collection of information via poisons information inquiries and direct observation in a poisoning treatment centre. We feel obliged to remind two of our critics that they contributed to a paper on paracetamol overdosage in which it was stated, "Within a few hours of ingestion of the drug most of the patients experienced anorexia, nausea, and vomiting, and this persisted in varying severity for the first and second days.³ Oral therapy is unreliable and impracticable if vomiting occurs. Indeed, Dr Vale and his colleagues themselves admit the possibility that severe liver damage occurred in their vomiting patients through failure of absorption of oral methionine.

It is strange that they object to our comments on the potential toxicity of methionine since we quoted their own paper, in which they stated that methionine may have contributed to hepatic encephalopathy.⁴ While we share their concern about the cost of intravenous N-acetylcysteine, comparison with the cost of oral methionine is relevant only if both have equivalent efficacy and safety. We have demonstrated the efficacy of intravenous N-acetylcysteine in patients at high risk and, unless Dr Vale and his colleagues can produce equally good results with oral methionine, N-acetylcysteine must remain the treatment of choice. We make no apology for the title of our paper.

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¹ Prescott LF, Wright N, Roscoe P, Brown SS. *Lancet* 1971;1:519-22.

² Prescott LF, Newton RW, Swainson CP, Wright N, Forrest ARW, Matthew H. *Lancet* 1974;1:588-92.

³ Clark R, Thompson RPH, Borirakchanyavat V, et al. *Lancet* 1973;1:66-70.

⁴ Meredith TJ, Newman B, Goulding R. *Br Med J* 1978;2:478-9.

Hepatitis and blood donation

SIR,—We feel that your expert's reply (27 October, p 1047) should be amplified. In 1975 the Maycock Committee¹ decided that volunteers with a history of jaundice might be accepted as blood donors provided that they had not had jaundice in the last year and that hepatitis B surface antigen (HBsAg) had never been detected in their serum.

Although Renton *et al*² reported an increase in HBsAg among volunteers with a history of jaundice a survey³ of computerised records of donors in the West of Scotland failed to confirm their findings even though 228 631 records were examined. This represents the majority of donors in Scotland over a four-year period. Similarly, our results did not show any increase in other markers of prior exposure to hepatitis B virus—namely, antibody to the surface and the core antigens (anti-HBs and anti-HBc)—by radioimmunoassay methods. In studies related to hepatitis A exposure (report submitted for publication), using a radioimmunoassay for hepatitis A virus antibody (anti-HAV) we have shown that the prevalence of antibody is much higher in people over 40 years. As most new donors are aged under 40 years we compared groups with and without a history of jaundice (JH) from our new donors aged 18-40 years. There is a highly significant increase in anti-HAV among the JH group.

These findings lead us to believe that in our

donor population the great majority of clinical jaundice is caused by hepatitis A virus. We support the view of the expert committee that a previous history of jaundice in our volunteers is not an indication of an excessive risk of HBsAg carriage.

As the majority of blood transfusion centres in the UK collect blood in plastic packs your repeated use of the word "bottle" is unfortunate. Our experience does not confirm that one blood donation in 1000 will contain HBsAg. In our region about 1:800 of new donors carry HBsAg but new donors account for only about 20% of our intake of blood. The remainder comes from donors who have previously been tested with negative results, and HBsAg is found in 1:16 000 of these donors. This means that approximately 1 unit in 3500 donations can be expected to be HBsAg positive.

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¹ Department of Health and Social Security. *Second Report of the Advisory Group on Testing for the Presence of Hepatitis B Surface Antigen and its Antibody*. London, HMSO, 1976.

² Renton PH, Roach DG, Stratton F. *Lancet* 1978;2:833.

³ Crawford RJ, Barr A, Macvarish I, Dow BC, Mitchell R, Follett EAC. *Lancet* 1979;2:155.

Poisoning with chlormethiazole

SIR,—We note the comments of Dr D B Scott (1 December, p 1437) concerning our letter on the subject of chlormethiazole poisoning (10 November, p 1218). However, his argument does not persuade us to alter our conclusions about the two patients whom we studied. Dr Scott criticises the adequacy of the clinical details which we presented but he should recall that these were necessarily limited by the constraints of a letter which was primarily intended to support and extend the observations of others (Dr R N Illingworth and colleagues—13 October, p 962). We propose to present the cases in greater detail elsewhere.

In the first case there is no need to presume that the cardiac rhythm changed at the time of arrest. His survival, despite presumably little change in the blood level of chlormethiazole over some time, does not invalidate our conclusion that the drug was implicated. Recovery from many drug-induced cardiac dysrhythmias can be expected with adequate supportive therapy, as provided here. The second patient was nursed in an intensive care area under the supervision of experienced faciomaxillary surgeons. There was absolutely no evidence of hypoxia or airway obstruction either before death or at the postmortem examination, our summary of which was ignored by Dr Scott. He also failed to appreciate the significance of our references to respiratory depression, which has previously been considered as the probable mode of death in patients dying while treated with chlormethiazole. Dr Scott goes on to make the error of estimating the total dose of chlormethiazole from the rate of infusion at the time of death. If he examines the second case report more carefully he will find that adequate information was provided for him to calculate the exact dose.

Dr Scott takes our comments on the importance of the hepatic biotransformation of chlormethiazole completely out of context. Here we were quite clearly discussing not only

our patients but also those described by Dr Illingworth and his colleagues, where hepatic insufficiency might well have been particularly significant. We did not comment on the influence of dose on the pharmacokinetics of chlormethiazole as implied by Dr Scott.

He provides us with anecdotal evidence of the safety of chlormethiazole infusion at high doses but gives us no information on his experience with this preparation in the treatment of chronic alcoholics during actual withdrawal. During this phase serious metabolic disturbances are common, making the alcoholic patient particularly sensitive to powerful drugs. We do not doubt that, in the majority of patients, chlormethiazole infusion can be given with safety but special care must be observed in certain patients, such as alcoholics during withdrawal.

Dr Scott's conclusion that a drug which can cause potentially lethal dysrhythmias in certain situations "should lead to its total withdrawal" is absolutely preposterous. If such a policy had been adopted then digoxin and other useful drugs would have been withdrawn many years ago.

Two case reports cannot establish conclusively a causal relationship between a drug and a potentially lethal complication since rechallenge is clearly unethical. In conclusion, however, we would reiterate that while chlormethiazole is a useful drug in the management of the acute symptoms of alcohol withdrawal it should be used, like other powerful drugs, with caution. In particular, the prescribing physician should consider the patient's age; respiratory, hepatic, and cardiac function; and his history of alcohol ingestion.

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SIR,—We were interested to read the report by Dr G T McInnes and colleagues (10 November, p 1218) of cardiac arrhythmias during infusion of chlormethiazole, and their comments about metabolism of the drug in alcoholics and in the elderly. We had to exclude discussion of chlormethiazole metabolism from our paper (13 October, p 902) when cutting it to the length allowed for a short report.

Your other correspondent, Dr R W Morris (10 November, p 1219), seems to believe that chlormethiazole is safe because he has observed no respiratory depression when using the drug, and because all our patients with overdosage survived. Some of these patients would undoubtedly have died if not treated and fatal self-poisoning with chlormethiazole has been reported previously.¹⁻³ Pentikäinen and others⁴ described six deaths in patients given intravenous chlormethiazole; five of these occurred in one year in one department, in which only about 130 bottles of chlormethiazole had been used. Four of their patients had chronic chest disease. Two developed complete heart block while receiving chlormethiazole and at least one died because of respiratory depression. Dr Morris and his patients seem to have been lucky.

Our comment (13 October, p 903) questioning the safety of chlormethiazole in the elderly related mainly to hypothermia, which occurred in three of our patients. Chlormethiazole causes hypothermia in animals^{5,6} and also in women (and their

babies) given infusions of the drug for pre-eclampsia.⁷ It therefore seems possible, but is not proved, that therapeutic doses of chlormethiazole may predispose old people to hypothermia. However, whether chlormethiazole is any better or worse than other hypnotics in this respect is not known, and some research is needed.

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¹ Jakobsson, S V, and Möller, M, *International Microform Journal of Legal Medicine*, 1972, **8**, 150.

² Oliver, J S, and Stewart, P D, *Medicine, Science and the Law*, 1975, **15**, 67.

³ Horder, J M, *British Medical Journal*, 1978, **1**, 693.

⁴ Pentikäinen, P J, Valtanen, V V, and Miettinen, T A, *International Journal of Clinical Pharmacology*, 1976, **14**, 225.

⁵ Svedin, C-O, *Nordisk Psykiatrisk Tidskrift*, 1963, **17**, 1.

⁶ Astra Chemicals Limited, *Heminevrin and its Application to Geriatrics, Alcoholism, Psychiatry, Pre-eclampsia and Other Convulsive States*. Watford, Astra.

⁷ Tischler, E, *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1973, **13**, 137.

As a result of our own experience and that of other units we have changed our policy and, as Robertson suggests,¹ "give all dyspnoeic infants a course of benzylpenicillin for at least 48 hours until cultures are known to be negative, unless some clearly non-infectious condition like pneumothorax or congenital malformation is responsible for the dyspnoea." That prophylaxis against early-onset group B streptococcal septicaemia does result in the saving of some lives has been very strongly suggested by the outcome of a study by Lloyd *et al.*² I feel that now few paediatricians with responsibilities for neonates would agree with the first part of Dr Valman's statement.

On the subject of meconium aspiration, Dr Valman might have stated that at the very least a wide-bore catheter should be passed through the glottis and meconium sucked out. There seems little doubt that with efficient early management hardly any babies with this condition will need to be ventilated.

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¹ Robertson NRC, *Arch Dis Child* 1979;**54**:838-44.

² Lloyd DJ, Belgaumkar TK, Scott KE, Wort AJ, Aterman K, Krause VW, *Arch Dis Child* 1979;**54**: 805.

cuts in expenditure. It is therefore time that we all did our share in working out how best to utilise the available resources and eliminate indiscriminate consumption. I feel that very few of us cannot spare an hour every week for what I believe is a worthwhile cause, and I hope that some of my colleagues will think likewise.

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Unwanted journals

SIR,—As a mailing house that handles many free-circulation medical journals, I was interested to see the correspondence in your columns recently (6 October, p 867; 3 November, p 1149) concerning unwanted journals.

Although our role is merely to provide a mailing list to the specification of the individual publisher, we always take care not to include those doctors who do not want to receive a particular journal, provided that such a request has been passed on to us by the publisher concerned. Perhaps I might be permitted the comment that in our experience few doctors take the opportunity of saying "No" when sent a request card, and indeed most of your correspondents have returned "Yes" cards for specific journals according to our records.

Your readers may also care to note that we mail the following journals and correspondence should therefore be directed to ourselves and not the Medical Mailing Company as suggested by Dr Sam Rowlands (3 November, p 1149): *Pulse, Update, Medicine, Medisport, Hospital Update, On Call, Hospital Doctor, and World Medicine*.

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Amnesty International's medical group

SIR,—Amnesty International, a worldwide organisation founded in Britain in 1961, has become an acknowledged defender of the human right to hold and express convictions without threat of torture or persecution. Unfortunately, its scope is steadily widening with the increasing number of individuals hounded, jailed, and tortured in countries of every political hue—for maintaining their political, religious, scientific, or artistic opinion.

A medical group was established within the British section of Amnesty International about a year ago, with the purpose of assisting the organisation's objectives wherever the health of the persecuted is concerned. Its functions are: (1) To advise the Amnesty International research department, by assessing damage to the internee's health during and after imprisonment and torture; reliable reports are scrutinised and whenever possible the victim is examined. (2) To exert pressure on health authorities and members of the medical profession in the countries concerned to provide all necessary care for the maintenance of the physical and mental health of all prisoners; and also to avoid any participation in the penal process, particularly in torture; within this frame must be included the spurious psychiatric treatment of dissenters. (3) Research on the sequelae of imprisonment

Mechanical aids to ventilation for use in the field

SIR,—Dr R Greenbaum (13 October, p 937) has suggested that time-cycled automatic ventilators may have advantages in allowing cardiac massage to synchronise with artificial ventilation. Most resuscitation training programmes stick to the American Heart Association (AHA) guidelines¹ by recommending massage at 60 compressions/min with a breath interposed every fifth without pausing. When a mechanical ventilator is used a high flow rate is essential in order to comply with this routine.

If the AHA guidelines are to be accepted, then the minimal gas flow rate required of a ventilator must be at least 60 l/min (100 l/min has been agreed by both American and Australian standards committees). There is currently no time-cycled machine with a gas flow rate approaching 60 l/min.

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¹ American Heart Association, *Journal of the American Medical Association*, 1974, **227**, No 7 (suppl).

Aggressive patients—what is the answer?

SIR,—First of all, may I thank you for publishing my controversial letter on aggressive patients (3 November, p 1147). It attracted much publicity in the lay press and eventually culminated in my appearance on Scottish television with an eminent Glasgow family doctor on 20 November. During our discussion, it was agreed that there was abuse of the National Health Service facilities, including doctors, in most parts of the country by a minority of patients, which was affecting the morale of many general practitioners and, indirectly, the medical care of the majority of patients. The emphasis was placed mostly on health education to make people realise that it is in their interest to use responsibly the facilities provided by the National Health Service, which perhaps is the best in the world from the patients' point of view.

How do we go about educating the public? I wonder whether it might be a good idea to have some kind of association including representatives of patients and doctors, to improve communications from every point of view. General practitioners should acquaint patients with the workings of the Health Service and its limitations, and how unnecessary and excessive demands can affect the care of those who really need it. Patients, on their part, would have the opportunity to explain their grievances—to which, of course, we should be quite open. I am sure that a responsible attitude by the patient to his own health, correct interpretation of his rights, an insight into the problems facing the general practitioner, and the realisation how his own behaviour can affect the quality of treatment can all go a long way in making for a better Health Service and at the same time conserve our valuable resources, both human and financial.

Every day we are reminded that the country is facing an economic crisis, with the worst yet to come, and with every public service facing

Breathing difficulties in the newborn

SIR,—Dr H B Valman states in his article (8 December, p 1483) that "antibiotics have no place in the treatment of respiratory distress syndrome, but some infants may need antibiotics as the group B streptococcus may produce a clinical picture similar to that of severe respiratory distress syndrome." I would agree with the second part of this statement, and our own experience in a unit caring for some 2500 deliveries a year is that we have had five babies in 1979 with fatal group B streptococcal infection. The illness of two of these and of one (who survived) with group D septicaemia masqueraded as hyaline membrane disease.