more specifically low in sugar, is associated with the healing of any ulceration that may accompany the dyspepsia, as well as relieving the symptoms.

JOHN YUDKIN

London NW3

¹ Doll R. *Scott Med J* 1964;9:183-96.

² Yudkin J. *Med Press* 1961;246:64-8.

³ Yudkin J, Evans E, Smith MGM. *Proc Nutr Soc* 1971;31:12A.

⁴ Szanto S, Yudkin J. *Postgrad Med J* 1969;45:602-7.

⁵ Hunt JN. *J Physiol* 1951;113:169-84.

SIR,—In your leading article "Eating and ulcers" (26 January, p 205) the advice offered appears to be that there is nothing to be done except keep on taking the tablets. While agreeing that conventional dietary regimens have little significance in the management of European peptic ulcers, we would like to draw attention to the increasing evidence of a relationship between diet and the incidence of duodenal ulceration in India.¹

Animal experiments in peptic ulcer cannot be dismissed quite so easily as you suggest. Their relevance to man in establishing the regulatory mechanisms of gastric secretion is surely acceptable. The fact that there is no difference in the acid output between patients on different diets from high- and low-incidence areas should not be used to dismiss diet as irrelevant, but rather to indicate that its effects are on some aspect of the aetiology other than acid.

Animal experiments based on dietary manipulation to resemble that of subjects from high- and low-incidence areas also show a correlation which may explain the geographical distribution in peptic ulcer.² Our experiments with the pylorus ligation technique in the rat clearly show that prefeeding the animals with diets similar to those eaten in low-incidence areas confers considerable protection against experimental ulceration.³ There is increasing evidence that foodstuffs from low-incidence areas contain a protective factor which is a lipid or liposoluble substance. If this is the case, no doubt a suitable therapeutic agent can be developed. However, a more logical approach would be appropriate modification of the diet. No diet exists with an inherent H₂ antagonistic activity, but diets probably already exist in India which protect against ulceration. We are not yet at the death of dietary regimens.

F I TOVEY
A PAUL JAYARAJ
C G CLARK

Surgical Unit,
University College Hospital Medical School,
London WC1E 6JJ

¹ Tovey Frank I. *Gut* 1979;20:329-47.

² Tovey FI, Jayaraj AP, Clark CG. *Postgrad Med J* 1975;51:366-72.

³ Jayaraj AP, Tovey FI, Clark CG. *Postgrad Med J* 1976;52:640-4.

Compliance or unnecessary prescribing?

SIR,—The two themes of your editorial (10 November, p 1168) are well illustrated by the drug treatment of epilepsy.

There is no doubt that poor compliance with anticonvulsant therapy, even the omission of one or two doses, does matter. The patient is thus exposing himself to the possibility of withdrawal seizures, the perpetuation of his problem, and occasionally to such disasters as the burning described by Drs W F Durward

and M G Harrington in the same issue (p 1218). This applies throughout the many years of such therapy and imposes particular difficulties on patients who are often asked to take complicated regimens of polytherapy several times a day. However, it is especially important in the early years of therapy as poor compliance is the major cause of recurrence of seizures, the apparent failure of the first drug, and the subsequent escalation to polytherapy.^{1,2}

On the other hand, there is no satisfactory evidence that polytherapy is more effective in the control of seizures than a single drug used to its maximum potential with the assistance of blood level monitoring.^{2,3} The aim of treatment should be to use one or at the most two drugs per seizure type, with the maximum of compliance and ensuring if necessary optimum blood levels. If the patient fails to comply with unnecessary polytherapy he may be at no disadvantage, provided he does not indulge in intermittent therapy.

S D SHORVON
A W GALBRAITH
E H REYNOLDS

University Department of Neurology,
King's College Hospital,
London SE5 9RS

¹ Shorvon SD, Chadwick D, Galbraith AW, Reynolds EH. *Br Med J* 1978;ii:474-6.

² Reynolds EH. *Lancet* 1978;ii:721-5.

³ Shorvon SD, Reynolds EH. *Br Med J* 1979;iii:1023-5.

Legal aspects of child injury or neglect

SIR,—We would like to correct a technical point in our paper "Legal aspects of child injury or neglect" (13 October, p 910).

In the final paragraph under the heading "Care order" (p 911) it is stated that a local authority or voluntary body can appeal to the Crown Court if they are concerned about the failure to obtain a care order, or are concerned by the termination of a care order by a juvenile court on the application of a parent. This statement is inaccurate in that, under the Children and Young Persons Act 1969 (Section 2 (12)), only the child in question can appeal to the Crown Court.

J A BLACK

Family and Community Services
Department,
Sheffield S1 2JQ

Children's Hospital,
Sheffield S10 2TH

Prolonged intravenous use of chlormethiazole (Heminevrin)

SIR,—We were interested to read the article by Dr S Lingham and others (19 January, p 155). Since 1974 we have found intravenous chlormethiazole (Heminevrin) to be effective in the treatment of status epilepticus in children who did not respond to conventional anticonvulsant therapy, including infusions of diazepam and lignocaine. Although rarely required, prolonged chlormethiazole infusion is sometimes both necessary and possible, as illustrated by the following case.

A girl presented at age of 27 months with progressive right hemiparesis and right hemiconic seizures. Six months after onset the seizures became exceedingly frequent and were then generalised as well as partial. Various antiepileptic therapies, including all available standard drugs, adrenocorticotrophic hormone, levo-dopa, and ketogenic diet were ineffective. Two computed

tomography scans and a carotid angiogram did not reveal a focal lesion, but on electroencephalography the seizures consistently arose from the left anterior head region. A left frontal brain biopsy showed "focal subacute panencephalitis" but no virus was visible on electron microscopy or detectable serologically.

Intravenous infusion of a 0.8% solution of chlormethiazole through a paediatric giving set (Travenol Laboratories Ltd, Norfolk) at a rate of 10-18 mg/kg/h was started when all conventional anticonvulsant therapy had failed to control the seizures. Treatment with this drug was continued for 43 days before the effect of partial section of the corpus callosum allowed us to tail off the infusion. Throughout most of the treatment period, the patient remained conscious and responsive. Thrombophlebitis was a problem on only two occasions and was simply dealt with by changing the infusion site. No haematological, renal, or hepatic toxicity was observed.

Although we agree with Dr Lingham and his colleagues that care is essential, patients should not be denied prolonged chlormethiazole infusion when no other therapy is possible, and particularly when later epileptic surgery is contemplated.

LOUIS LOW
J B P STEPHENSON
K M GOEL

Royal Hospital for Sick Children,
Glasgow G3 8SJ

Whooping-cough immunisation

SIR,—I was not surprised at the reasons that Professor R S Illingworth (19 January, p 179) quotes for parents' refusing immunisation. I think, however, that there is in fact a different explanation for the sources of the myths he mentions.

In our practice more than three-quarters of the mothers of 7-month-old children express misgivings about the safety of immunisation and in particular the pertussis component of the triple vaccine. When asked why they are worried they quote friends, the lady down the road, parents, a man at work, and often a doctor on television. What is so interesting is that the reasons are the same as Professor Illingworth gives as coming from doctors and health visitors in his sample. Dare I suggest that he has yet to learn not to believe all he is told by parents?

GRAHAM CURTIS JENKINS

Ashford, Middx TW15 2TU

Training for hospital practitioners

SIR,—As a contribution to the solution of the problems of staffing structure, the employment in specialist departments of general practitioners in the hospital practitioner grade has considerable merit and helps to bridge the division between the two major branches of the profession. However, general practitioners are now largely recruited from among those doctors who have primary care as their aim from the time of graduation, rather than from those who have spent a considerable period in specialist hospital work. The new arrangements for vocational training emphasise short but wide-ranging experience in hospital medicine. Thus there will be few principals in general practice with sufficient qualifications to undertake a hospital role in specialist clinics without further instruction.

Some encouragement must therefore be given to general practitioners with an interest in a specialist subject and anxious to forge a