more recently have contained small numbers (less than 24 organisms per ml) of spore-bearing *Bacillus* species.

While we have no evidence that any patient became infected by pseudomonads of these species, it would be unwise to assume that they may not take on an opportunistic role in patients who are immunologically impaired. We would therefore recommend that control of infection teams are alive to this possibility, that hospital water is from time to time monitored microbiologically, and furthermore that domestic hot water in general hospitals is maintained at a temperature adequate to kill vegetative bacteria.

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¹ Department of Health and Social Security, *Hospital Services Engineer* No 30. London DHSS, 1976.

The wrong drug

SIR,—I read your leading article "The wrong drug" (12 May, p 1233) with interest. It seems to me that you left out the problem of drugs prescribed by hospital doctors at outpatient clinics and by general practitioners.

It has been my practice to have a look at the drugs I prescribe for my outpatients. Every time they come to see me I ask them and their relatives to bring the drug bottle. This has several advantages. The doctor gets an opportunity, firstly, to see whether the patient is getting the right drug or drugs and the right dosage and to find out what other drugs the patient is taking, as patients do receive treatment from more than one doctor for different ailments and the communication between doctors does break down; secondly, to see whether the patient is taking them as prescribed; thirdly, to discuss the side effects of the drugs with the patients and relatives and to point to which drug is causing what side effects (this is particularly useful when the patient is on more than one drug); fourthly, to be confronted by different types of drugs, which by their sheer number may have some sobering effect on the prescription habit; and, finally, to establish a better doctor-patient relationship by giving the patient the impression that he does care by checking the medicine he orders.

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Falciparum malaria despite chemoprophylaxis

SIR,—The letter from Dr S J Bentley continuing the discussion about partial suppression of falciparum malaria by chemoprophylaxis (19 May, p 1351) raises some important points concerning suitable prophylactic measures.

Having spent three and a half years in the Gambia, I fully endorse his statement that pyrimethamine in a dose of 25 mg weekly does not give adequate prophylactic cover. An increase of the dose to 25 mg every five days or 50 mg weekly is usually fully effective. There is also an increase in resistance to proguanil (Paludrine) in a daily dose of 100 mg. My wife has the dubious distinction of being the first

recorded case of malaria in the Gambia in a subject taking regular proguanil. I am not altogether happy about the suggestion of taking chloroquine as a prophylactic. This is a very valuable therapeutic agent for the treatment of overt attacks of malaria and its widespread use as a prophylactic agent is likely to speed up the development of resistant strains of plasmodia. These are already widespread in parts of the Far East.

A further point to consider is the question of chemoprophylaxis in women starting a family. Pyrimethamine, as a potent inhibitor of folate metabolism, is not to be recommended. I have seen the detrimental effects of chloroquine when continued throughout pregnancy. Many of the expatriate community in the Gambia used chloroquine and, although this was by no means a controlled study, many women had small babies, delivered early, and—in one case at least—with auditory defects, probably attributable to the drug. Martindale's *Extra Pharmacopoeia* recommends proguanil as the drug of choice for malaria prophylaxis in pregnancy, but what advice should be given to women in areas where there is marked resistance to this drug?

It is very important that those travelling abroad, whether on business or on holiday, should receive advice about malaria prophylaxis that is up to date. Such advice is very important but is not easily come by. Chemoprophylaxis is very effective, if the correct drug for the situation is taken in an adequate dose and continued for four weeks after exposure.

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One man's schizophrenic illness

SIR,—I was very impressed by the excellent description presented by Mr Peter Wescott (14 April, p 989) in his personal paper "One man's schizophrenic illness." After reading his report a second time, I had the strong impression that Mr Wescott, despite the fact that he can write so well and present his symptoms in such a comprehensible manner, could possibly be doing even better if his medication regimen were modified.

Mr Wescott's description of the "four suicidal attempts and some period of suffocating depression" suggests that his diagnosis should possibly be modified to be that of schizoaffective illness, or what Dr Carlo Perris of Sweden prefers to call cycloid illness. If Mr Wescott had been treated at our medical centre, he would have been on an adequate course of lithium; small dosages of a neuroleptic would have been added only if he had shown an insufficient response to lithium. I am quite sure that the same treatment would have been rendered in Dr Perris's medical faculty. The reason for my writing this letter is that Mr Wescott sometimes feels "that the richness of my pre-injection days—even with brief outbursts of madness—is preferable to the numbed cabbage that I have become." He goes on to say, "... once I lived in a fascinating ocean of imagination, I now exist in a mere puddle of it." These excerpts are excellent examples of the side effects of neuroleptics and at the same time indicate that he should have the opportunity of an adequate exposure to lithium therapy, only being given neuroleptics in very small doses if the lithium falls short in the therapeutic goals.

Mr Wescott's comments about the "family GP" and about psychiatrists in general should be a teaching lesson for all of us psychopharmacologists. I hope that Mr Wescott has the opportunity to read a review of this problem by Carlo Perris.¹ I not only wish Mr Wescott the very best in the future but also hope that he has the opportunity to return to the richness of his pre-injection days.

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¹ Perris, C, *Archives of General Psychiatry*, 1978, **35**, 328.

How to use an overhead projector

SIR,—Dr T S Murray's (3 March, p 602) "How to do it" article on the overhead projector missed one unique and very versatile feature. It is possible, by use of a xerox machine or similar copier, to produce projectable transparencies from books, drawings, tables, or EKGs in a matter of seconds. An 8½ × 11 inch sheet of acetate or similar material is simply substituted for paper in the machine. The resulting transparency is obtained quickly and inexpensively and is usually of high quality.

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Doctors and children's teeth

SIR,—I should like to raise an additional point regarding your recent leading article "Doctors and children's teeth" (12 May, p 1231).

In the last 25 years as a psychiatrist working with children I have often questioned a mother about the attitude of the father or stepfather towards the child, and only too frequently the answer is: "Very good, doctor. He always brings him sweets when he comes home." This social pattern of making sugar equate with affection must be altered in any fight against dental caries or obesity, or any other illness caused by excessive consumption of sugar.

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Drugs for epilepsy

SIR,—I refer to the article on epilepsy by Drs D F Smith and J C Mucklow (14 April, p 1000). The statement that phenytoin is now generally regarded as the anticonvulsant of first choice in treating tonic-clonic epilepsy is not entirely accepted by most dealing with epilepsy. It is indeed a broad-spectrum anticonvulsant but there are many problems with its use in practice, particularly in younger patients. The disfiguring skin manifestations like acne, hyperkeratosis, hirsutism, etc, are certainly unacceptable.

In the case mentioned the combination of phenytoin, primidone, and clonazepam is, I think, against the modern practice of single-drug therapy. Clonazepam is a very weak anticonvulsant when used orally. It is very essential to classify the type of epilepsy in such cases and then a suitable single drug should be tried in