A major reason for failure to attend outpatient appointments is the inappropriateness of this offer. The appointment often involves a two-week delay and no offer to see the same interviewer, or the opportunity to contact him in the intervening time if necessary (the time of highest risk for repetition). I systematically visited overdose patients one week after the act and so often the story was that they had desperately needed to talk since discharge. They could not really see the point of going back to the clinic a week or more hence. Many still had a high level of neurotic symptoms.

There is no doubt that present psychiatric management of overdose patients is poor and ineffective and the need for change is urgent.

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One drug for epilepsy

SIR,—I was interested to note that Dr S D Shorvon and his colleagues (25 February, p 474) did not consider it necessary to use a concurrent control group in order to assess the additional benefit resulting from the use of drug blood level monitoring in the treatment of epilepsy. I will therefore continue to wonder if a policy of gradual dose increment for continuing seizures is really markedly improved by the addition of blood level monitoring.

In addition, I am puzzled by the data presented in table II of their paper, especially when it is compared with the earlier report on the group treated with phenytoin.¹ Five patients fewer are now tabulated, but a comparison of the present data with the earlier figures reveals that there are now one fewer patients controlled with suboptimum levels, four fewer controlled with optimum levels, and two fewer uncontrolled with levels always suboptimum. However, there are now two more cases classed as having been uncontrolled with suboptimum levels but controlled with optimum levels. Although a mean duration of follow-up is quoted, such figures are meaningless unless they apply to a specific time after commencement of treatment. To illustrate this point, the survival rates following cancer treatment are of value only if the time to which they refer is known.

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¹ Reynolds, E H, Chadwick, D, and Galbraith, A W, *Lancet*, 1976, **1**, 923.

*We sent a copy of this letter to Dr Shorvon and his colleagues, whose reply is printed below.—ED, *BMJ*.

SIR,—Dr MacRae has misunderstood the object of our trials (25 February, p 474). The value of drug blood level monitoring was not primarily in question. Ample evidence of its value has accumulated in many countries in the last 18 years.¹⁻³ The question we asked was: What is the value, if any, of polypharmacy—that is, adding a second or more drugs in patients uncontrolled by one? For these patients we planned to add either a second anticonvulsant or a placebo. However, as only 12% of our patients have failed so far on monotherapy, we are still unable to answer this question. As we discussed, our data

suggest that the success of monotherapy was largely, but not wholly, due to the availability of drug level monitoring. There was a 98% reduction in grand mal attack rate in the optimum range for both phenytoin and carbamazepine. Without monitoring 60-70% of our patients might possibly now be on multiple drugs instead of 12%.

The difference between table 2 in our earlier report⁴ and the present report of the phenytoin trial are, as pointed out, due to changes in the outcome of therapy between the two times of follow-up (mean 14.7 months and 28.5 months), including the loss of four patients to follow-up and the withdrawal of one patient with a tumour. We are preparing a detailed report of the phenytoin trial, including case histories, which will describe the outcome in each individual patient.

Finally, we agree with Dr MacRae about the importance of duration of follow-up, a point we have always stressed. Indeed, among the numerous deficiencies of anticonvulsant trials a remarkable feature has been their brevity compared with the duration for which we usually treat our patients.⁵ This is all the more important as there is evidence that seizure control tends to deteriorate with increasing duration of follow-up.⁶ However, we do not understand Dr MacRae's reference to cancer statistics, as the problems of treating cancer and epilepsy are very different. While attempts are made to "cure" cancer, anticonvulsant drugs probably only "suppress" seizures during the time of their administration. It is not possible to relate our drug data to "a specific time after the commencement of treatment," as drug levels will often vary independently of duration of follow-up. In future, we believe prognostic studies in epilepsy will have to take more account of drug level monitoring.

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¹ Buchthal, F, Svensmark, O, and Schiller, P J, *Archives of Neurology*, 1960, **2**, 624.

² Kutt, H, and Penry, J K, *Archives of Neurology*, 1974, **31**, 283.

³ Lund, L, *Archives of Neurology*, 1974, **31**, 289.

⁴ Reynolds, E H, *Proceedings of the Royal Society of Medicine*, 1975, **68**, 102.

⁵ Richens, A, *Drug Treatment of Epilepsy*. London, Henry Kimpton, 1976.

⁶ Reynolds, E H, Chadwick, D, and Galbraith, A W, *Lancet*, 1976, **1**, 923.

⁷ Coatsworth, J J, *Ninds Monograph*, No 12, 1971.

⁸ Rodin, E A, *Progress in Epilepsy*. Springfield, Illinois, C C Thomas, 1968.

Happy to starve

SIR,—Your leading article "Happy to starve" (8 April, p 874) draws attention to the possibility of underfeeding in some breast-fed babies and stresses the importance of regular weighing of babies. Paediatrics, as I believe Dr John Apley first said, is "a growing specialty" and any doctor seeing a child in his clinic or surgery is incompletely equipped if he does not have on his desk an appropriate percentile chart. For babies the most useful chart is the one drawn up by Gairdner and Pearson¹ and available from Creaseys Ltd of Hertford. Regular use of such charts is the only way to ensure that deviant growth, in either direction, is detected early. Hopefully the error involved in your misprint (the weekly weight gain should be around 190 or

200 g and not 19 g) is too gross to cause confusion.

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¹ Gairdner, D, and Pearson, J, *Archives of Disease in Childhood*, 1971, **46**, 783.

Safety in laboratories

SIR,—Your leading article (8 April, p 871) suggests that some of the recommendations of the Howie working party are unrealistic.

What is even more unrealistic is your suggestion that laboratories might be inspected for safety by environmental health officers. These excellent and already overworked men and women have no training in laboratory procedures and rarely have any knowledge of microbiological hazards. Perhaps you mean Health and Safety Executive (factory) inspectors. Some of these are already well qualified to do this work, and I understand that others are in training.

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SIR,—With reference to your leading article on safety in laboratories (8 April, p 871), it is sometimes useful to express the alternative point of view. This joint hospital and public health laboratory functioned for more than a quarter of a century in an antiquated converted Victorian workhouse, much of the time without benefit of a single exhaust cabinet or other protective device, examining more than a million clinical specimens in microbiology, haematology, histopathology, and clinical chemistry. There was no evidence of ill health among our work force which could sensibly be attributed to conditions of work.

We now have up-to-date premises with numerous safety measures—though still not everything which the mind can devise. Though doubtless it could be said that in the past we did not look carefully enough for evidence of illness in our staff, I personally feel no greater sense of security as a result of modernisation—on the contrary only more anxiety.

There was a time when, like the well-motivated nurse, we put our service to the patient first in our thoughts. Can it be that something is now being lost? Certainly we are spending a great deal of money in the "safety" industry. I must add that we did not and still do not deal with work from kidney units or organ transplant patients. I think our staff are more at hazard coming to work than at work.

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Treatment of paracetamol poisoning

SIR,—We have been interested to read the recent article (11 February, p 331) and correspondence (1 April, p 856) concerning the safety and efficacy of cysteamine and N-acetylcysteine in the treatment of paracetamol poisoning. Since 1974 the National Poisons Information Service has advocated the use of oral methionine for the treatment of this condition, provided it is administered within 10 hours of ingestion of the overdose.¹ Many hospitals have used methionine on our