while all five significant increases concern summer months. When the same calculation is made for 1975 there are two further significant results: an excess in March and a deficit in December. So December 1975 did have a significant drop in admissions ($\chi^2=4.41$; $DF=1$; $P<0.05$) but then so did December 1974 ($\chi^2=5.05$; $DF=1$; $P<0.025$). To my knowledge there was no industrial action in 1974.

My letter could have ended here. However, in order to minimise the effect of seasonal variation a calculation of monthly figures based on three-month totals was made. The result (see table) shows that when the crucial month is compared with the preceding and the following month the statistically significant drop obtained earlier disappears ($\chi^2=2.56$; $DF=1$; $P>0.10$). On this evidence Dr Jones's claim that the junior doctors' industrial action caused a drop in self-poisoning has to be rejected.

Observed (O) and Expected (E) numbers of admission for self-poisoning in three Sheffield Hospitals. (Expected numbers based on yearly three-month totals)

Year	November		December		January	
	O	E	O	E	O	E
1970-1	60	73.7	67	76.2	99*	76.2
1971-2	56	56.4	63	58.3	54	58.3
1972-3	74	72.4	67	74.8	81	74.8
1973-4	76	74.3	79	76.8	73	76.8
1974-5	81	79.2	76	81.9	86	81.9
1975-6	92	84.1	72	86.9	94	86.9

* $\chi^2=6.86$; $P<0.005$.

I have two questions and I hope somebody may already have the answers. Was there a reduction in the *total* number of admissions or attendances to casualty departments during December 1975? Could it be that, in the same month, some medical services were withdrawn or was it purely a threat of withdrawal?

D J PALLIS

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¹ Crockett, G S, *British Medical Journal*, 1976, **1**, 92.

² Pallis, D J, and Nelson, B, *British Medical Journal*, 1976, **1**, 342.

SIR,—The article by Dr D I R Jones (1 January, p 28) arouses a great deal of interest. He is alarmed at the increase in the number of cases of self-poisoning, but it would be helpful if figures could be supplied for the alternative methods of attempted suicide. We suspect that these have decreased.

He also seems to think that the number of cases is still increasing alarmingly, but even allowing for abnormal December 1975 figures it seems fairly clear that the 1975 total would have been less than the 1974 figures. Perhaps a peak has been reached.

Another interesting factor is the increase in the number of patients who take someone else's pills. This suggests that at least one-third of people who take an overdose have someone else in their family or living with them who has needed to be treated with psychotropic drugs. This is surely a point in favour of those doctors who believe that much emotional and mental illness concerns a family rather than an individual.

Finally, and perhaps most important, Dr Jones states that two-thirds of the patients consulted a doctor in the month prior to the

overdose. Now if the figures are accepted it would seem that 100 000 people annually are admitted to hospital for overdoses, which works out at an average of roughly four per general practitioner. In common with other GPs we see several people *every day* suffering from emotional or mental illness. It would be very interesting if one were able to determine how many people did *not* attempt suicide following consultation with their doctor. It may well be that, contrary to the argument that too many drugs are being prescribed, perhaps the incidence of attempted suicide could be even greater and that GPs are responsible, by psychotherapy and/or by drugs, for keeping the risk under control.

In fact, is there any evidence whatever to support two of the media's favourite arguments—that doctors prescribe excessively or to get rid of patients—which were supported (albeit not very strongly) by Dr Jones on the radio on 5 January?

M M SUNDLE
S M AMIEL

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SIR,—Dr D I R Jones states (1 January, p 28) that there was a 20-fold increase in hospital admissions for self-poisoning during the 20 years from 1954 and that in 1955 there were "under 50" such admissions to the three major acute hospitals in Sheffield. I have been working in one of these hospitals since 1946 and I can assure Dr Jones that the figure of 50 is entirely fallacious. Self-poisoning has increased, but it was a common emergency even in 1955. This act was then a criminal offence requiring investigation by the police and it was usual not to describe the true cause of admission on the front of the notes. The diagnosis was usually described as "depression," "anxiety state," or "coma" or not classified. A number of patients were seen in the casualty department and discharged home.

F J FLINT

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SIR,—In reporting the Sheffield experience over the past 20 years, Dr D I R Jones (1 January, p 28) has once again drawn attention to the ever-increasing problem of self-poisoning. In Sheffield, as in many other cities, this constitutes a very significant proportion of all medical admissions to hospital and is frequently the most common cause of emergency admission among women. The significance of a high-density population area within cities is stressed by Dr Jones. In contrast, self-poisoning in rural Scotland is relatively uncommon. The experience over a decade (1961-70) at this hospital¹ was that admissions due to self-poisoning were increasing slightly each year but that even in 1970 they accounted for only 3.1% of the medical admissions. Young women were the main group involved, but the age range of patients was wider than in the urban centres and suicide was frequently the intention. Barbiturates were the drugs most frequently used and alcohol was ingested by about 17%.

We have just reviewed our experience during 1976. The number of admissions rose from 34 in 1970 to 48 in 1976 and the percentage of all medical admissions to 4%. The age range was again wide—14-76 years—and suicide was the wish of 14 patients (29%). Seventeen had

made previous attempts at self-poisoning and 18 (37%) had taken alcohol in quantity. A range of 22 drugs was used, aspirin, diazepam, and nitrazepam being the most common; barbiturates were taken by only four patients. There were no deaths.

Thus although self-poisoning is increasing in this rural part of Scotland, the increase is slow and slight. The pattern of drugs taken has changed slightly and associated ingestion of alcohol has increased. The intention to commit suicide is still important.

J A TULLOCH

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¹ Tulloch, J A, *Scottish Medical Journal*, 1972, **17**, 278.

Allergy to diazepam

SIR,—In the case report by Dr Louis Milner from Sweden (15 January, p 144) in which an allergic reaction followed the intramuscular injection of diazepam no mention is made of the fact that the solvent in the preparation used (Stesolid) is cremophor EL, whereas the solvent in the preparation of diazepam most frequently used in Britain (Valium injection) is glycoferol-alcohol-benzoic acid.

So far as I know, no allergic reaction has yet been reported following the injection of Valium. Cremophor EL, however, is the solvent used for propranolol (Eponol) and in Althesin (alphaxalone+alphadolone) and has been suspected as the cause of the many allergic reactions reported following the use of those drugs.

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SIR,—The report by Dr Louis Milner on allergy to diazepam (15 January, p 144) prompts me to report a further case.

A 60-year-old woman with non-Hodgkin's lymphoma and gross generalised lymphadenopathy received an intravenous injection of 10 mg diazepam (as Valium injection) prior to bone marrow aspiration. She immediately developed facial oedema and stridor and became cyanosed. There was no skin rash or circulatory embarrassment. Breathing improved after the insertion of an oropharyngeal airway, and hydrocortisone and antihistamines were administered. The facial oedema resolved over the next 36 h.

There is little doubt that this patient had an anaphylactic reaction to intravenous diazepam and the stridor was probably aggravated by pre-existing narrowing of her airway due to lymphadenopathy.

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Arthrography of the knee

SIR,—In his otherwise balanced description of arthroscopy of the knee (8 January, p 87) it was a pity that Mr Adrian Henry found it necessary to suggest that arthrography was valueless. He supported this suggestion by quoting from only two unrepresentative articles which gave an error rate for the examination of over 30%.^{1,2} In his selective quotation from the article by Jackson and Abe Mr Henry neglects to mention the authors' comment that with experience the diagnostic

accuracy of their radiologists improved so that their results approached those of other authors in the final stages of the series. This is a case of comparison of an experienced arthroscopist with an inexperienced arthrographer. A similar series with reversal of the degree of experience would show an adverse and unfair reflection on the arthroscopist.

Arthrography of the knee is a routine radiological procedure in much of Europe and North America. It is being employed increasingly in Britain because of its diagnostic accuracy, of the order of 95%, in lesions of the menisci. Many papers have been published indicating the value of the procedure.^{3,4}

Although arthroscopy and arthrography are often complementary, arthrography has distinct advantages over arthroscopy in that use of the operating theatre is not required; it is an outpatient procedure requiring no general anaesthetic and demonstrates certain areas of the meniscus which are seen with difficulty on arthroscopy. The combination of diagnostic accuracy and comfort to the patient makes arthrography the investigation of first choice in the diagnosis of meniscal injury. Arthroscopy is best reserved for those cases in which arthrography is inconclusive or where an arthrographic service is not provided.

I hope that the enthusiasm of arthroscopists will not result in an unreasonable bias against arthrography which is not supported by the facts.

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¹ Jackson, R W, and Abe, I, *Journal of Bone and Joint Surgery*, 1972, **54B**, 310.

² Klenerman, L, and Butcher, C, *Journal of Bone and Joint Surgery*, 1974, **56B**, 564.

³ Butt, W P, and McIntyre, J L, *Radiology*, 1969, **92**, 487.

⁴ Nicholas, J A, Freiburger, R H, and Killoran, P J, *Journal of Bone and Joint Surgery*, 1970, **52A**, 203.

Activity of sisso-mycin against gentamicin-sensitive organisms

SIR,—We were interested to see the comparison of the differing aminoglycoside antibiotics by Dr F A Drasar and others (27 November, p 1284) and would agree with their findings except in one respect. They note that the aminoglycoside sisso-mycin was less active against gentamicin-sensitive organisms than gentamicin itself. This is contrary to our observations and that of many other workers.^{1,2} In a recent multicentre study we investigated the sensitivity of urinary tract pathogens from four centres (our two hospitals, the Whittington Hospital, London, and the Adelaide Hospital, Dublin). A total of 1940 isolates were examined by a technique almost identical with that used by Dr Drasar and her colleagues and the sensitivities to gentamicin, tobramycin, sisso-mycin, amikacin, and kanamycin measured simultaneously. The geometric

mean median inhibitory concentrations (MICs) are shown in the table.

There was a statistically (but not clinically) significant difference between the sensitivity of these organisms to gentamicin and sisso-mycin, sisso-mycin being somewhat more active (Student's paired *t* test, $P < 0.05$). When the data were expressed as "Mode MIC" sisso-mycin appeared to be as active as gentamicin except against *Pseudomonas aeruginosa*, in which case the former drug appeared to be about twice as active as the latter.

Care should be taken in choosing the way in which one expresses results. Minor differences in drug activities may not be appreciated if a method such as "mode MIC" is used.

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¹ Klastersky, J, et al, *European Journal of Cancer*, 1973, **9**, 641.

² Naumann, P, et al, *Deutsche medizinische Wochenschrift*, 1976, **101**, 1277.

* * * The Medicines Commission has recommended that, to avoid conflict with a very similar proprietary name, the spelling "sisso-mycin" be used in the UK in preference to the Continental and American spelling "sisso-micin." "Sisso-mycin" will appear in the next supplement to *Approved Names 1973* issued by the British Pharmacopoeia Commission.—Ed, *BMJ*.

SI: two years on

SIR,—As a retired engineer married to a retired consultant pathologist I have followed the references to SI units in the *BMJ* for the past two years with considerable interest but some anxiety. After reading your leading article (1 January, p 5) I feel impelled to write to you making some comments.

First of all I am concerned to see how very few references there are to the publications by national and international authorities concerned with SI. The original Health Service Circular of May 1975¹ contains a perfunctory reference to the British Standards Institution's publication PD5686² but I have not seen any other reference to that national organisation, which is the United Kingdom contact point or clearing house for everything relating to SI. There is also the particularly topical European Economic Community Council directive of July 1976³ (obtainable through BSI channels) which includes the 26 named SI units and their 16 numerical prefixes that will be

mandatory for all member countries from 21 April 1978.

I do realise that the BSI activities in the unit field have so far been mainly limited to the so-called exact sciences and to technology and that standardisation within the life sciences is a very different thing. Nevertheless, I cannot help feeling, when I see in some hospital conversion tables international units for measuring enzymes listed in the same column as SI units, that there is scope for at least some degree of interdisciplinary co-ordination.

Dr P R Pannall (6 March 1976, p 583) refers to the conservative objections by some members of your profession 20 years ago to changing from imperial to metric units for prescriptions and hospital reports. While there may have been unreason in most of these objections, especially since the objectors would have learnt all their early science in metric units, they had some justification over equivalent weights. Twenty years on from now may there not be some analogous second thoughts about the mole?⁴ The generalised mole would seem to be a rather elusive animal, but at least one hospital traps it within its original definition as a gram-molecule.

Drs D R John and A H James (6 March 1976, p 582) make a plea for no further changes in units, for the SI upheaval to be the last. This plea may well have a dusty answer to follow. SI, compared with the older version of the metric system is still relatively new and is still to some extent evolving. Two new named units of interest to the medical profession have appeared within roughly the last year and there are two more numerical prefixes. There are also some difficulties of interpretation over SI practice and there is a degree of confusion over the retained non-SI units like day, litre, degree of angle, etc. The SI units are all, by definition, coherent,^{2,4,5} but there are units so totally bound up with the present order of things that they are "recognised by the International Committee of Weights and Measures for use with the International System."⁵ The EEC Council directive³ lists 13 such units for general use and four more for special fields. The British Standard,⁵ generally following *SI: The International System of Units*⁴ and ISO 1000,⁶ lists nine units for general use, four for special fields, and 12 more to be accepted temporarily.

For these and other reasons it does seem that further detailed attention may be needed in some quarters before SI finality is reached.

A C HUTCHINSON

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¹ Department of Health and Social Security, Health Service Circular (Interim Series) HSC(IS)140. London, DHSS, 1975.

² British Standards Institution, *The Use of SI Units*, BSI Publication PD5686. London, BSI, 1972.

³ *Official Journal of the European Communities*, Council Directive of 27 July 1976.

⁴ International Bureau of Weights and Measures, *SI: The International System of Units*, p 8. Paris, OFFILIB, 1974.

⁵ *The International System of Units (SI)*. British Standard 3763:1976. London, BSI, 1976.

⁶ *SI Units and Recommendations for the Use of their Multiples and Certain Other Units*. International Standard ISO 1000. Geneva, International Standards Organisation, 1973.

Geometric mean MICs of five antibiotics

	No of strains	Gentamicin	Tobramycin	Kanamycin	Sisso-mycin	Amikacin
<i>Escherichia coli</i> ..	1441	0.62	0.89	3.96	0.57	1.88
<i>Proteus mirabilis</i> ..	245	0.87	1.06	4.04	0.82	3.14
<i>Klebsiella</i> ..	142	0.46	0.59	4.82	0.42	1.37
<i>Proteus</i> sp. ..	52	0.75	0.96	3.15	0.70	2.14
<i>Pseudomonas aeruginosa</i>	28	0.76	0.40	27.59	0.49	1.60
<i>Enterobacter</i> ..	26	0.50	0.63	2.29	0.45	1.41
<i>Alcaligenes faecalis</i> ..	6	0.56	0.56	2.52	0.40	1.26
Total	1940					

Gentamicin MICs differ significantly from those of sisso-mycin ($P < 0.05$).

SIR,—The letter from Dr Eva Lester (8 January, p 102) both annoys and saddens me. If indeed SI experts go home now, it will be to weep.

There is nothing good about change for change's sake, but SI was not produced without a great deal of thought. Dr Lester appears