the choline. Other side effects included depression (three patients) and nausea (three patients).

These preliminary results indicate that careful assessment will often reveal some improvement in limb co-ordination in ataxic patients on choline therapy but that this functional improvement is not of an order likely to improve disability significantly.

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¹ Legg, N, *British Medical Journal*, 1978, **2**, 1403.

Pindolol and pulmonary fibrosis

SIR,—Through the report from Western Australia (8 September, p 581) we became aware of a case of pulmonary fibrosis occurring in a patient who was under long-term treatment with pindolol. This is the only such reaction hitherto brought to our notice although pindolol has now been available for over 10 years. It is one of the most often prescribed β -adrenoceptor-blocking agents, with an esti-

mated total exposure of more than 2.5 million patient years worldwide.

On the basis of one observation it is, of course, not possible to be certain about the causation of the pathology in this case. From the published report, however, it appears that after seven years of treatment with pindolol the lung was the only organ involved in the fibrotic process. Such an observation, if correct, would distinguish this patient from previously reported cases of pulmonary fibrosis associated with β -adrenoceptor-blocking agents. In these, antinuclear antibodies were common and the pulmonary changes would have occurred only as a late feature, following symptoms attributable to fibrosis in other organs or to the oculomucocutaneous syndrome. The observation that the patient had no finger clubbing cannot on its own exclude "classical" cryptogenic fibrosing alveolitis. It might, however, suggest some rapidly evolving underlying pulmonary condition which led to a relatively short period of tissue hypoxia.

Although the available data do not allow one to exclude pindolol as the cause of the reported condition they certainly give no conclusive proof of such a relationship. Moreover, we cannot accept the authors' hypothesis that a nitrogen atom attached to an aromatic ring may be implicated in the fibrosing reactions induced by practolol, pindolol, or methysergide. Fibrosing changes in various tissues have been associated with β -adrenoceptor blocking agents not possessing a nitrogen in the aromatic ring. There are on the other hand a number of drugs commonly used in long-term therapy with a nitrogen atom on the ring which have never been suspected of eliciting fibrotic processes—for example, acetaminophen and indomethacin.

P KRUPP
J M CRAWFORD

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Wanted: a new wound dressing

SIR,—I was rather surprised at one or two statements in your leading article "Wanted: a new wound dressing" (22 September, p 689). For the last 15 years or so of my working life—which finished in 1971—I treated all clean closed wounds by exposure to air without dressing of any kind, and certainly without any "ritualistic practice" of a plastic spray. I did not realise that I was in any way exceptional in this method; indeed I thought it was almost universal.

I did have some qualms in the early days about the effect on the patient of exposing my "affront to his body's integrity" directly to view, but never once found any mental reaction. Indeed, the sight of a sinuous lazy-daisy stitch meandering for 15 inches across the chest wall after a radical mastectomy more often than not produced interesting discussion between patient and surgeon on various methods of embroidery.

These wounds are sealed by nature within an hour or two of operation, and a loose theatre gown will take up any slight loss of blood arising in those few hours. Subsequently the patient can carry out her own toilet with soap and water and so save nursing time.

May I suggest, sir, that we already have a copious supply of a dressing whose use will

save our hard pressed Health Service a great deal of money. It is called fresh air.

ROBERT BEWICK

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Royal Medical Benevolent Fund Christmas Appeal 1979

SIR,—Annually, thanks to the generosity of the medical profession, the Royal Medical Benevolent Fund is able to give every one of its beneficiaries something extra for Christmas. Many of these are children to whom the fund's gift is essential to a happy day.

In 1978 the response to my appeal was most generous and the record total of £23 351 was subscribed. Each year, however, the need is greater as costs rise and our efforts must match it. The Royal Medical Benevolent Fund relies solely on doctors and their families for support and I am confident that they will respond as always. Contributions may be passed direct to the treasurer or medical representative of the local guilds of the Royal Medical Benevolent Fund or sent marked "Christmas appeal" to the director of the fund at 24 King's Road, Wimbledon, London SW19 8QN.

T HOLMES SELLORS

President,
Royal Medical Benevolent Fund

London SW19 8QN

Review of composition of the General Optical Council

SIR,—Your readers may be interested to know that the Privy Council is proposing to conduct a general review of the composition of the General Optical Council, using for the purpose the machinery provided by paragraph 13 of the Schedule to the Opticians Act 1958.

This provision enables the Privy Council, after the required consultations, to make by Order such alterations in the membership of the General Optical Council and the numbers and qualifications of its members as may be expedient in view of changes in circumstances since the council's establishment, or the last such Order, as the case may be.

I have already notified both the General Optical Council and a number of interested bodies of this proposal but think it appropriate to give it wider publicity through your columns and those of other relevant professional journals.

I would be grateful if any national organisations (including organisations representing the interests of Scotland, Wales, and Northern Ireland) wishing to make representations to the Privy Council on this subject could send them to me at this office (10 copies, please) not later than 30 November. If this deadline presents special difficulties, requests for a reasonable extension of time will, of course, be considered.

N E LEIGH
Clerk of the Council

Privy Council Office,
London SW1A 2AT

Unblocking beds

SIR,—It is so clearly undesirable for elderly patients to be misplaced in acute hospital wards that if a mere change in clinical policy could solve this perennial problem no efficient department of geriatric medicine would have

failed to implement it. Why then is Dr C Joan McAlpine (15 September, p 646) able to transfer patients so quickly when many of her colleagues in geriatrics cannot do so?

Dr McAlpine points to one cause of delay—absolute shortage of geriatric beds. But shortages can also be relative, and delays can be disastrously long even when the total bed provisions in a hospital group are fairly generous. To put the matter very simply, if a well-bedded hospital group has 600 beds for geriatrics and medicine, there is a world of difference between a distribution of 400:200 and one of 300:300. Where the bed ratio is 2:1 or more in favour of geriatrics, this type of misplacement should not occur. Dr O'Brien and others,¹ whose group had 297 geriatric and 91 medical beds, achieved a high turnover: only 10.6% of patients in medical wards were over 65 years of age and only six medical patients needed to be transferred in a year.

It is an entirely different matter when the number of beds in geriatric and medical (including general practitioner acute) units are roughly equal. Then potentially long-stay elderly patients will tend to be diverted to the medical side. The geriatric service, presented with mainly, chronic illness² from home and hospital, will have a relatively low overturn; and, whatever its desired or stated policies, it will be unable to arrange expeditious transfers after meeting the reasonable needs of its community. Similar considerations influence exchanges between geriatrics and orthopaedics, psychiatry, and residential homes.

Where misplacement is unacceptable, its causes should be looked for in the balance of beds and other resources between specialties; and, given sound clinical work and organisation, it is the relevant policies of hospital authorities, not of consultants, which determine the rate and volume of transfers. There is every indication of important differences in bed ratios in different areas, and it is surely time for central departments to undertake careful and sophisticated studies of the allocation of beds and make their findings freely available.

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¹ O'Brien, T D, Joshi, D M, and Warren, E W, *British Medical Journal*, 1973, **4**, 277.

² Wilson, L A, and Levy, M G, *Age and Ageing*, 1979, **8**, 152.

Cost of treatment in the NHS

SIR,—Congratulations to Dr R A Keable-Elliott (22 September, p 749) on his very sensible article on the cost of drug treatment in the NHS. What a pity there were not more people of his ilk on the Royal Commission.

One important point he omitted was the necessity of bringing home to both patients and doctors the cost of treatment prescribed. If patients knew the true cost of the drugs they take, this would result in a much greater compliance and fewer valuable drugs left on the shelf or thrown down the toilet.

A year or two ago we were asked by the DHSS to send suggestions for containing costs in the National Health Service. I wrote suggesting that all prescriptions should be labelled with their true cost for the reasons mentioned above. I received a reply saying that, firstly, the pharmacists would require payment for this and, secondly, some patients might be put off having repeat prescriptions

by the high cost of the drug they had been taking free. Truly it is said that "against stupidity the Gods themselves fight in vain."

J C SMITH

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Health centres apparent

SIR,—I should like to commend to all doctors caught up in the conundrum of whether or not to build or go into a health centre the sensible solution arrived at by Drs Harvey Gordon and R A Bennett at Bookham (29 September, p 811). Their "health centre apparent" is a group-practice centre with clinics attached. This is precisely the solution we arrived at in Harlow in the 1950s and 1960s, when, with Nuffield Trust money, we were trying to provide an ideal "extra-hospital health service" for a town of 80 000 people. We found that it was essential to guarantee the autonomy of both the GPs and the public health services. This we achieved by building six group-practice centres with clinics attached, on almost precisely the same lines as those which Drs Gordon and Bennett have followed. These buildings were described in the *Lancet*.¹⁻³

The major lessons we learnt were the following. (1) It is essential to separate physically the GP and the public health wings. (2) There must be a "back door," so that doctors called out urgently can get away without walking through a full waiting room. (3) The number of GPs should not exceed four (with approximately 10 000 patients). (4) The waiting area should be big enough to do its job. (5) There must be adequate parking space for patients' cars, and reserved space for doctors, nurses, and health visitors.

The Bookham centre is perfect in the first three respects. I suspect that the waiting area may prove to be on the small side if all three consulting rooms are in use at once. In every other way this is a splendid job: it combines efficiency and economy with autonomy. What more could one wish for?

TAYLOR

Glyn Ceiriog, Clwyd

¹ Taylor, S, *Lancet*, 1952, **1**, 253.

² Taylor, C, *Lancet*, 1955, **2**, 863.

³ Bach, H E, et al, *Lancet*, **2**, 1055.

Points

Prediction of fetal sex: a cautionary tale

Dr J A NUNEZ (Park Hospital, Manchester M31 3SL) writes: . . . I am on Dr A J Williams's side if he implies (29 September, p 767) that the sex we should accept in an individual with the testicular feminisation syndrome is the one shown by the phenotype, which is the one accepted by the patient, the family, and society. But we should bear in mind that what we aim at when predicting the sex by amniocentesis is the genotype. In this sense the prediction is always certain, and it proved correct in Dr Williams's case.

Familial appendicitis

Dr MONTAGUE SEGAL (Halifax General Hospital, Halifax HX3 0PW) writes: . . . With

reference to the paper "Is appendicitis familial?" (22 September, p 697), Bailey and Love's *A Short Practice of Surgery* points out that the generally accepted fact of familial susceptibility "can be accounted for by an hereditary abnormality in position of the organ, which predisposes to infection. Thus the whole family may have a long retrocaecal appendix with a comparatively poor blood supply." . . . Most practitioners, whatever their special interest, sooner or later are asked for an opinion, whether by relatives, friends, or patients, and awareness of this possibility in history taking in atypical cases may be crucial. . . .

Easy-rider sling

Dr TESSY K HANID (Kingston Hospital, Kingston upon Thames, Surrey KT2 7QB) writes: I am afraid the point of my letter (4 August, p 335) has been missed by Dr J R Gillespie (1 September, p 555). The advantages of using the sling are numerous and in no doubt. But the technique of carrying the babies in the front is hazardous and care should be taken if people still choose this method despite the warning.

Remedy for excessive salivation

Mrs ROBERTA A BUTLER (Merton, Sutton, and Wandsworth Area Health Authority, London SW12 0AD) writes: I was interested to see your items about reducing excessive salivation in the mentally handicapped (5 May, p 1200; 19 May, p 1355). Speech therapists are at present undertaking programmes to control excessive salivation by the use of battery-operated vibrators.¹

¹ McCracken, A, *American Journal of Occupational Therapy*, 1978, **32**.

Photographing slides during scientific presentations

Dr R T JUNG (Dunn Clinical Nutrition Centre, Addenbrooke's Hospital, Cambridge CB2 1QE) writes: I would wholeheartedly agree with Dr S Mann (29 September, p 798) that it is impolite of delegates to photograph slides during scientific presentations and it is about time this growing practice was curbed. At the World Nutrition Congress in Rio de Janeiro last year I was shocked to find that the organisers had allowed professional photographers to take flash pictures not only of the speakers but also of individual delegates during the actual lectures and symposia. This, as you can imagine, was most disturbing and should also be prohibited. . . .

Art and audacity

Dr H G EASTON (Glasgow G12 0XX) writes: In Dr Alex Paton's fascinating account of the achievements of that eminent medical truant Dr Tom Honeyman (22 September, p 711) there is a slip. The title of Honeyman's autobiography is not *Art and Authority* but *Art and Audacity*. The difference is important, for Honeyman, who despised the official mind, had the audacity to defy authority all his days.