polio, and therefore possibly increase the protection against pertussis too.

Unfortunately, with the third dose not due until 13-14 months, many children did not complete the course and were inadequately protected. The situation has been made worse since 1974 by what appear increasingly to be unfounded assertions that pertussis vaccine causes brain damage. Mass hysteria, fanned irresponsibly by television and the press, resulted in such low vaccination rates that small babies were no longer being protected indirectly by vaccinated older siblings; and this occurred in spite of the resolute advice of the DHSS.

It is therefore prudent, now, to vaccinate as soon as the child can respond satisfactorily—that is, at 3 months.² The intervals between doses are of much less consequence, the “delayed” schedule showing no obvious advantage over the “early” one as far as the pertussis response is concerned.³ My own preference is for the “early” one—to protect against whooping cough as soon as possible, and to complete the full course before the parents’ enthusiasm wanes. This too is what the DHSS now offers as an alternative course when whooping cough is prevalent; and, thanks to the adverse publicity of the mid-1970s, the present epidemic situation is likely to persist for many years—until a steady vaccination rate of over 80% has been re-established.

One lesson that we can all learn from whooping-cough in the 1970s is that preventive medicine often consists of measures that cannot be switched on and off as danger threatens and recedes. Advances may be dramatic; but without eternal vigilance and steady consolidation, unspectacular and mundane though these may seem, the whole front retreats in disarray.

NOEL W PRESTON

Department of Bacteriology
and Virology,
University of Manchester

¹ Perkins, F T, *British Medical Journal*, 1969, 4, 429.

² Preston, N W, *Lancet*, 1976, 1, 1065.

³ Preston, N W, et al, *Journal of Hygiene, Cambridge*, 1974, 73, 119.

Clofibrate

SIR,—My colleagues and I¹ in 1973 showed that 33 consecutive patients with serum cholesterol levels over 7.8 mmol/l (300 mg/100 ml) and thyroid antibodies had a mean serum cholesterol of 9.5 mmol/l (366.8 mg/100 ml) (SD ± 1.7) before treatment with clofibrate and 6.2 mmol/l (239.4 mg/100 ml) (SD ± 0.9) after treatment. The reduction of 39.5% in our group of patients compares with 9% reported from the multicentre trial of clofibrate.² About the time that we wrote our paper Krasno and Kidera³ showed that 30% of all patients with hypercholesterolaemia failed to respond significantly to clofibrate. We subsequently found that the reduction of the hypercholesterolaemia by clofibrate in patients with autoimmune thyroiditis is so constant that failure of the serum cholesterol concentration to fall suggests that the abnormal lipid pattern is not associated with thyroid disease.⁴ We have used clofibrate to lower the serum cholesterol concentration of patients with angina complicating myxoedema who could not tolerate full doses of L-thyroxine despite β -adrenergic blockade. Baschieri and his colleagues⁵ have shown that

a third of patients with hypercholesterolaemia have an abnormal pituitary thyroid axis.

If a trial on the use of digitalis in heart disease were set up with the skill and care that Oliver and his team have shown in this trial on clofibrate, it might provoke similar comments to those of your leading article (9 December, p 1585). Discrimination is needed in the use of clofibrate as with most other drugs. It is to be hoped that reports in the *Financial Times*⁶ that the drug may be banned in West Germany are premature. Such a panic move at this time smacks of totalitarian medicine.

P B S FOWLER

Charing Cross Hospital (Fulham),
London W6

¹ Fowler, P B S, Banim, S, Ikram, H, unpublished observations.

² Committee of Principal Investigators, *British Heart Journal*, 1978, 40, 1069.

³ Krasno, L R, and Kidera, G J, *Journal of the American Medical Association*, 1972, 219, 845.

⁴ Ikram, H, Banim, S, and Fowler, P B S, *Lancet*, 1973, 2, 1405.

⁵ Baschieri, L, et al, *Française d'endocrinologie clinique, nutrition et métabolisme*, 1975, 16, 211.

⁶ *Financial Times* 21 December 1978.

Return of whooping cough

SIR,—In writing about the return of whooping cough (9 December, p 1639) Mr Roger D Strachan contends that the increased incidence must be due to the decline in immunisation, which in turn was largely caused by adverse publicity in recent years.

The evidence to test these assumptions exists wherever reasonable immunisation registers are kept. For instance, data from Hertfordshire¹ clearly show that whooping cough attack rates in non-immunised children (841/100 000) are more than 10 times greater than those in the immunised (80/100 000). The non-immunised comprised 37% of children under 5 years.

Since whooping-cough immunisation is an automatic component of DPT vaccine, the decision to exclude it shows a definite change in behaviour. This began to occur in 1974, as seen in the figure, which shows the monthly whooping-cough immunisations given in Hertfordshire as a percentage of all primary immunisations including diphtheria, tetanus, or whooping-cough vaccine. Not only is the fall-off of whooping-cough immunisation

clearly shown but so also is the association with the major events in the media (arrowed) which featured the whooping cough controversy during that period.

The whooping cough controversy is a good example of the problem of behaviour and risk. Lord Rothschild, in his recent Richard Dimbleby lecture on risk,² suggested that “What we need . . . is a list or index of risks and some guidance as to when to flap and when not”; for “there is no such thing as a risk-free society.” Furthermore, “we are much more conscious of risks today . . . not only because we are better educated . . . but also because the media . . . bring to your notice infinitely more information.”

I think that the medical profession needs to respond to this challenge and produce an index of health risks, meaningfully related and straightforwardly stated. The whooping cough controversy and its consequences is a clear example for the need of such an index.

MICHAEL CHURCH

Health Education Council,
London WC1

¹ Church, M A, *Hospital Doctor*, 1978, 1 (4), 10.

² Rothschild, Lord, *The Listener*, 30 November 1978, p 715.

Motorcycle and bicycle accidents

SIR,—As a recently retired surgeon who has returned to cycling after 50 years, I read the informative article “Motor cycle and bicycle accidents” by a special correspondent (6 January, p 39) with considerable interest. After having cared for many patients with head injury in my wards (frequently motorcyclists, with fewer cyclists), I now find myself in a reversed situation, being at risk as a cyclist on the roads.

There are several points of importance as regards cyclists which were not mentioned in the article. It struck me very soon that good hearing is almost as important as good eyesight when cycling. Normal hearing has often made me aware of the approach of a heavy goods vehicle from the rear and enabled me to take evasive action. This is especially so in the country roads. Apart from the dangers of heavy articulated vehicles and the sudden opening of stationary car doors, cars towing caravans can be a menace. Some car drivers

Monthly whooping-cough immunisations given in Hertfordshire 1971-78, as a percentage of primary immunisations including diphtheria, tetanus, or whooping-cough vaccine. Arrows indicate media events which featured the whooping cough controversy, as follows:

1. January 1974: television programme—*Nationwide*; 2. March 1974: TV programme—news; 3. September 1974: TV programme—*Aspel and Co*; 4. February 1975: TV programme—*Nationwide*; 5. May 1976: articles in the *Sunday Times* and the *Guardian*; 6. January 1977: TV programme—*Pebble Mill at One*; 7. February 1977: TV programme—*Nationwide*; 8. March 1977: TV programme—*Pebble Mill at One*; 9. April 1977: TV programme—*Inside Medicine*.

seem to be completely unaware that the caravans they tow are wider than their car. I certainly have missed catastrophe by inches from towed caravans.

I would make a special plea for the separation of cyclists from motor traffic by special cycle routes or tracks in towns. Your correspondent says that the entrance and exit of cycle tracks may be awkward, but these could be controlled by traffic lights.

I do not think that a cycling proficiency test for any adult cycling on a main road should be mandatory, but all children who cycle should certainly take a school or similar cycling test. The wearing of helmets by cyclists should be encouraged, but it could be enforced legally only with difficulty. It must be remembered that the beauty of cycling, apart from exploring the byways that many motorists have forgotten, is the convenience for short journeys—no getting the car out of the garage, no difficulty with starting, no parking problem at the shops, etc.

May I suggest that your special correspondent might have got in touch with the Cyclists' Touring Club (69 Meadow, Godalming, Surrey), the cyclists' national body which runs an insurance scheme for cyclists and has the widest knowledge of the hazards of cycling, especially for adults. May I further suggest that anyone in later life taking up cycling for exercise and enjoyment would find the CTC most helpful in many ways quite apart from accidents, as I have done.

NOEL F KIRKMAN

Sale, Cheshire

No driving licences for alcoholics?

SIR,—With reference to your recent articles on road accidents and the unfit driver (25 November, p 1471) and on road accidents and driving behaviour (2 December, p 1551), I wonder how many doctors realise that all alcoholics are expected to notify their "disability" to the Driver and Vehicle Licensing Centre, Swansea, and are liable to a fine not exceeding £100 if they do not do so. Under present interpretation of the regulations it appears that they are likely to have their licences withdrawn unless or until they can claim or prove two years' total abstinence. I was astonished to learn that this was so when I was recently approached by the DVLC about a patient treated in this unit who had applied for routine renewal of his licence. (No offence had been committed, nor had the previous licence lapsed.) Only after I had reluctantly undertaken to notify the DVLC if this man took any drink, or failed to keep in touch with me every week, was a new (temporary) licence issued.

I am wholeheartedly in favour of road safety and I unreservedly condemn driving under the influence of alcohol; but it seems to me that the regulation is invidious, ineffectual, impractical, and likely to bring the law into disrepute. Alcoholics, when sober, are arguably no worse drivers than the rest of us, and many alcoholics are careful not to drive when drinking. Furthermore, very few alcoholics are likely to notify the centre and it is the more irresponsible and less insightful who will fail to do so.

How is the DVLC to be satisfied that two years' abstinence has in fact been reached? Are doctors to become big brothers for Swansea and lose the trust and co-operation of their patients? And what about the

(admittedly few) alcoholics who attempt to revert to social drinking or who have only an occasional lapse? The DVLC claims to have expert advice that "one year of complete abstinence should give rise to optimism, and two years to confidence in the provision of a driving licence." I wonder if the expert anticipated the results of his advice?

W A ELLIOTT

Tayside Area Alcoholism Unit
Sunnyside Royal Hospital
Montrose, Tayside

Erythromycin in legionnaire's disease

SIR,—Your leading article on legionnaire's disease (11 November, p 1319) comments that "American enthusiasm for erythromycin was not justified by the British experience." We saw three patients with a confirmed diagnosis of legionnaire's disease last summer who were all treated with erythromycin. They all recovered, though one developed renal failure requiring temporary peritoneal dialysis.

A particularly dramatic clinical response to erythromycin was shown in the third case, that of a 34-year-old woman admitted five days after returning from holiday in Spain. She had been unwell for three days with cough, headache, and vomiting with some diarrhoea. She was ill with a temperature of 40.6°C and a dry cough but had no abnormal signs in the chest. Splenomegaly was present. Chest x-ray demonstrated pneumonic consolidation at the base of the right lung and the clinical diagnosis of legionnaire's disease was confirmed by a titre of 1/32 rising to 1/1024 after a week. Erythromycin was started on admission, resulting in defervescence and rapid improvement within 24 h. The response was directly associated with the use of erythromycin and this was the only antibiotic used. In a disease which carries an appreciable mortality erythromycin should be administered promptly in any case of suspected legionnaire's disease. Response may be unsatisfactory in some patients but may be dramatic and life-saving in others.

M W MCKENDRICK
A M GEDDES

Department of Communicable and
Tropical Diseases,
East Birmingham Hospital,
Birmingham

Smear campaign

SIR,—I read with interest the letters from Mr T R Cullinan and Dr Leslie Ellis (16 December, p 1711) and am in full agreement with their thoughts on this subject. As one who has had more than 25 years' experience in vaginal cytology, may I explain some of the points they raise?

Firstly, the form of which Dr Cullinan so aptly comments. Having myself been many years in advance of the Department of Health and Social Security I had to design my own form and I soon learnt that the more items you put on it the less likely you are to get any worthwhile answers. My form required 11 pieces of information which I considered necessary to the correct interpretation of the smear. Over many years I found I was lucky if I got 75% of these facts filled in. I was concerned at national level over the setting up of the present form. My role was to prevent it ever seeing the light of day, but, alas, in this object I was singularly unsuccessful. Among

its main disadvantages are its length and complexity and the fourth carbon copy never seems to come out. It does not fit easily into any known filing cabinet and in its present form it is unsuitable for computerisation. These things I discovered by using it in conjunction with my colleagues both in hospital and in general practice.

Both Mr Cullinan and Dr Ellis ask for information on the timing of resmearing, and the answer to this is easy. In the first instance, the resmear should be in one year (a small percentage of first smears are false-negatives) and thereafter at five-year intervals until the age of 60, when it can be discontinued.

Dr Ellis quotes the mystical figure of age 35 as the time of taking the first smear and I can tell him how this was arrived at. Many years ago the late Dr Joe Bamforth was asked by the Department at what age smearing should commence. Not being a clinician he consulted a senior gynaecological colleague (who, incidentally, was not known for his interest in cervical cancer), who replied that he had never seen the disease before the age of 35. Thus this figure stuck and of course anything which sticks at the Department can only be removed by revolution or explosion. It is many years since Dr Bamforth told me these facts, but, despite the arguments of many of us, this mystical and mythical figure is largely adhered to. The fact is that ideally the first smear should be taken as soon as possible after the first act of intercourse, however young that may be.

STANLEY WAY

Gosforth,
Newcastle upon Tyne

Comparison between communities

SIR,—The series "Epidemiology for the Uninitiated" by Professor Geoffrey Rose and Dr D J P Barker makes fascinating reading to those interested in the epidemiology of diseases in developing populations.

In their recent article on "Aetiology-comparison between communities" (25 November, p 1483), we were taken aback by the view that the reported low incidences or prevalences of certain diseases in developing populations—for example, in Africa—may be more apparent than real, depending on how hard one looks. However, not all observations are made at small, isolated, rural mission hospitals: some are made at large, well-equipped city hospitals, of which there are several on this continent.

The authors refer to appendicitis. Locally (1) from records of operations in hospital, (2) from prevalences of operations in school pupils, and (3) from prevalences of operations in the huge number of labourers in the mines (whose medical facilities are excellent) we know that the low prevalence of appendicectomies in blacks is entirely real and not apparent. In large centres of population patients are assuredly not "more likely to die before they reach hospital."

Uncertainties due to variations in diagnostic practice are mentioned. In numerous fields there are differences in standards or in diagnostic criteria—growth, blood pressure, rickets, diabetes, coronary heart disease, etc. Accordingly the problem of determining whether ulcerative colitis (cited by the writers) is or is not rare is appreciated. However, the very much lower occurrence of the disease in urban South African blacks is undoubted.