that a senior member of a department of radiology can reduce barium studies to the status of entirely non-medical examinations. He should be aware, furthermore, that such barium studies would almost certainly be performed by junior radiographic staff, as their senior colleagues, in the absence of radiologists, would find their time fully occupied in trying to assist the clinicians in their attempt to undertake highly specialised examinations such as vascular or neurological procedures.

I take further exception to Dr Thomas's statement that radiology should be performed by technicians under the guidance of clinicians. These technicians presumably would be either personnel untrained in matters relating to radiation safety or radiographers. If the former, then this is highly undesirable; if the latter, then he is impertinent in thinking that radiographers can be simply "let out" to clinicians alongside the equipment and x-ray rooms. Any such major change in their role could not be contemplated without full consultation with the College of Radiographers.

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Beta-blockers in treatment of hypertension

SIR,—We agreed to the inclusion of labetalol in Dr R G Wilcox's study (5 August, p 383) to discover whether a once-daily regimen was an appropriate method of starting labetalol treatment. Dr Wilcox found that when treatment was begun using doses of 300 mg and 600 mg once daily it was ineffective in controlling the blood pressure over the full 24-h period and that there was more lethargy and nausea than with the plain beta-blocking drugs. This is what we expected from a drug which can lower the blood pressure within two hours of starting oral therapy; but it was necessary to examine a once-daily dosage regimen in clinical trial. Thus our recommended starting dose for labetalol (Trandate) in the treatment of hypertension is 100 mg thrice daily. This dose is doubled, if necessary, after one to two weeks. Further increases may be necessary in patients with more severe hypertension. These doses were chosen as the result of an extensive programme of clinical evaluation of labetalol.

We have monitored the use of labetalol in the treatment of hypertension in general practice for the past 17 months. Nearly 7000 patients from 2000 general practices entered

the survey. After treatment with 100 mg three times a day for three and six months 80.5% and 81.6% of patients had a reduction in diastolic blood pressure of at least 15 mm Hg. Similar figures were obtained in those patients who were treated with 200 mg three times a day and when labetalol was added to the existing antihypertensive treatment which over half the patients were receiving when they entered the survey, the drugs involved being given in divided doses according to the manufacturers' recommendations. The table records the commonest side effects encountered following the use of all the available beta-blocking drugs, methyl dopa, and labetalol. The overall incidence of side effects with labetalol is certainly not more than with the other drugs and may be less than that with plain beta-blockers. The special advantage with labetalol is, however, that its hypotensive effect results primarily from a reduction in the total peripheral resistance¹⁻³ and not, as with plain beta-blockers, from a reduction in the cardiac output.^{4,5} A more detailed account of the labetalol monitoring scheme is now being written for publication.

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¹ Koch, G, *British Journal of Clinical Pharmacology*, 1976, 3, suppl 3, p 725.

² Koch, G, *British Journal of Clinical Pharmacology*, 1976, 3, suppl 3, p 729.

³ Edwards, R C, and Raftery, E B, *British Journal of Clinical Pharmacology*, 1976, 3, suppl 3, p 733.

⁴ Tarazi, R C, and Dustan, H P, *American Journal of Cardiology*, 1972, 29, 633.

⁵ Lund-Johansen, P, *British Journal of Clinical Pharmacology*, 1976, 3, 445.

Investigating stroke

SIR,—Your leading article (10 June, p 1503) was appropriate, but Dr C Twomey (26 August, p 637) draws false and erroneous conclusions from his review of 1000 vascular strokes and 30 symptomatic brain tumours seen in a geriatric unit over a period of seven years. To suggest that "progressive mental and/or focal neurological symptoms are the two most significant features [of brain tumour] in the elderly, while headache or epileptic seizures are far less common than is the case with younger patients" is totally illogical because there is nothing special or characteristic about the clinical presentation of cerebral tumours in the age group Dr Twomey is concerned with. This creation of artificial and superficial differences between the different age groups in this instance where

none exists in reality is wholly unwarranted.

He also expresses surprise at finding only four patients with subdural haematoma compared with 1000 with vascular strokes and 30 with symptomatic brain tumours and concludes that even though many elderly people fall, only very few of them suffer from subdural haematoma as a result. The plain unvarnished truth is that if an elderly patient, irrespective of age, is suspected of having a subdural haematoma or an intracranial tumour the last place he or she will be referred to is a geriatric unit.

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Chlormethiazole addiction

SIR,—The very interesting case report by Dr Josephine M Cushnie and others (29 July, p 355) once again "underlines the dangers . . . of the long-term use of chlormethiazole in alcoholics" which have been previously stressed in your columns¹⁻³ and elsewhere.⁴

At a time when many practitioners regrettably seem to have started using the drug for their ambulant alcoholic patients for long periods these warnings are timely, but at the same time they should not be taken out of context. Our own experience over the past 15 years in the withdrawal treatment of many hundreds of male and female alcoholics at the St Bernard's Hospital Alcoholic Unit⁵ has not only fully confirmed the findings of many (mainly) Scandinavian and German observers that chlormethiazole is an extremely valuable drug in the treatment (and prophylaxis) of severe alcohol withdrawal symptoms (including delirium tremors)⁶ but has also indicated that when used in inpatients and for a limited period only (as a rule for no longer than six or seven days)⁵ the risk of dependence is extremely low. In fact we never saw any cases of dependence among these patients, but we have come across a number of cases of dependence (mainly psychological but in one or two instances also physical) in alcoholics who had been prescribed the drug by their doctors for lengthy periods on an ambulatory basis.^{4,7} In all these instances the patients were emotionally highly unstable individuals who often in the past had also misused other drugs apart from alcohol.

In our experience, therefore, the—undoubtedly very real—risk of chlormethiazole dependence applies in the main to its indiscriminate, lengthy use in unstable alcoholics treated as outpatients.⁷ This view conforms

Symptoms reported by hypertensive patients (percentages) receiving various antihypertensive drugs or no treatment

Side effect	α -Methyl-dopa (n=280)	Propranolol (n=96)	Oxprenolol (n=55)	"Slow" oxprenolol (n=55)	Atenolol (n=36)	Metoprolol (n=24)	Acebutolol (n=37)	Other β -blockers* (n=26)	No treatment (n=1832)	Labetalol			
										3 months		6 months	
										≤ 400 mg (n=1061)	401-600 mg (n=280)	≤ 400 mg (n=317)	401-600 mg (n=110)
Lethargy	15.4	10.4	7.3	10.9	13.9	12.5	5.4	14.3	1.4	3.9	5.0	2.5	3.6
Dizziness	9.3	4.2	3.6	9.1	8.3			14.3	5.3	4.5	3.2	2.5	3.6
Headache	5.7	4.2	3.6	3.6	8.3				6.8	1.9	5.7	1.6	2.7
Upper gastrointestinal tract symptoms (including nausea)	2.9	2.1	7.3	3.6	5.6	4.2	5.4	3.6	0.8	2.6	2.1	1.3	0.9
Postural hypotension	6.1		1.8	1.8					0.2	0.7	1.4	0.6	2.7
Depression	4.3			5.5					0.2	0.7	0.7		
Dyspnoea	1.8	1.0		1.8	5.6	4.2			1.3	1.4	1.4	0.9	2.7
Tingling sensation in skin/scalp†	0.7	1.0				4.2			0.5	1.0	1.1	0.3	1.8

*Pindolol, timolol, and sotalol.

†Includes other paraesthesiae.

to the conclusion arrived at by Hodson⁸ after a detailed review of the international literature regarding the use and misuse of chlormethiazole in general—that is, also in geriatrics or obstetrics (pre-eclamptic toxæmia, eclampsia). No cases of dependence have been reported among geriatric or obstetric patients and those reported among alcoholics (and with sufficient detailed data available) referred as a rule to highly unstable personalities. It should therefore be stressed that the risk of chlormethiazole dependence is a real one when the drug is “misused” in (unstable) alcoholics but seems very low when it is used in the withdrawal phase of alcoholics in the correct way, and equally so when used among the non-“dependence-prone” segment of the population.

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- ¹ Bradley, J J, *British Medical Journal*, 1977, **2**, 774.
² Glatt, M M, *British Medical Journal*, 1977, **2**, 1088.
³ Horder, J M, *British Medical Journal*, 1978, **1**, 693.
⁴ Glatt, M M, *Alcoholism—A Social Disease*. London, English Universities Press, 1975.
⁵ Glatt, M M, George, H R, and Frisch, E P, *British Medical Journal*, 1965, **2**, 401.
⁶ Frisch, E P (ed), *Acta Psychiatrica Scandinavica*, 1966, **42**, suppl 192.
⁷ Glatt, M M, Lecture at the 22nd International Institute on Prevention and Treatment of Alcoholism, ICCA, Vigo, Spain, 1975.
⁸ Hodson, K, personal communication.

Breathing other people's smoke

SIR,—A recent study,¹ to which there was no reference in your leading article (12 August, p 453), sheds a little more light on the possible health risks of breathing other people's smoke. As part of a population study in three USA towns the contribution of familial factors, including smoking, to lung function and respiratory symptoms was investigated in 376 families with 816 children. Neither lung function nor respiratory symptoms of a non-smoking husband or wife were affected by a smoking spouse. Parental smoking appeared to have no effect on children's respiratory symptoms. The children themselves answered questions about cough and phlegm. In other studies which have shown an association between children's symptoms and parental smoking parents answered the questions for their offspring and this may have biased the results. Also in the USA population study¹ there was no convincing evidence that parental smoking adversely affected children's lung function. Out of five different measurements of lung function the only significant association was that daughters' maximum expiratory flow rates at 50% of forced vital capacity were lowest in families in which the mother smoked and the father was a non-smoker. The effect was small and could have been a chance finding. However, smoking parents compared with non-smokers had a significant reduction in forced expiratory volume in 1 s and the results for forced vital capacity and flow rates showed similar trends.

The only definite evidence that parental smoking may affect their children's respiratory system is that infants of smoking parents have more respiratory illness during the first year of life than infants of non-smoking parents,² but in the same population this association was absent in children aged 1-5 years. At present there is no firm evidence that these illnesses in children under one year have a serious and lasting effect as no excess of respiratory illness

or diminished lung function has been found in the older children of smoking parents.

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- ¹ Schilling, R S F, et al, *American Journal of Epidemiology*, 1977, **106**, 274.
² Colley, J R T, Holland, W W, and Corkhill, R T, *Lancet*, 1974, **2**, 1031.

SIR,—In your leading article on this subject (12 August, p 453) you write that “small amounts of nicotine inhaled by non-smokers are unlikely to have any medical importance.” In a recent publication in *Allergie et Immunologie*¹ I describe an atopic dermatitis affecting five members of my family who are clinically hypersensitive to the nicotine alkaloid of *Nicotiana tabacum*. We have a specific degranulation of the basophils (DIB test of Benveniste²) with the hapten nicotine bound to human serum albumin and the passive cutaneous anaphylaxis test is strongly positive in the rabbit. A single puff of tobacco smoke can induce an anaphylactic reaction of the skin—“atopic dermatitis” or “asthma of the skin” (Tuft).

We are at present carrying out investigations with Professor A L De Weck, of the Institute for Clinical Immunology in Berne, the results of which will be published shortly.

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- ¹ Sudan, B J-L, *Allergie et Immunologie*, 1978, **10**, 36.
² Benveniste, J, *Annals médicales de Nancy*, 1977, **16**, 49.

SIR,—Your leading article (12 August, p 453) explained that two cases of lung cancer per 100 000 per year are caused by the benz(a)-pyrene in environmental tobacco smoke, that environmental tobacco smoke may endanger persons with coronary heart disease, and that children of smokers have more upper respiratory tract infections than children of non-smokers. Yet you conclude that breathing other people's tobacco smoke does not pose “serious risks to health.” I feel certain that those two persons with lung cancer caused by environmental tobacco smoke, those many persons whose attack of angina pectoris was exacerbated by environmental tobacco smoke, those children of smokers with upper respiratory infections, and those thousands of persons with either pre-existing respiratory ailments or allergies to tobacco smoke would believe that tobacco smoke *did* pose a serious risk to their health. However, the issue is not whether tobacco smoke poses “serious” risk to non-smokers; it is whether smokers have a right to expose non-smokers to *any* risk. Tobacco smoke, unlike emissions from automobiles or factories, is not the product of a socially necessary activity.

Finally, you state that since environmental tobacco smoke does not pose serious risks to health, non-smokers' assertion of “the right to breathe smoke-free air must be based on aesthetic considerations.” Legal considerations are totally neglected. At English and American common law a battery is the “intentional, unpermitted, offensive touching of the person of another,” regardless of whether such touching causes harm to the health of

the other. The legal harm is the offensiveness of the touching (kissing an unwilling party may be a battery). The touching may be with an instrument (a rock, smoke). Your readers have social and legal as well as medical grounds to insist on smoke-free air.,

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* * * This correspondence is now closed.—ED,
BMJ.

Uniform style for biomedical journals

SIR,—So far your published correspondence on this topic has not included the views of those likely to benefit the most—namely, biomedical writers and their long-suffering secretary/typists. Perhaps they are afraid to put their names on record for reasons of modesty? Not being so inhibited, we are presuming to write on behalf of the myriads who have spent countless hours of work in adapting and readapting the style of references. Such a morass of minute and conflicting requirements is so ridiculous as to be laughable and so expensive of time and money as to be a reproach to our joint sense of responsibility.

The International Steering Committee of Medical Editors (20 May, p 1334) deserves not merely thanks and appreciation but, wherever it might be effective, wholesale support. For instance, those of us who submit manuscripts could invariably adopt the recommendations (including any subsequent refinements or modifications).

Perhaps the day may come when you, Sir, and your fellow editors will find further modification unnecessary. There will be little lost but much would be gained.

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Misdiagnosis of amoebiasis

SIR,—It was with some concern that I read the letter from Dr T H Foley and his colleagues (5 August, p 428) and your leading article on the same subject (p 379), both of which appeared to undermine public confidence in the availability of reference services for the diagnosis of amoebiasis.

At the invitation of Sir James Howie, at that time Director of the Public Health Laboratory Service, a reference service for the diagnosis of this potentially lethal but curable disease was instituted at this hospital in October 1969. The service has remained freely available to every hospital and microbiology laboratory in the United Kingdom and is in fact used regularly by the very hospital from which Dr Foley writes. Of the many thousands of requests for investigations relating to the diagnosis of amoebiasis since the service was begun, none has ever been declined.

The service has been listed annually, together with other diagnostic services, in the *PHLS Year Book and Directory*, copies of which are available to every hospital laboratory throughout the country. Judging by the ever-increasing (though welcome) demands made