provided by the NHS, local authorities, or the community. Various approaches to this task have been reported.¹ They provide a sounder basis for progress in this difficult area of planning than calls for a uniformity which is unattainable in the present economic conditions.

M E NORRIS

Centre of Organisational and Operational Research,
Tavistock Institute of Human Relations,
London NW3 5BA

¹ Wager, R, *Care of the Elderly—An Exercise in Cost-benefit Analysis*. London, Institute of Municipal Treasurers and Accountants, 1972.

² Towell, D, and Harries, C (editors), *Innovation in Patient Care*. London, Croom Helm, 1979.

³ Gregory, E, and Norris, M E, *Planning for the Elderly in Redbridge*. Birmingham, Clearing House for Local Authority Social Services Research, No 4, 1977.

⁴ Canvin, R, et al, *Health and Social Services Journal*, 18 August 1978, p C17.

SIR,—Our combined experiences, derived from clinical and research involvement with old people in need of services, lead us to question the optimism expressed in your important leading article (20 October, p 952).

The predictions that in the future more elderly people will have been married and a higher proportion will have had children are insufficient to justify the assertion that pressure of institutional care will be lessened. Other demographic and social changes (increases in the numbers of the very old, greater likelihood of widowhood or divorce, increased geographical mobility, smaller family size, increased employment of women, etc) suggest that the numbers of elderly people without support in the community will increase. This, combined with the fact that many of these individuals will be disabled by diseases, among which the dementias are the most common and most likely to terminate social competence, suggests that pressure on institutional facilities will increase during the next 20 years.

Many disabled old people can be responsibly managed only where supervision is available round the clock. "Sheltered housing," as currently conceived, is often less able to cope with the problems than are the households from which people have been moved.¹ Residential homes, despite low staffing levels and the virtual absence of the remedial skills of occupational therapists and physiotherapists, do cope. However, there is little doubt that the social milieu of such environments could be improved. It is not our experience that there are armies of misplaced people in these homes who would be "cured" by medical intervention. Most have been thoroughly investigated and have received appropriate treatment within the limitations of the medical model. Neither are there large numbers who would benefit from or even be accepted for sheltered housing.

At the present time practitioners struggle to share out the meagre facilities available among people becoming disabled through illness in old age. It will not be long, as you rightly point out, before matters are compounded by a need to provide care for many chronically impaired psychotics who have experienced the rigours of "community care" and who are now growing old.² They will surely be strong competitors for the same meagre facilities.

Clarity of thought and well-defined principles will go a long way but there will be immense hardship among blameless old people and their relatives unless they are matched

by a massive increase in expenditure to bring the capacity of services in line with the needs.

DAVID JOLLEY
G EVANS
BEVERLEY HUGHES
IAN STOUT
D WILKIN

Psychogeriatric Unit,
Withington Hospital,
Manchester M20 8LR

¹ O'Brien, T D, MD thesis, University of Cork, 1970.

² Hawks, D, *British Journal of Psychiatry*, 1975, **127**, 146.

"Moon dust" and eye injury

SIR,—A few days ago a girl was seen in my department with a subconjunctival haemorrhage. This had occurred immediately after she had got some crystals of "moon dust" or "pop rocks" on her fingers and rubbed them in her eye. Until then I had not heard of this material, which I gather is on general sale to children. The individual crystals explode in the mouth with considerable force, and it is obvious that if they come into contact with moisture in an eye they can also explode with considerable force, resulting in damage.

I wonder whether anyone has had experience of a similar incident.

CYNTHIA ILLINGWORTH

Accident and Emergency Department,
Children's Hospital,
Sheffield S10 2TH

Ethics of drug promotion

SIR,—Dr G K Crompton writes about the policy of Sandoz Products Limited in relation to the promotion of the recently introduced product Zaditen (3 November, p 1141). His criticisms have been noted and those points in his letter which are relevant to the Code of Practice for the Pharmaceutical Industry are being investigated with a view to referral for examination by the Code of Practice Committee of the Association of the British Pharmaceutical Industry.

ARTHUR G SHAW

Secretary, Code of Practice Committee

Association of the British
Pharmaceutical Industry,
London W1R 6DD

SIR,—Although Dr Graham K Crompton's views as a clinician must be respected, we cannot let the statements and allegations about Zaditen (ketotifen) made in his letter (3 November, p 1141) pass without rebuttal.

His allegation that the clinical trial data in support of the efficacy and safety of Zaditen is scanty is simply untrue. Zaditen has been extensively researched and is well documented as an orally active agent for the prophylaxis of asthma, with a long duration of action and a demonstrated steroid-sparing effect. It was introduced in Switzerland in January 1978, and has subsequently been introduced in seven other countries including Germany, Ireland, and Holland. The product has also been approved by the licensing authorities in France and Belgium and is the subject of 30 clinical publications, and results have been presented at many international congresses. UK trials demonstrating safety and efficacy were considered by the Committee on Safety of Medicines before a product licence was

issued. Contrary to Dr Crompton's assertion about "undisclosed 'data on file'" he, like many others, has sought and readily obtained from us additional clinical data substantiating our claims.

There is also criticism of the post-marketing surveillance (PMS) which we are conducting. However, the need for such surveillance, in order to monitor long-term safety and efficacy of any new drug, is widely accepted in academic medicine, the DHSS, and the pharmaceutical industry. Furthermore, reference to the readily available literature on the subject shows clearly that the Zaditen PMS is based on various earlier PMS schemes. The support of the medical profession is essential to the success of any such project and payment to individual doctors for the extra work to which they commit themselves is accepted practice.¹

Clearly the Code of Practice Committee of the Association of British Pharmaceutical Industries is fully competent to decide on the issues raised and my company is confident of the outcome. Equally we believe that Zaditen will find its place in the treatment of asthma according to the experience and judgment of the medical profession in general.

M G MEISTER

Sandoz Products Limited,
Pharmaceutical Division,
Feltham, Middx TW13 EP

¹ *Post-marketing Surveillance of Adverse Reactions to New Medicines*: report of meeting held on 7 December 1977 under the chairmanship of Sir Richard Doll, p 16. Medico-Pharmaceutical Forum Publication No 7, 1977.

Aspirin and transient ischaemic attacks

SIR,—Aspirin is a potent antiplatelet agent, and randomised trials on many thousands of patients have suggested that daily aspirin in the year or two following myocardial infarction will prevent about one-fifth of the late deaths that would otherwise have occurred. Reports on three more large trials (one organised in Cardiff and two in America) are now in press, and if they confirm the pattern suggested by the trial results so far available then no reasonable doubt will remain that most discharged myocardial infarction patients should be offered daily aspirin for a time, unless some specific contraindication is evident. However, in our view this will be the only category of patient for which daily aspirin is of proved value. There are many other categories of patient (for example, patients with transient ischaemic attacks (TIA), diabetics, hypertensives, those with a distant history of myocardial infarction, etc) where it might be of value; but in all of these direct proof is lacking.

Trials have also been reported on TIA patients with quite promising results^{1,2} but these trials were very much smaller than the postmyocardial infarction trials; the confidence limits on the estimated benefits were wide; and in our view it is still quite possible that on balance TIA patients will derive little or no material benefit from daily aspirin, despite its present promise. Twenty-seven neurological centres throughout Britain are therefore collaborating in a randomised trial of aspirin, financed by the Medical Research Council, which will we hope be larger, and therefore more precise, than the TIA trials thus far available. Rather than accept your medical expert's advice (29 September, p 785) that

TIA patients should simply be given daily aspirin, we would urge general practitioners or others who see any TIA patients over the next few years to refer them to one of the neurologists collaborating in the UK TIA aspirin trial, so that reliable information will eventually emerge. We would be pleased to supply inquirers with the name of a nearby collaborator.

RICHARD PETO
CHARLES WARLOW

UK-TIA Aspirin Study Office,
Radcliffe Infirmary,
Oxford OX2 6HE

¹ Fields, W S, *et al*, *Stroke*, 1978, 8, 301.

² Canadian Co-operative Study Group, *New England Journal of Medicine*, 1978, 299, 53.

Reflux oesophagitis trials

SIR,—Dr Roger Ferguson and others (25 August, p 472) are to be commended on their objective evaluation of medical treatment of reflux oesophagitis, an exercise all too infrequent despite the burgeoning practice of fibre endoscopy.

There is an urgent need for a revised classification of reflux lesions since the conventional one used by the authors is inaccurate and therefore should be abandoned: grade I—reddening—grade II—friability—are too subjective for critical evaluation; while category III—ulceration—would require grading of the type and extent. A revised classification must incorporate discrete shallow ulcers,¹ which in my experience are not only the most common endoscopic manifestation of reflux² but also the most common of all observable upper gastrointestinal lesions encountered at medical endoscopy clinics.

B A SCOBIE

Wellington Hospital,
Wellington 2,
New Zealand

¹ Allison, P R, *Lancet*, 1979, 2, 199.

² Scobie, B A, *Medical Journal of Australia*, 1976, 1, 627.

Chance, coincidence, serendipity

SIR,—Dr William Evans' article (6 October, p 847) brings to mind a case which I managed while acting as medical officer to the British Colombo Plan Team at Thakhek in Central Laos in 1965.

A 5-year-old boy was admitted having been shot in the left leg five days previously. He had been carried to the hospital from his village by his parents. On admission, he was unconscious from exsanguination. He had been shot twice; the first bullet had passed harmlessly through the fleshy part of his left thigh, and the second bullet had struck the left shin causing an area of skin loss 10 × 7.5 cm and fracturing and removing part of the tibia. Fortunately, he was of the same blood group as his father, from whom a pint of blood was taken and given directly to the son. This transfusion was sufficient to bring him round and make him fit for an anaesthetic.

I felt that the best treatment would be amputation of the left leg through the knee, but the family refused to agree to this, saying, probably correctly, that if he lost his leg he would be unable to plant his rice fields when he grew up and therefore it would be better for him to die. The family, however, gave permission for exploration of the wound under anaesthesia. An extensive debridement was

carried out but the result was not entirely satisfactory. Two jagged bone ends projected into the wound and were exposed on the surface, and it was difficult to know after five days whether all the necrotic tissue had been removed. The wound was dressed and then, following Professor Trueta's advice given at the time of the Spanish civil war, a split plaster was applied and nature allowed to take its course.

Within a few days the plaster was wet from suppuration and the odour in the ward extremely unpleasant so that, for the sake of the other patients, the child had to be isolated. Maggots then began to appear through the split in the plaster. The family were extremely distressed because they believed that the maggots would travel throughout the boy's body. I explained that maggots live only on carion and would make a far better job of cleaning the wound than I could do surgically. I applied more plaster and took the plaster shears home for safe keeping.

The family formed a rota and sat on guard over the plaster day and night with a pair of forceps at the ready to grab any maggot unwise enough to show himself. This was kept up for three weeks, after which the pressure to remove the plaster became too great to resist. The theatre was full of spectators about whom I could do nothing and the atmosphere frankly hostile. The wound was exposed to reveal an extraordinary sight. The jagged bone ends had disappeared. The skin margin was already epithelialising and the wound itself a bed of pink granulation tissue completely free from any sign of secondary infection. In the centre of this bed, curled up as if asleep, lay one pearly white maggot. I redressed the wound and applied a second plaster.

Two months later the plaster was removed and the boy walked out of the hospital, thanks to Professor Trueta and the maggots.

B W HACKMAN

Peterborough Maternity Unit,
Peterborough PE3 6BP

SIR,—Surely the nursing sister from the London Hospital, in Dr William Evans's story about the liver treatment of pernicious anaemia (3 November, p 1123), was none other than the remarkable Rose Simmonds, well known in the hospital 50 years ago? She specialised in diets and dietary treatment, as of diabetes and obesity; quantifiers used to calculate the number of tons of fat she had removed from the stout ladies of Whitechapel whom she saw in outpatients and convinced that dieting was worthwhile. The hospital gave her leave of absence to study in Boston, where she saw what Minot and Murphy were doing before it came to be published. On her return, so it was said, she reported to her medical superiors that liver would cure pernicious anaemia, and wept with frustration when they would not listen to her—until they read it in print.

ROBERT AITKEN

Birmingham B15 2PH

Celestin tubes

SIR,—I was interested to read recently the report by Dr P Brown and Mr R G Hughes (20 October, p 970). The complication reported is, of course, unfortunate and should

be preventable in the future with minor design modification to either the Celestin tubes or the Nottingham introducer. It would be unfortunate if this report inhibited the use of endoscopic tube insertion, which is a major advance in the safe palliation of oesophageal cancer. I have personally inserted more than 30 tubes in this way, the only mishap being a single oesophageal perforation early in the series. Others, I am sure, have more extensive experience.

All tubes are liable to blockage or slippage and one of the major advantages of the Nottingham system is the ease with which tubes can be removed and replaced with little upset to the patient. This is in marked contrast to operative insertion, which is associated with major morbidity in terms of wound infection and a very significant mortality.

JOHN BANCEWICZ

University of Manchester Department of Surgery,
Hope Hospital,
Salford M6 8HD

SIR,—In attributing the disintegration of a Celestin tube to faulty technique in its introduction Dr P Brown and Mr R G Hughes (20 October, p 970) have overlooked the fact that considerable deterioration often occurs in the latex of these tubes after they have been in position for six months irrespective of the means of their introduction. Denaturation of the latex results in loss of elasticity, softening, and ultimate disintegration along the whole length of the tube and we now inspect and if necessary replace tubes six months after insertion.

In over 80 intubations using the Nottingham introducer we have not encountered damage to the tube, but it could easily be recognised if the endoscope is passed down the inside of the tube immediately after its insertion to inspect its wall and check the position.

R FERGUSON
A L OGILVIE
M ATKINSON

University Hospital,
Nottingham NG7 2UH

SIR,—In their article "Late complication of endoscopic oesophageal tube insertion" (20 October, p 970), Dr P Brown and Mr R G Hughes report that deterioration of Celestin tubes has previously been reported only after they had been in position for more than two years. This is not so.

A report from this hospital published elsewhere¹ detailed two cases in which patients with tube deterioration of the kind described by Dr Brown and Mr Hughes presented 14 months after insertion. In these cases the tubes were inserted at laparotomy for benign stricture, so that neither undue force on the tube wall at the time of introduction nor post-operative irradiation could have contributed to the deterioration. As the tubes in all cases were found either in the stomach or beyond, it is possible that deterioration and fracture occurred subsequent to their distal displacement beyond the stricture.

JAMES BRISTOL

Royal United Hospital,
Bath BA1 3NG

¹ Ranson, M B, and John, H T, *British Journal of Surgery*, 1979, 66, 110.