for skilled advice on occupational health matters, and in consequence many previously neglected environmental problems have come to light which call for medical help. It is the duty of those who undertake to advise them to make it plain that these are the important tasks, and that occupational medicine does not consist of routine examinations of new employees on the pretence that the doctor can forecast future sickness absence experience or survival.

F H TYRER

Bettws Newydd,
Usk, Gwent

¹ Taylor, P J, *British Journal of Industrial Medicine*, 1967, 24, 93 and 169.

² Taylor, P J, *British Journal of Industrial Medicine*, 1968, 25, 106.

³ Taylor, P J, *Transactions of the Society of Occupational Medicine*, 1968, 18, 96.

Uniform style for biomedical journals

SIR,—The decision of the International Steering Committee of Medical Editors (20 May, p 1334) to recommend the adoption of the style of abbreviations of names of journals as used in *Index Medicus* will be welcomed by most medical librarians, as this decision follows the recommendations of the Library Association Medical Section.¹ May I, however, point out a current trend which is rather disturbing?

The redesign of journal covers, in line with modern design practice, often gives prominence to the initial letters of the title. The example known to most of us is the *Journal of the American Medical Association* (known almost everywhere as *JAMA*). Thus the current list of journals indexed in *Index Medicus*² includes, as well as *JAMA*, the following: *AJR*, *JAOA*, *JCU*, *JNM*, *JOM*, and so on, but the most striking example is that two journals are listed as *ZFA* (Dresden) and *ZFA* (Stuttgart), where the A is not even the abbreviation for the same word.

The adoption of an international standard for the abbreviation of titles of periodicals is highly desirable, and was pioneered by the *British Medical Journal* with its compilation of *World Medical Periodicals*,³ now sadly out of date. The scheme used by the National Library of Medicine for *Index Medicus* follows very closely ISO-4-1972,⁴ with the exceptions noted above, but I wonder how long it will be before it is reduced to a set of incomprehensible initials.

D J WRIGHT
Deputy librarian, BMA

BMA House,
London WC1

¹ Library Association Medical Section, *Reference Citation Recommendations*. London, Library Association, 1972.

² United States National Library of Medicine, *List of Journals Indexed in Index Medicus*. DHEW Publication No (NIH) 78-267. Washington, US Govt Printing Office, 1978.

³ Fleurent, C H A, (editor), *World Medical Periodicals*, 3rd edn. New York, World Medical Association, 1961.

⁴ International Standards Organisation, *International Standard ISO-4-1972 (E). Documentation—International Code for the Abbreviation of Titles of Periodicals*. Geneva, ISO, 1972.

Axillary hyperhidrosis

SIR,—Dr David Bird's helpful letter (29 July, p 357) adds a further five patients to the lengthening list of cases of axillary hyperhidrosis whose distressing symptoms have been eliminated by the use of a modification

of the regimen originally reported by Hurley and Shelley.¹

I write only to amplify a sentence of Dr Bird which I think might perhaps mislead. He suggested: "It is too soon to abandon surgery completely since the long-term results of this topical treatment are not known." He clearly refers to the possibility of loss of effect of the aluminium chloride hexahydrate preparation with the passage of time. Although we considered it too early to include it in our paper, the average time between treatments in our patients has steadily lengthened, so that an increasing number now have to make applications only once every two to three weeks.

K T SCHOLES

Princess Margaret Hospital,
Swindon

¹ Hurley, H J, and Shelley, W B, *Journal of the American Medical Association*, 1963, 186, 109.

Dangers of glass doors

SIR,—I have just come across yet another incident of an extremely serious injury involving a glass door. One wonders whether the aesthetic value of such doors justifies the injuries that occasionally occur. It seems to me that it ought to be illegal to use full length glass doors, screens, or windows without a horizontal dividing or preventive bar, strong enough to take the weight of a fairly heavy person falling against it. An alternative would be to use armoured glass.

A J PIM

Nettlebed,
Henley on Thames

Atenolol self-poisoning

SIR,—The recent reports provide several examples of self-poisoning with β -adrenoceptor blocking agents. The outcome of these cases has varied from being relatively uncomplicated¹ to fatal.² The opinion that these agents, even in massive overdosage, represent little hazard to the normal healthy subject whose myocardial performance is not dependent on sympathetic drive has already been expressed.³ We therefore consider it of interest to report what we believe is the first recorded case of atenolol self-poisoning in a patient with normal cardiac function.

The patient, a 24-year-old woman with a psychiatric history, was being treated for hypertension secondary to chronic pyelonephritis. In recent months her blood pressure had been well controlled on a combination of clonidine and atenolol. A recent assessment of her renal and cardiac function (including serum urea, electrolyte, and creatinine estimations and electrocardiography) showed nothing abnormal. In attempting suicide she took about 1200 mg of atenolol, the number of tablets being reliably confirmed by a relative who was familiar with her treatment and her current supply.

On admission to hospital, two to three hours later, her general condition was very good. Her

pulse rate was 80 beats/minute, with a recumbent blood pressure of 150/110 mm Hg. There were no signs of cardiac decompensation. None of the tablets were recovered from the gastric contents on lavage. She was closely monitored over the ensuing days both clinically and electrocardiographically, during which time her pulse rate varied between 66 and 80 beats/minute in sinus rhythm. Renal function remained normal. With the temporary withdrawal of all medication, however, her blood pressure rose gradually, reaching 190/120 mm Hg five days later. Control was then re-established with a combination of atenolol and prazosin. Her further clinical course was uncomplicated.

In addition to normal myocardial function, other features are worthy of mention. Although tolerance to most beta-blockers is very variable, atenolol has a much narrower effective dose range.^{4,5} Doses over the average 100-200 mg/day regimen, although further affecting pulse rate, do not confer any additional benefit in hypertension. Large doses of atenolol have been well tolerated by volunteers,⁴ after gradual titration, and perhaps the existing beta-blockade in our patient conferred a similar protective titrating effect.

F L J SHANAHAN
T B COUNIHAN

Mater Misericordiae Hospital
and University College,
Dublin

¹ Wermut, W, and Wojcicki, M, *British Medical Journal*, 1973, 3, 591.

² Khan, A, and Muscat-Baron, J M, *British Medical Journal*, 1977, 1, 552.

³ Boakes, A J, and Boeree, B H, *British Medical Journal*, 1973, 4, 675.

⁴ Zacharias, F J, and Cowen, K J, *Postgraduate Medical Journal*, 1977, 53, suppl No 3, p 111.

⁵ Zacharias, F J, Hayes, P J, and Cruickshank, J M, *Postgraduate Medical Journal*, 1977, 53, suppl No 3, p 114.

Efficacy of rubella vaccination

SIR,—The timely letter from Dr W J C Roberts on the efficacy of rubella vaccination (5 August, p 433) reminds us that not all women shown by laboratory tests to be susceptible to rubella develop rubella haemagglutination-inhibiting (HI) antibodies after vaccination. Unfortunately he does not name the vaccine he used or the dilution of the patients' serum without antibody which indicated susceptibility. If facilities are available we would support his suggestion of testing a postvaccination serum sample and revaccination if the patient has not developed antibodies.

In some maternity units in this area post-natal rubella vaccination with Cendevax is offered to patients if previous laboratory tests have shown that they are susceptible to rubella. A serum sample is collected approximately eight weeks after vaccination (unfortunately this period varies with circumstances), and the pre- and post-vaccination serum samples are tested in parallel for rubella antibodies. The table shows that during the period February 1977 to March 1978 4.9% of women with a titre of <1/8 failed to produce HI antibodies after vaccination. Of the four postvaccination serum

Post-vaccination rubella HI antibodies in serum from 82 women with titres <1/8 who were vaccinated with Cendevax

No tested	Weeks after vaccination when serum was collected	Post-vaccination rubella HI antibody titres							
		<1/8	1/8	1/16	1/32	1/64	1/128	1/256	1/512
62	5-9 (mean 7)	4	1	4	16	25	10	2	—
20	≥10 (mean 22)	—	2	3	5	6	1	2	1