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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Hospital crises

SIR,—Our hospital faces yet another ongoing crisis situation. Regular readers will recall last year's contretemps, when, in the regretted absence of circuit diagrams, we attempted the recommended DHSS test for electrical safety (500 V is applied to instruments designed for use at 240 V).¹ Our electrician is much better since finding a job in industry; but, as might have been foreseen, the authorities have abolished the need for circuit diagrams by the laughably simple expedient of providing no money for new hospital equipment.

Last year we asked the district for items of medical and surgical equipment amounting to £100 000 plus depreciation. We received £25 000. This year we need £250 000. We have received—nothing. The increasing demand arose partly through the effluxion of time and partly through an influx of new, young consultants hot from the centres of excellence with strange ideas about raising standards, no financial provision for their arrival having been made by the employing authority.

We have tried to solve the perennial dilemma by asking the district management team to set aside 3% of its annual budget for replacing unsafe or worn-out equipment and for buying novel instruments of proved quality relevant to our work as a bread-and-butter hospital (we did not ask for jam). The district management team, to its eternal credit, has done so. Unfortunately, it soon became apparent that the district was seriously in the red. (This is known as "cost limits.") Our 3% will now be absorbed in recouping some of the 1978-9 deficit. Meanwhile we are short of equipment worth £250 000, of which, at a modest estimate, probably a good three-

quarters really is necessary. At the same time, in the absence of square deal RAWP, we continue to overspend revenue at the rate of some thousands of pounds a week. (People in our district have an irritating and non-cost-effective habit of getting ill; that, and their inborn craving for medicine, is really one of the most serious difficulties with which we have to contend.)

The solution to which we were inescapably driven was to seek help from our League of Friends. We hated to do this. We see it as wrong to ask the Friends to provide money which will eventually be used by doctors and nurses to treat patients: that was, and is, the statutory obligation laid on the National Health Service in 1948. However, our need was clamant. We had to compromise our beliefs in what we saw to be the best short-term interests of our patients. In the long term, of course, we have created an unforgiving precedent.

If we are now to assume that the bulk of the hospital service is to be financed from flag days, an interesting philosophical point arises. What happens, let us say, if the League of Friends decides to raise capital for a scanner for computed tomography (CT)? What if, after superhuman efforts by many decent people, a CT-scanner is duly provided? Who then is to pay for the running costs? Embarrassed health authorities, no doubt, will in due course pass on their embarrassment to the Department of Health and to the Secretary of State. In the meantime, if the equipment is not to gather dust, management teams will have been forced into changing their priorities, or acting in some other way which is likely to be to the detriment of patients.

If you spend a capital sum, whether it comes from the coffers of an impoverished Health Service or from raffle tickets, there will always be a revenue consequence, however small. To find that extra revenue on a fixed budget with little or no development money is almost an impossibility; the patient is bound to lose out somewhere along the line. That is something for our colleagues up and down the country to ponder as they strive to offer twentieth century medicine at the nineteenth century prices which the public has already paid. Give us the tools, and we will finish the job.

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¹ Scott, P V, *British Medical Journal*, 1978, 2, 632.

Which prophylactic drugs for malaria?

SIR,—The continuing trickle of letters in your columns concerning imported tropical diseases underlines the growing awareness of the importance of this subject. Rightly, chief interest centres on the control of malaria, with emphasis on the importance of publicising the need to take prophylactic drugs. However, while debate continues on the best way of ensuring that the public understands the need to take drugs for the correct period, relatively little thought seems to have been given to the question of which drug to take.

Authorities recommend, in general, that the most appropriate antimalarial drugs for most areas are pyrimethamine and proguanil. It is always dangerous to rely on others' anecdotes

and one's own experience; but in my own four years in Eastern Africa, with constant contact with patients suffering from malaria (mainly *Plasmodium falciparum* and *P. vivax*), I saw a number of patients with malaria, proved on blood slide, who, I had no doubt, had taken recommended antimalarial drugs as directed. My colleagues with similar experience and I felt there was no doubt that, at the very least, pockets of relative or absolute resistance to both the above drugs existed, and tended to recommend either one of the pyrimethamine combination drugs, such as Maloprim (pyrimethamine plus dapsone) or Fansidar (pyrimethamine plus sulphur). We used chloroquine, despite its dangers when taken over a prolonged period and the theoretical danger of developing chloroquine resistance. It is entirely reasonable to assume that a number of cases were due to poor patient compliance, but entirely unreasonable to suppose that, when one is dealing with a large number of expatriates with average or above-average intelligence, all such cases are due to this. The potential danger of inadequate prophylaxis was underlined by two cases in which relatives of my patients, after a "safari holiday" on inadequate prophylactics, died after return to Europe; in both cases, as they had been taking what was thought to be an appropriate prophylactic drug, the diagnosis of malaria had not been seriously considered, even on hospital admission. One of my patients, while on leave in England, developed cerebral malaria while being investigated for "influenza" in an English district general hospital.

Perhaps, when consideration is given to ways in which the taking of prophylactic drugs may be emphasised to the public, more thought should be given to communication with doctors in those areas of the world where malaria is endemic, and which attract large numbers of tourists. Theoretically, pyrimethamine and proguanil are the correct drugs to use in many areas of the world; theoretically, persons contracting malaria in these areas cannot have taken the drug correctly; in practice, this is just not so, and there is a real danger to visitors who rely on the advice given to them by their practitioners, who, reasonably enough, rely on expert advice given to them.

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Polio immunisation and travel

SIR,—Many recent articles, including the document produced in September by the Office of Health Economics, have brought attention to the problem of low levels of immunisation against poliomyelitis. Although the DHSS claims an overall immunisation coverage against polio approaching 80%, a number of surveys have confirmed the existence of areas where no more than 50% of children have received a full course of polio vaccine. In spite of the probability of autoimmunisation between children in a community, there clearly must be a risk that considerable numbers of children and adults are currently susceptible to infection with polio. There must be a risk of epidemic spread should the "wild" virus be reintroduced from infected areas.

The purpose of this letter is to draw your attention to the magnitude of this risk. Several

surveys in countries popular in the tourist circuit, such as Thailand and Egypt, have shown that the prevalence of residual paralysis after polio is much higher than has been officially reported to the World Health Organisation. Our own surveys in several tropical countries have shown an annual incidence of 37 cases per 100 000 children, approximately 15 times the reported incidence.

Clearly, our priority must be to eliminate the disease in those countries still harbouring endemic transmission, but almost as important should be the inclusion of polio immunisation as a prerequisite for all travellers to the tropics and the maintenance of high levels of immunisation in the developed world. The minor risk of vaccine-associated cases is outweighed by the potential tragedy of polio among travellers and the risk of further epidemics in polio-free countries.

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Measles and vaccine protection

SIR,—I believe Dr G A Jackson may have misinterpreted his data on measles and measles complications among vaccinated and unvaccinated individuals (4 August, p 332).

Most epidemiologists would apply a statistical test to the measles complication rate observed in those vaccinated ($18/147 = 12.2\%$) and those unvaccinated ($34/348 = 9.8\%$). The chi-squared test using the Yate's correction factor indicates that these two rates are not significantly different ($\chi^2 = 0.43$, $P > 0.05$). There is also no significant difference in the proportion of vaccinated and unvaccinated cases classified as being severe.

More importantly, the complication rates in the two groups—even if different—cannot be used to assess correctly the protection afforded by measles vaccine (that is, the vaccine efficacy). Rather, one needs to know, as Dr Jackson points out, the measles attack rate of vaccinated (AR_{vac}) and unvaccinated (AR_{un}) individuals. Dr Jackson's table provides only the proportion of measles cases which were either vaccinated or unvaccinated. The vaccine efficacy (VE) is the percentage reduction in the measles attack rate attributable to measles vaccine—that is, $VE = [(AR_{un} - AR_{vac})/AR_{un}] \times 100$. Reported measles vaccine efficacy has been at least 90% in most studies.¹²

When the data necessary to calculate vaccine efficacy are available, it is essential to realise that as the proportion of vaccinated individuals in a community increases, the proportion of measles patients with a history of previous vaccination will increase.¹³ These cases are a result of primary vaccine failure, which can be expected in 5-10% of vaccine recipients who fail to seroconvert and are thus unprotected.⁴ Dr Jackson should not therefore be surprised that almost one-third of his patients had been vaccinated. Ideally, when 100% of the population has been vaccinated, 100% of the few measles cases which may occur will be in persons who have been vaccinated. Causes of primary vaccine failure, in addition to the inherent 5-10% non-seroconversion rate, are, as Dr Jackson notes, improper vaccine shipping, storage, and handling.¹ Waning vaccine-induced immunity (that is, secondary measles vaccine failure) has not been observed.¹⁴

As measles vaccine coverage increases, a

full understanding of the concept of vaccine efficacy becomes increasingly important. Along with surveillance data, it is one of the best tools to illustrate to the public that vaccines are safe, useful, and effective.

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¹ Hayden, G F, *Clinical Pediatrics*, 1979, 18, 155, 167.

² Marks, J S, Halpin, T J, and Orenstein, W A, *Pediatrics*, 1978, 62, 955.

³ Center for Disease Control, *Measles Surveillance 1973-1976*. Atlanta, Georgia, CDC July 1977.

⁴ Krugman, S, *Journal of Pediatrics*, 1977, 90, 1.

Smallpox vaccination

SIR,—The article on smallpox vaccination (8 September, p 617) coincided with a further case of accidental vaccinia which I saw at our eye hospital. A 5-year-old boy had sustained an accidental vaccinia of his left eyelids through contact with a family who had recently been vaccinated before going abroad.

Over the years I have seen a number of such cases. They are always worrying in case corneal involvement should take place with permanent scarring. It seems to me that such cases may become more common now that routine vaccination has been stopped and we have a totally susceptible childhood population. When vaccination is carried out would it not be wise to cover the vaccinated area to limit the possible spread to others?

In this recent case, as in previous ones, the Public Health Laboratory Service Laboratory at Colindale kindly provided hyperimmune gammaglobulin both for intramuscular injection and to be made up as a topical application in the form of eye drops.

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Smallpox vaccination in the Forces

SIR,—I have recently been approached by one of my patients who is a member of one of the Royal Naval reserves and who is about to go to Germany on his annual camp. He came to see me requesting smallpox vaccination since it was three years since he had had his last one, and produced for me a letter instructing him that he must obtain such vaccination before he joined his unit. I explained to him the situation with regard to the prevalence of smallpox in the world today and the requirement for vaccination, but while he appreciated my arguments he pressed for vaccination since he did not wish to be turned away from his camp.

It seems to me most strange that the Forces are still requiring smallpox vaccination in such circumstances and I should like to question this as a general policy.

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Are breast-fed babies still getting a raw deal in hospital?

SIR,—I was greatly encouraged to read the paper by Dr Phyllis Culley and others (13 October, p 891). At last the medical profession is coming to recognise what many nursing