diazepoxide is also reported to have caused non-urticarial reactions.⁸

In most cases the abnormalities resolved after the offending agent was discontinued. However, rechallenge in some instances with the aetiological agent at a later date was rapidly followed by reappearance of the allergic reactions noted earlier.

This brief review clearly establishes the fact that, although hypersensitivity reactions to diazepam and other benzodiazepines are rare, they are far from being undocumented.

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When is an immigrant not an immigrant?

SIR,—The interesting article by Dr K M Goel and his colleagues from Glasgow (12 March, p 676) contains a common but misleading misuse of the word "immigrant." Of the "immigrant" 56 children they describe, 30 were born in the United Kingdom (which incidentally is 54%, not 72% as stated). According to the *Shorter Oxford English Dictionary* an immigrant is "a person who migrates into a country as a settler." The parents of these children were presumably truly immigrants (as I would be if I went to live in Scotland), but the majority of the children were not. To go on calling these child citizens of the United Kingdom immigrants is not only socially unfortunate: it also conceals the fact that their medical problems may differ from those of children who have actually migrated from overseas, and did so differ in this valuable article.

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Psoralens

SIR,—In view of recent publicity which has been given to the oral use of 8-methoxypsoralen we think it is desirable that clinicians should be aware of the fact that no product licence has been granted for oral presentations either of this substance or of 2, 4, 8-trimethylpsoralen. In consequence the position is that under the Medicines Act such products cannot be legally imported into the United Kingdom except by way of special importation by or to the order of a practitioner for administration to a

particular patient of his, or in accordance with a clinical trial certificate.

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SIR,—Following the recent publicity on the treatment of psoriasis with ultraviolet light (A) and 8-methoxypsoralen many patients will be demanding this form of therapy. It is probable that local appeals will provide funds for the purchase of the equipment and it is possible that this may be given by non-dermatologists. Although the treatment appears to be effective in many cases, the long-term effects in psoriasis are not known. All who use this, the so-called PUVA method, are asked to keep careful records of the patient response to measured exposure of the light and amount of drug given and to report any side effects encountered to the Committee on Safety of Medicines even though it might not be possible to show with certainty that these effects are produced by the psoralens.

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Amoxil and Talpen

SIR,—Dr A N P Speight (12 March, p 710), writing in support of Dr I W B Grant (12 February, p 442) states that it was impertinent of me in my reply (p 442) to question Dr Grant regarding his personal experience of amoxycillin and talampicillin. On the contrary, I would have thought it highly pertinent to inquire whether the writer has had any personal experience of the antibiotics about which he is writing. Dr Speight, however, has no such inhibitions and infers that he does not wish to be confused by the facts and states quite unashamedly that these are "minor points compared with the major issue, which is the economic one." He then, sir, takes up three-quarters of a column of your journal to discuss pricing, patents, and marketing, and includes for good measure reference to the advertising of cigarettes and detergents. He finishes with a final prod at the *British National Formulary* and an exhortation to the *Drugs and Therapeutics Bulletin* to do something about it all. I view with some suspicion the true motives of those who dwell unduly on commercial considerations, important as they are, under the cloak of academic discussion.

In contrast, Dr Grant's second letter (12 March, p 710) is worthy of serious comment as he draws attention to the comparative incidence of severe diarrhoea between ampicillin and talampicillin.¹ The figures, however, that he has extracted from table 7 of my paper completely misrepresent the data, and the fallacy of the conclusion drawn from these figures would be seized upon by even an inexperienced statistician. Dr Grant's elementary error is an example of one of the classic pitfalls that all statistical students are taught to avoid in the earliest days of their training.

The true picture is that five (1.3%) of 394 patients on talampicillin suffered from severe diarrhoea compared with eight (2.0%) of 405 patients on ampicillin. Hence Dr Grant's

conclusion that "severe diarrhoea is, if anything, more liable to occur with talampicillin than with ampicillin" is completely false. He also overlooks the other major reference² to a trial involving some 607 patients in which none suffered severe diarrhoea on talampicillin whereas three suffered from this symptom on ampicillin.

I feel that the public "nit-picking" of tables from papers must be extremely boring to your readers and rarely leads to any definitive conclusion. I would have hoped that Dr Grant would have kept his options open on amoxycillin and talampicillin, for I have no doubt that in the future he could well be applauding the virtues of these newer products.

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¹ Knudsen, E T, and Harding, J W, *British Journal of Clinical Practice*, 1975, **29**, 255.

² Jaffe, G, Murphy, E J, and Robinson, O P W, *Practitioner*, 1976, **216**, 455.

"Geriatricide"

SIR,—I stand delightfully corrected by Professor J C Brocklehurst (19 March, p 775) and plead guilty to an etymological offence in coining the word "geriatricide" (26 February, p 555). While my meaning, of course, was clear, I would hope, at least for the present, not to see my geriatrician colleagues under threat.

I am chiefly ashamed, however, of having mixed Greek and Latin. I have received the suggestion that "senecicide" would be more correct, but I doubt my ability to rise to such pedantic heights, let alone to pronounce it in the course of an oration.

Perhaps I should have persisted in language mixing and spoken of "geronticide," but then I might have been accused of sex discrimination in ignoring the female of our species. I accept checkmate.

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Effect of intravenous disopyramide on premature beats

SIR,—Disopyramide is an effective anti-arrhythmic agent which has been available for some years as an oral preparation.

We recently administered disopyramide intravenously to 10 patients with chest pain and arrhythmias of whom eight were subsequently shown to have myocardial infarction. Seven patients had ventricular premature beats, two had ventricular tachycardia, and one had atrial tachycardia. Heart rate, blood pressure, and a rhythm strip of the electrocardiogram were taken immediately an arrhythmia was noted. The measurements were repeated after 5 min, when a bolus injection of inert vehicle was given, followed by active disopyramide in a dose of 150 mg 5 min later. Further measurements and blood samples were taken at 5-, 15-, and 30-min intervals after the active drug was given.

In four patients the arrhythmia ceased before the active drug was injected, in two before and in two after the vehicle. Sinus rhythm was restored at 30 min in all but one patient whose ventricular premature beats persisted but were less frequent. Mean levels