weekends. Many experts do not approve of the use of a long-acting sulphonamide (as in Fansidar) or sulphone in Africa at all, or in other areas for long periods of time. Thus there is a current reluctance to recommend Fansidar or any similar combination in Africa even if chloroquine or proguanil have failed in prophylaxis. Therefore in any prospective study it would seem reasonable to include a regimen comprising both chloroquine and proguanil (for example, proguanil 200 mg daily on weekdays with chloroquine 150 mg daily on weekend days), especially in people who have suffered an attack of malaria despite the regular ingestion of one of the drugs given alone. Sequential chemosuppression with proguanil and chloroquine could also be used in practice.

As noted in our article, Fansidar is effective as a chemosuppressant against malaria when administered every one or two or four weeks. Several studies in chloroquine-resistant areas have indicated that dosing every four weeks gives a high degree of protection^{1,2} and this is supported by the lengthy elimination half-lives of pyrimethamine and sulfadoxine.³ However, in one study in a chloroquine-sensitive area (Africa) fewer breakthroughs occurred when Fansidar was given every week or two weeks rather than every four weeks.⁴ In a recent extensive study in a chloroquine-resistant area Fansidar was very effective when given every two weeks,⁵ but there has been little experience with weekly dosing of Fansidar in a chloroquine-resistant area. People often prefer a firm recommendation, and fortnightly dosing (two tablets in adults) would appear to be the optimum dosage interval for Fansidar. Weekly dosing (one tablet in adults) would probably be equally satisfactory.

Since so many people develop malaria after return from endemic areas current prophylactic practice is obviously inadequate. Much of this malaria is due to failure to take the drugs. However, if people are instructed to take their drugs for eight weeks rather than four weeks then it may be hoped that the drugs will be taken on average for a longer period and the prevalence of malaria reduced. The WHO report mentioned by Professor Peters recommends drug prophylaxis for at least four weeks and preferably for six to eight weeks.

Professor Peters notes that prophylaxis for four weeks after leaving an endemic area is sufficient to prevent falciparum malaria. What is his evidence for that statement? He also notes that continued prophylaxis for eight weeks is needed to prevent vivax breakthroughs. This supports the eight-week recommendation since prophylaxis is intended to prevent both falciparum and vivax malaria.—Ed, *BMJ*.

¹ Lewis, A. N., and Ponnampalam, J. T., *Annals of Tropical Medicine and Parasitology*, 1975, **69**, 1.

² O'Holohan, D. R., and Hugoe-Matthews, J., *Southeast Asian Journal of Tropical Medicine and Hygiene*, 1971, **2**, 164.

³ Peck, C. C., Lewis, A. N., and Joyce, B. E., *Annals of Tropical Medicine and Parasitology*, 1975, **69**, 141.

⁴ Shafiei, A. Z., *Journal of Tropical Medicine and Hygiene*, 1975, **78**, 190.

⁵ Pearlman, E. J., et al, in preparation.

Risks of exotic infections

SIR,—Professor N R Grist's plea for a sense of proportion over the risks of imported infections (4 December, p 1382) is timely. That viruses should be projected in the public mind as species of invisible locusts swarming everywhere in relentless pursuit of unwitting

victims correlates with the media's desire to scare people (Minerva, 20 November, p 1267) but not with more orthodox views of the nature and properties of viruses. Even official pronouncements on safety in laboratories seem to reflect greater experience at the committee than the laboratory bench. Why, with our knowledge of viral characteristics, we should be reverting to an era reminiscent of the red flag for the motor car is a mystery. Is the virologist, booted and wrapped in his swaddling clothes and with hands numbed by multilayered gloves, any more fitted to do cultural manipulations than is the surgeon to operate with one hand tied behind his back? It does not appear so.

Of course viruses, being infectious, are capable of the unexpected. Yet examples of lack of secondary spread in the face of numerous opportunities of exposure to persons acutely ill with virus infections are commonplace. The later reports of the recent outbreak of Marburg-like disease in Africa indicate a more limited spread even within families than was at first thought. The precipitate evacuation of some 60 patients from Coppett's Wood Hospital because of the presence of the unfortunate scientist from Porton was therefore startling.

Fascination with safety is laudable. Like crossing a busy road, a code is one thing; its implementation, however, does need trust, not exasperation.

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Comparative diagnostic accuracy of barium meal and endoscopy

SIR,—We were interested to read the paper by Dr G W Stevenson and others (25 September, p 723) on the comparison of double-contrast barium-meal examination and fiberoptic endoscopy in acute upper gastrointestinal haemorrhage and the subsequent correspondence from Dr M W Dronfield and others (23 October, p 1010) and Dr P B Cotton (13 November, p 1197). We would like to make a number of comments on the points that they have raised.

The paper by Dr Stevenson and his colleagues might lead many of your readers to believe that endoscopy had made a precise and accurate diagnosis of the bleeding source in 89% of their cases. We would suggest that this is not a proper interpretation of their results. In our opinion¹ the demonstration of a non-bleeding lesion is not acceptable as a positive diagnosis and one must, either by endoscopy or barium-meal examination, have evidence that a lesion is actively bleeding or has recently been bleeding to constitute a positive diagnosis. Lesions not showing these features are of interest but do not constitute a positive diagnosis. Dr Stevenson and his colleagues comment that active bleeding or adherent clot was seen at endoscopy in 36 of their patients out of a total of 53 and thus in our view their positive diagnostic rate was 68% rather than 89%. This compares very favourably with our own previously published series.¹ We would suggest that the remaining 11 of the 53 patients in whom a lesion was found had non-bleeding lesions only.

With regard to the barium-meal examination they comment that the 11 radiological failures or partial failures occurred in patients

in whom endoscopy showed active bleeding or adherent clot. This suggests that this examination has been accurate in only approximately 25 of the 36 patients who had by our criteria a positive endoscopic diagnosis. This represents a positive rate for the barium-meal examination of approximately 25 of the 53 patients—that is, around 50%. We feel it is most important that physicians and surgeons appreciate that the recognition of a non-bleeding lesion does not mean that that lesion has been the site of blood loss.

Our experience of reviewing deaths in acute upper gastrointestinal haemorrhages has shown that patients who die have severe concomitant disease.² It is therefore of interest that in Dr Stevenson's paper the five deaths occurred in patients who were not suitable for surgery. We have already pointed out that it is unlikely that early endoscopy will benefit these patients² and to this extent we entirely agree with the views expressed by Dr Dronfield and his colleagues. Dr Cotton rightly points out that looking at the overall mortality across the broad spectrum of upper gastrointestinal bleeding may well obscure improvements in one area and adverse trends in another. We entirely agree with him that endoscopy will be essential in therapeutic trials studying the management of particular bleeding lesions. However, this is not a justification for early endoscopy as part of the routine clinical management of every patient with upper gastrointestinal bleeding. Our experience leads us to believe that the establishment of an early and accurate diagnosis in those cases in which surgical intervention is not already contemplated is at best of marginal benefit to the patient. Despite the publications of Hoare³ and Hellers⁴ there is as yet no convincing evidence that early endoscopy improves mortality in this situation.

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¹ Forrest, J A H, Finlayson, N D C, and Shearman, D J C, *Lancet*, 1974, **2**, 394.

² Logan, R F A, and Finlayson, N D C, *Lancet*, 1976, **1**, 1173.

³ Hoare, A M, *British Medical Journal*, 1975, **1**, 27.

⁴ Hellers, G, and Ihre, T, *Lancet*, 1975, **2**, 1250.

Labelling of foodstuffs for patients with coeliac disease

SIR,—There is a proposal for an EEC council directive (COM(76)107 Final) on the approximation of the laws of member States relating to the labelling, presentation, and advertising of foodstuffs for sale to the ultimate consumer currently being considered in Brussels. The Irish Coeliac Society considered that the directive if adopted would allow foodstuffs to contain gluten without any reference to its presence in the listing of the ingredients. The society was also worried that dietary food directives R 3244/73 would not be in a position to countermand such a directive if adopted.

Accordingly we sought a meeting with the Irish joint committee on secondary legislation of the European communities (the All Party Parliamentary Committee on the EEC). I am pleased to report that following this meeting the committee asked for an amendment of the directive so that food manufacturers would have to print on all packets a statement on whether or not there was any gluten in the product. I am writing this letter in the hope