erythema by absorbing ultraviolet B rays. The efficacy of some of these compounds, however, is being questioned.³ Some sunscreens may themselves be phototoxic⁷—for example, amyl dimethylaminobenzoate (Padimate A, Escalol 506). Some can prevent erythema, but not premalignant changes in the epidermis⁸—for example, mexenone (2-hydroxy-4-methoxy-4-methylbenzophenone). Furthermore, a 5% ethanolic solution of para-aminobenzoic acid (PABA), though an effective sunscreen, cannot protect against drug-induced phototoxic reactions.⁹ Broad-spectrum sunscreens combining a PABA ester with a benzophenone ester appear currently to provide the most protection from ultraviolet light.⁹

The Council of Europe is currently considering sunscreens and one hopes that in the future proper standardisation and toxicological tests will be required for all sunscreens and tanning aids, studies which would dispel much concern regarding their safety.

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Distalgesic poisoning—cause for concern?

SIR,—Dr Robert Wall and others are right to draw attention to the dangers of dextropropoxyphene (17 May, p 1213).

Some years ago I became aware that patients for whom Distalgesic had been prescribed frequently requested further supplies in circumstances which, in my opinion, did not warrant this level of analgesia. It was also noticeable that the difficulty of weaning patients off this preparation increased in proportion to the duration of medication. I now rarely prescribe Distalgesic or similar drugs, and never for more than a short period.

In my view any preparation containing dextropropoxyphene should be controlled under the Misuse of Drugs Act, and the dangers of dependence should be publicised widely.

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SIR,—Any Glasgow graduate of my vintage will have clear memories of the depressing remark by our brilliant professor of "materia medica," the late Professor Ralph Stockman, when at the end of nearly an hour's discourse on some drug he would sum it all up with a deprecating "But it is of no use whatever."

Younger generations can hardly realise how few were the really effective drugs that were at our disposal in these presulphonamide days of the early 1930s. The corollary that the highly effective drugs of today result in many

unexpected and dangerous side effects appears to occasion surprise and sometimes what seems undue alarm. The correct action is surely to accept their benefits while retaining an alert outlook for any unwanted reaction.

With regard to the specific warnings on the dangers resulting from Distalgesic, although I do not rank as a "controlled experiment" yet I can speak from personal experience, having suffered from severe disability from back pain and sciatica, which started a year ago and which eventually put me on my back for some weeks. A slipped disc and any more sinister cause having been excluded, it may be guessed that almost all the available range of analgesics was tried (hiatus hernia and a tendency to peptic ulceration being a problem). I can assure Drs R J Young and A A H Lawson (12 April, p 1045) that Distalgesic, in association with the peripherally acting aspirin in the form of Nu-seals, was quite the most effective, avoiding the disastrously constipating effect of codeine. Certainly the pain was such that I at one time required a daily total of 390 mg of dextropropoxyphene, 3.9 g paracetamol, and 3.9 aspirin, in addition to various physical forms of treatment in combination with the anti-inflammatory indomethacin.

Despite this large dosage, there were no ill effects and I had no difficulty in gradually reducing it as the condition improved, until now I am down to single capsules a day with no withdrawal symptoms or apparent development of dependence. Is it not true, with perhaps the exception of the hard drugs (although after a month of codeine I stopped it with alacrity), that much of addiction depends as much on a patient's personality as on the particular drug? The patient of Dr Robert Wall and others (17 May, p 1213) seems to be a case in point.

Let us not throw out the baby with the bath water but retain Distalgesic for what it can do, without forgetting the caution in the use of any drug that Stockman would have approved.

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Investigating constipation

SIR,—Your leading article (8 March, p 669) "Investigating constipation," which described the pathological and iatrogenic causes of the condition, contained some questionable statements—for example: "From infancy the British are brought up to regard a daily bowel action almost as a religious necessity and to believe in autointoxication from the cesspool of the unemptied colon; so it is little wonder that their doctors see vast numbers of patients obsessed with the frequency, consistency, diameter, and appearance of their stools." This, surely, is an exaggeration and carries with it the unfortunate implication that regular bowel habits are of little importance.

This illustrates once again that physiological yardsticks, in numerical terms, for human bowel function are badly needed.¹ Recently, a number of investigators²⁻⁶ have compared the effects of high- and low-fibre diets on bowel function. Their data suggest that in healthy subjects good fibre-containing diets produce at least one motion daily, stool wet weight of 150-200 g/day, and a transit time of approximately 48 hours. Multicentre studies are now necessary to confirm these findings; and close co-ordination is essential to secure

uniformity of methodology, which should include an objective method of measuring consistency.⁷ Reference values established in this way would have wide applications in pharmacological research, clinical practice, and health care and would also provide the basis for a scientific definition of constipation. In the mean time Painter⁷ has provided a useful working definition, which states: "Any patient who strains to defecate and does not pass at least one soft stool daily without effort is constipated."

With the present enthusiasm for the "bulk" principle it has become somewhat fashionable to denigrate chemical laxatives as unnecessary evils—as is evident in your leading article. That there has been gross abuse of laxatives in the past and is some continued misuse today is unquestioned. However, there is ample evidence to show that a chemical laxative, carefully selected and used, has a valuable place in many cases of disordered gut motility.⁸ Painter⁷ illustrates the complementary actions of a chemical laxative and dietary fibre when he states: "Idiopathic slow transit constipation, megacolon and megarectum are a persistent problem. Besides dietary fibre they require standardised senna tablets (Senokot). Usually 2-4 tablets daily are sufficient, but the dosage must be found by trial and error. It may be possible to reduce the initial dose when the high-fibre diet has taken effect."

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Diagnosis of infectious mononucleosis

SIR,—Your leading article (10 May, p 1153) dealt with a common problem—the accurate diagnosis of infectious mononucleosis—in which there is much misunderstanding. Pfeiffer's¹ "glandular fever" was a different disease from that of Sprunt and Evans.² In the former the disease occurred in infants, was very contagious and of short duration, and atypical lymphocytes were not described. The infectious mononucleosis of Sprunt and Evans occurred in adolescents, was not very contagious and lasted longer, and atypical lymphocytes were present.

The diagnosis of infectious mononucleosis formerly depended on finding clinical, haematological, and serological evidence of the disease. Recently, the presence of specific IgM anti-Epstein-Barr virus antibody has been accepted as diagnostic of the disease. This test is of particular value in children and in the elderly, where the Paul-Bunnell-Davidsohn test may be negative and the illness atypical. However, many laboratories use only commercial screening kits (for example, Monospot), which are associated with a number of false-positive results. We have studied the serology of 100 patients with clinical and haematological evidence of infectious mononucleosis.³ All patients had atypical lymphocytes constituting over 20% of the total leucocyte count. Positive

serological tests were obtained in 69 of these patients. Of the remaining 31 patients, significant antibody titres to toxoplasma were obtained in five and to cytomegalovirus in two. In 24 patients the cause of the illness was undiagnosed.

In our series the level of atypical lymphocytosis was critical: all 19 patients with atypical lymphocytes forming over 45% of the total leucocyte count gave a positive result in the Paul-Bunnell-Davidsohn test; and all 27 patients with over 40% of atypical lymphocytes were either positive in the Paul-Bunnell-Davidsohn test or had significant titres of IgM anti-Epstein-Barr virus antibodies. Thus it appears that high levels of lymphocytes (over 40%) are diagnostic of infectious mononucleosis, whereas at lower levels of atypical lymphocytes an appreciable number of patients do not have infectious mononucleosis.

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¹ Pfeiffer E. *Jahrbuch für Kinderheilkunde* 1889;29: 257-64.

² Sprunt TP, Evans FA. *Bull Johns Hopkins Hosp* 1920 31:410-7.

³ Ho-Yen DO, Martin KW. *J Infect*: (in press.)

Hypoplastic anaemia associated with legionnaires' disease

SIR,—Dr D O Ho-Yen in his letter (1 March, p 647) about our case report (9 February, p 366) comments on the possible role of co-trimoxazole in producing hypoplastic anaemia and gives reference to two papers to support his view. However, in the first paper¹ patients were treated with co-trimoxazole for at least 12 months (our patient received this drug for five days), and although they had depressed reticulocytes, neutrophils, and platelets their marrow did not show hypoplasia. In the second paper² two patients with aplastic anaemia are referred to but further details are not given.

The second point made by Dr Ho-Yen is that chronic acquired aplastic anaemia cannot be excluded. We agree with this point; but, because of the clearcut effect of the infection on the marrow during the acute phase and the subsequent apparent recovery when the infection was controlled, we speculated on a possible permanent effect of the legionnaire organism on the marrow.

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¹ Dawborn JK, Castaldi PA, Kilgour A, Parkin JD, Pattison G. *Med J Aust* 1973;i:spec suppl, 52-6.

² Salter AJ. *Med J Aust* 1973;i:spec suppl, 70-4.

Genital herpes

SIR,—Your comprehensive leading article on genital herpes (7 June, p 1335) concludes by stating that the most important aspects of the management of this disease are "sexual abstinence to avoid infecting a partner and tracing sexual partners who may be at risk." Advising sexual abstinence has never been a very successful method of preventing any sexually transmitted disease and is likely to be

especially ineffective in genital herpes as the disease may be transmitted by patients in the absence of signs or symptoms. Most patients can, or will, refrain from sexual intercourse when genital lesions are present but one cannot expect them to remain continent in their absence. The risk of infection in such circumstances is admittedly much less but it is still present.

Finally, what does one do when "a potentially infected partner has been traced?" If examination reveals no sign of the illness there is no guarantee that subclinical infection (and hence potential infectivity) has taken place. On the other hand, if overt disease is found, as is made clear in your leading article, there is no really effective remedy. Unfortunately many, if not all, patients with genital herpes remain intermittently infectious for long periods, if not for life. If in addition they are sexually promiscuous then such a combination of events provides an almost impossible situation to control. What is needed is a drug which is capable of dealing with the virus present in the sensory ganglia, and possibly acyclovir may offer some hope here.

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Review Body award

SIR,—The Review Body has recommended that doctors and dentists should receive an increase of 18.7% in their remuneration to offset the effects of inflation, while other Health Service workers have been warned that their increase cannot be more than 14%. There are good reasons for the higher award to doctors and dentists but the fact that they are receiving more must give rise to deep resentment. All the partners in this practice are agreed that they would like to see doctors and dentists given the same increase to offset inflation as other Health Service workers. This would mean a reduction of 4.7% in the increase already agreed, but that should not present an insuperable obstacle and it would surely help to create a happier spirit within the service. We feel that many doctors and dentists must share our view and we would ask our leaders to find out if this is so.

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SIR,—Have the Yaxley doctors (7 June, p 1379) forgotten that we have waited for two years for this award, which, including an amount for inflation, finally brings us up to date? I should be interested to know to which charity, and this includes the Inland Revenue, they would like to give the top 5% of the award which they are willing to have delayed by one year.

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SIR,—I was very encouraged to read in your journal (7 June, p 1379) that Dr C J R Hart and others are willing to accept a delay of one

year in the implementation of the top 5% of the recent pay award. As a consultant I would like to suggest to my colleagues throughout the NHS that we forego 10% of the proposed new award until there is evidence of significant improvement in the country's economy.

We claim to be a caring profession—can we not give practical proof of this by showing concern for the underprivileged, our school-children, and the aged, who are so vulnerable in the present serious economic situation, and set an example to the nation?

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Two-tier registrar grade

SIR,—As a consultant in a peripheral hospital in an industrial northern city, I would like to express my apprehension at Dr John Nabarro's plan for a two-tier registrar grade (17 May, p 1237). We have already seen the failure to redistribute senior registrar and registrar posts from the London teaching hospitals to the rest of the country. My fear is that the influential teaching hospitals and those hospitals that geographically are able to participate in rotational training schemes will hold on to the higher-tier registrar posts and the peripheral hospitals will be further disadvantaged by being recognised only for lower-tier general training posts.

It will mean that only candidates of inferior quality will apply for peripheral posts and anyone who shows unexpected merit will have the greatest difficulty in moving to a recognised training post.

All trainee specialists must realise that they may eventually become peripheral consultants and it is in their interest to ensure that training posts are not confined to a few centres.

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Subsidising private patients?

SIR,—In this hospital private patients admitted for coronary angiography and discharged on the same day pay the hospital authorities £112.80. If they remain overnight their total charge is only £63. The cost for catheterisation, excluding medical fees, at the only private catheter laboratory in London is at present £235. At a time when the National Health Service is short of money the Minister should surely take steps to change the method of charging so that we no longer subsidise overseas patients but make a profit.

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London's medicine

SIR,—I read Dr Gareth Jones's letter (22 March, p 870) with interest. The thesis which he propounds, that medical students trained in a particular vicinity will remain to practise in that area, is a well-known myth. Even though the University Grants Committee and the DHSS have poured millions of pounds into the new Cardiff Hilton—sorry, I mean the University Hospital of Wales—this has