rehousing can prevent violence to children, an assumption which is not supported by current studies.

Although housing problems can contribute to family stress,⁶ many people in deprived sections of the community do not batter their children,⁷ and in most samples of violent parents all social classes are represented.⁸ Studies of the social characteristics of battering parents show that they are no worse off than parents in the same social class who never batter their children.³ There is nothing to support the view that parents become violent if they have a housing problem, and it seems more likely that they batter their children and have housing problems for the same reasons: their emotional and personality problems. Constitutional personality factors have proved to be more fundamental than financial factors in the causation of baby battering.^{9,10}

Some studies even claim that rehousing, although it provides temporary relief from external pressures, may actually precipitate battering incidents.^{11,12} In one study¹³ nearly two-thirds of the parents had received financial assistance during or before the year of the battering incident. Although every effort has to be made to improve the housing conditions of the population at large, we must resist the attraction of the utopian view that violence will disappear once we have solved the housing problems of violent families. Since everybody is now talking about lack of cash, I wonder whether the money which the report suggests spending on the rehousing of violent families would not be better spent on providing more nursery placements for children from these families.

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¹ Department of Health and Social Security, *Violence to Children: a Response to the First Report from the Select Committee on Violence in the Family (Session 1976-77)*. London, HMSO, 1978.

² Davoren, E, in *Battered Child*, ed R E Helfer and C H Kempe. Chicago, University of Chicago Press, 1968.

³ Nurse, S M, *Smith College Studies in Social Work*, 1966, 35, 11.

⁴ Schaffer, H R, and Schaffer, E B, *Occasional Papers on Social Administration*, No 25, London, Bell and Sons Ltd, 1968.

⁵ Smith, S M, et al, *British Journal of Psychiatry*, 1974, 125, 568.

⁶ West, D J, and Farrington, D P, *Who Becomes Delinquent?* London, Heinemann, 1973.

⁷ Paulson, M J, and Blake, P R, *Child Welfare*, 1969, 48, 86.

⁸ Kempe, C H, *Hospital Practice*, 1969, 4, 44.

⁹ Scott, P D, *Medicine, Science and the Law*, 1969, 13, 197.

¹⁰ Smith, S M, et al, *British Medical Journal*, 1973, 4, 388.

¹¹ Gibbens, T C N, et al, *Cruel Parents*. London, Institute for the Study and Treatment of Delinquency, 1956.

¹² Skinner, A E, and Castle, R L, *Seventy-eight Battered Children: a Retrospective Study*. London, NSPCC, 1969.

¹³ Gil, D G, *Violence Against Children: Physical Child Abuse in the United States*. Cambridge, Mass, Harvard University Press, 1970.

Disposable clothing for operating theatre staff

SIR,—To lessen the amount of skin shed by male personnel in operating theatres have Dr N J Mitchell and his colleagues (18 March p 696) considered the use of clothing made with a microporous membrane of polytetrafluoroethylene (PTFE) (developed, I understand, for haemodialysis machines) bonded to fabric? Such a material is now being used by the back-packing fraternity because it is permeable to water (perspiration) vapour but

not to liquid water and so is useful and comfortable in heavy rain. It should be sterilisable.

Dr Mitchell and his colleagues do not quote the water vapour transmission of their Fabric 440; a commercial version of PTFE as above (Gore-tex) is claimed to have a transmission of about 4800 g/m²/24 h, much the same as Ventile.

My hiking friends assure me that this fabric is indeed comfortable in rain when they are climbing hard, so it may well be useful in the theatre. I have no commercial interests in the material and indeed do not own any, as I don't hike enough (alas!).

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Sweet cigarettes

SIR,—Sweet cigarettes are offered for sale at prices which young children can afford. They are given to youngsters by parents and other adults, thus giving an indication of adult approval, yet they are imitations of the real thing, similar to the packet of 10 with sometimes a cigarette card too—all that is lacking is the Government Health Warning.

In view of the very early age at which smoking is being presented as an attractive habit it is surprising that there appears to be so little comment from those interested in the smoking and health campaign. Since a letter appeared in the *Medical Officer* in 1963¹ I have been unable to trace any other references to the topic. An indication of the views of one group of health professionals, however, has been given by the analysis of a questionnaire recently sent to dentists in this health district; 128 questionnaires were despatched with prepaid envelopes for reply, 67 dentists replied as follows:

Sweets resembling cigarettes are easily available for children.

Do you consider this—

(a) of no consequence?	14	21%
(b) should be discouraged	39	58%
(c) calls for a national ban?	11	16%
Don't know	3	4%
		74%

Although dentists as distinct from general medical practitioners and chest physicians are not continually reminded of the health hazards of smoking cigarettes, 74% of this group support some discouraging action.

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¹ Hilton, M E, *Medical Officer*, 1963, 109, 111.

Maintenance treatment of duodenal ulcer with cimetidine

SIR,—We read with interest in your leading article on cimetidine (3 June, p 1435) the implied suggestion that the nocturnal dose of choice for maintenance treatment in duodenal ulceration might be 800 mg rather than the 400 mg recommended in the data sheet.

In a study of overnight gastric secretion Blackwood and Northfield¹ showed that 400 mg of cimetidine taken orally at 11 pm produced greater than 90% inhibition of acid secretion during the period 1 am to 7 am. Following a dose of 800 mg there was no alteration in the degree of suppression of either total acid output, acid concentration, or volume of gastric juice. Similarly, a study by Longstreth

and his colleagues² reported over 90% suppression of overnight acid secretion with 400 mg of cimetidine.

Studies employing endoscopic assessment of maintenance of healing of duodenal ulcers by 400 mg of cimetidine at bedtime have shown relapse rates of 19% over 12 months in a large non-selected ulcer population³ and 27% over six months in patients with severe ulcer disease.⁴ In the only study reported in which an 800-mg nocturnal dose was employed⁵ the relapse rate in a six-month period was 24%.

We would submit that there is no evidence on either pharmacological or therapeutic grounds for use of a larger dose of cimetidine at night than 400 mg to prevent relapse of duodenal ulceration.

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¹ Blackwood, W S, and Northfield, T C, in *Proceedings of the 2nd International Symposium on Histamine H₂-receptor Antagonists*, ed W L Burland and M Alison Simkins. Amsterdam, Excerpta Medica, 1977.

² Longstreth, G F, Go, V L W, and Malegela, *New England Journal of Medicine*, 1976, 294, 801.

³ Bodemar, G, and Walan, A, *Lancet*, 1978, 1, 403.

⁴ Gray, G R, et al, *Gastroenterology*, 1978, 74, 397.

⁵ Blackwood, W S, Maudgal, D P, and Northfield, T C, *Lancet*, 1978, 1, 626.

Ballot of consultants and registrars

SIR,—On 6 June I complained to the controller of ballot services of the Electoral Reform Society that of 18 consultants and 11 senior registrars in histopathology, microbiology (including PHLS), and haematology at the University Hospital of Wales, Cardiff, and its associated hospital, the Cardiff Royal Infirmary, only seven consultants and one senior registrar had been circulated with ballot papers.

The controller replied on 10 June admitting that the first distribution of ballot papers "left something to be desired" and expressed a hope that a late despatch of ballot papers, each containing an enclosure notifying the decision to extend the closing date from the publicised 9 June to 13 June, would correct the matter. This extension of the ballot served to net only two additional persons in the population I describe. The controller acknowledged that minor deficiencies will occur in any ballot, but he expressed confidence in the overall coverage of the electorate, basing this on a quoted number of 17 000 papers despatched. However, he made the point that his organisation played no part in the issue of ballot papers, or, presumably, in determining the electoral list.

I am sorry I cannot share his confidence. The electoral list has not been published and as far as I know no open attempt has been made to construct one. Consequently nobody is in the position of being able to judge whether those unfortunately omitted in the ballot circulation are drawn from certain sections of those eligible to vote. Confidence can possibly be restored if you will publish this letter to prompt others to compare their experience with mine; but, more importantly, the analysis of the ballot must give the breakdown for each of the specialties, including the honorary consultant component, as allowed for in the data entered on the ballot papers.

Only from knowledge of the size of the response from these various subgroups may the even-handed construction of the electoral