"toxaemia" were higher in every one of the six years. Deaths from these two causes in 1969 amounted to 6.8 per 1000 and in 1975 to 8.8 per 1000 births, an increase almost exactly equal to the reduction in the rate for the "mature, cause unknown" category. Increases in both premature birth rates and maternal toxaemia have been reported in association with high induction rates, so these changes may be more than coincidental. If this is the case it may explain the failure of high induction rates to reduce overall perinatal mortality rates, even if some unexplained deaths of mature infants are thereby prevented.

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Sedatives for alcoholics

SIR,—A little while ago (21 August 1976, p 476) I wrote to you, concerned at the appearance of people referred to me who are being given chlormethiazole (Heminevrin) apparently as a "treatment" for alcoholism. The situation appears to be even worse than I supposed, since I am now beginning to meet old patients of mine who have seemed to transfer their dependence from alcohol to chlormethiazole. One such man appeared at the alcoholic unit this last weekend asking for advice. He appears to be visiting four different general practitioners at the same time and obtaining considerable supplies of chlormethiazole tablets from each, so that he is taking upwards of 40-50 tablets each day at hourly intervals.

There seems little point in our developing an alcoholism rehabilitation service if the effect is simply to allow people to transfer their drug dependence to other sedatives such as chlormethiazole, and here I would include also a caution about minor tranquillisers in general in this connection.

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The Mahler revolution

SIR,—I read with interest your leading article on this subject (30 April, p 1117). In developing countries lack of resources and unhealthy economic conditions have largely contributed to the shift in emphasis from building spacious and multistoried hospitals to health centres. In some countries the villages are so sparsely populated that even the building of a rural health centre in each of these villages is economically unviable. Rightly, these countries have embarked on the difficult exercise of regrouping smaller villages into a reasonably large area so that the provision of health services and other facilities in these areas prove economically viable projects. Many developing countries have to cope with diversity of health problems caused by rapid rural-urban drift of populations. This is a difficult problem without a simple and easy solution. The long-term solution to this rural-urban drift is to make villages more habitable and attractive.

It is important to emphasise that much of the mortality and morbidity in the slums and rural areas can be reduced by (a) provision of clean, potable water for domestic purposes, (b) cheap and safe disposal of human and

domestic wastes, and (c) health education programmes for the prevention of diseases and promotion of good health. The efforts of WHO in the field of developing and undertaking vaccination programmes in the developing countries are highly commendable, but there is an urgent need to develop cheaper and stable vaccines. In remote rural areas machines cannot be maintained and the provision of a refrigerator in a rural health centre is not a panacea to all the problems associated with vaccine administration.

The training of medical personnel should be geared to tackling the local health problems. For years to come in the developing countries the medical assistant and the "barefoot doctor" or its equivalent will play a leading role in alleviating the human misery and promoting good health. It is a good thing to have socialisation and democratisation of health services, but it slows down and retards decision-taking. A good example is the question of fluoridation of water supplies in Britain.

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Unbearable headache of temporal arteritis

SIR,—Clinicians when discussing temporal arteritis usually describe the headaches as "severe," "persistent," or "boring." Patients with temporal arteritis describe their headaches, when asked, in terms which are both more vivid and more powerful. Four of my patients, women aged 60-87, with temporal arteritis described their headaches in these words:

"It was like red hot coals on top of my head. It went right down to my toes. It was a different kind of headache. It was different altogether. It made me feel I didn't know what to do with myself."

"It went on and on day and night. I had one or two awful nights. Then one night I woke up and thought—oh, I can't get up. I must have a tumour on the brain."

"It felt as though someone had been hitting my head hard, pummelling it. I didn't know where to put it. I can cope with an ordinary headache, but this was unbearable. It made you wish to goodness you weren't here."

"It was absolutely unbearable. I have suffered from headaches all my life, and migraine. But the headache that suddenly came, well, you could hold your head in your hands and not know how to bear it. The whole of my head ached, on the top, everywhere. It was one big ache."

These four patients are well known to the practice. They have lived in this small town for between 20 and 60 years. They are not emotional women with a low pain threshold. Yet they described their headaches in an over-emphatic, even hysterical way. The nature and severity of the pain was such that they expressed themselves in words quite foreign to their usual restrained manner.

Since this discrepancy was noted five years ago further experience has shown that when an elderly woman describes her headache in flowery language and with unseemly vigour the clinician should be alerted to the possibility of a diagnosis of temporal arteritis. A patient with temporal arteritis is at high risk of serious consequences unless the diagnosis is made rapidly. Any diagnostic pointer which is available in the consulting room is valuable. It is suggested that the way and words in which

elderly persons describe their headache might be such a pointer.

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¹ Russell, R W R, *Quarterly Journal of Medicine*, 1959, **28**, 471.

Noxythiolin as a possible cause of peritoneal adhesions

SIR,—The use and advantages of noxythiolin (Noxyflex) for peritoneal lavage have been well documented by Pickard,¹ while Ellis² fully reviewed the cause and prevention of adhesions. I was interested to read that Gilmore³ in his Hunterian lecture suggested that noxythiolin lavage may prevent adhesion formation, but his research was carried out on rats. I wish to report two cases in humans in which noxythiolin may have contributed to adhesion formation.

A 12-year-old boy already had abdominal pain when his brother jumped on his abdomen. Laparotomy revealed a small jejunal perforation with minimal soiling together with an inflamed obstructed appendix. Noxythiolin lavage was carried out. Recovery was uneventful but four months later he was readmitted with intestinal obstruction. Further laparotomy showed that masses of filmy plastic-type adhesions filled the whole peritoneal cavity. He did well postoperatively and has remained well since. Histological examination of mesenteric lymph nodes showed reactive changes only.

A 13-year-old boy had lavage with noxythiolin when a ruptured appendix was removed. Post-operatively recovery was slow and at three weeks he developed small-bowel obstruction. Laparotomy showed a similar picture to that in the previous case in which the whole peritoneal cavity was involved. Postoperatively he again did poorly and did not settle on conservative treatment. Further laparotomy was performed after 2½ weeks. He now fortunately did better and has been well since. Histological examination showed non-specific inflammation.

In both the cases the peritoneal soiling was minimal and localised, whereas the adhesions were widespread and of a thin, filmy, plastic type. Noxythiolin would seem to be the most obvious cause. I wonder if anyone has noted this possible complication previously.

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¹ Pickard, R G, *British Journal of Surgery*, 1972, **59**, 642.

² Ellis, H, *Surgery, Gynecology and Obstetrics*, 1971, **133**, 497.

³ Gilmore, O J A, *Annals of the Royal College of Surgeons of England*, 1977, **59**, 93.

More thought for the elderly

SIR,—Dr C Roberts (30 April, p 1156) has highlighted an issue which has not been given sufficient thought, although it is central to the whole policy of care for the elderly. The White Paper on "Priorities for the Health and Personal Social Services"¹ discusses important changes in hospital accommodation and in community health and social services but begs the crucial question, "What is part III accommodation for?" Part III is not coping with the sort of problems for which it was originally introduced, to provide residential care for fit old people; it is coping with a clientele indistinguishable from the long-stay population of geriatric and mental hospitals. In Britain