the limits of their own recognised competence in both diagnosis and treatment, but I think that Dr Waxman's use of the term "lay" is ambiguous. While "lay" originally meant "non-clerical," it is now sometimes understood to mean "non-medical," and hence his reference to "lay therapists" in the first paragraph of his letter is perhaps misleading. The fact that his own society is helping to give training in hypnosis to professionals who are neither medically nor dentally qualified should make clear the recognised status of hypnosis in therapy today.

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¹ Marks, I M, in *Advances in Behaviour Therapy*, ed P M Herson. New York, Academic Press, 1974.
² *British Journal of Psychiatry Supplement*, 1973, 123, 26.

Patient package inserts

SIR,—Your leading article (26 August, p 586) mentions a number of criticisms of patient package inserts, including making patients afraid of adverse reactions. It is also possible for the inserts to make patients afraid of their illness. Ten years ago I wrote to the manufacturers of Quinoderm acne cream objecting to the wording on their insert. This states that "the pustular and cystic forms of acne are of major importance, as the destruction of tissue and resultant scarring produce permanent disfigurement in a disease which often resolves spontaneously in later life." In my opinion this description is both unnecessary and, more important, when read by the troubled adolescent with acne must produce much unhappiness and anxiety. The dread of all with acne, but the outcome of only a few, is that the lesions will never clear—this insert appears to confirm the secret dread.

Ten years ago a representative of the manufacturers assured me that they would change the wording to a more suitable form. I now invite the manufacturers to carry out this undertaking. In the meantime, as and when I prescribe the product I shall continue to note on the prescription, "Without insert."

J DEANE COLLINGE

Sleaford, Lincs

Side effects of antibiotics in mountain climbers

SIR,—Dr D S Reeves and his colleagues (5 August, p 410) state that, compared with the original compounds, tetracycline derivatives may give improved blood concentrations, "but whether this results in fewer side effects is unproved." Mountain climbers are prone to many infections of the gastrointestinal and respiratory tracts for which

antibiotics are indicated but have learnt by bitter experience that both the illness and the side effects of antibiotics can be equally enhanced and distressing at great heights. The following small study may be useful.

Forty mountain climbers in the Peruvian Andes climbed at heights between 4900 and 6400m (16 000 and 21 000 feet). They often suffered from a variety of intestinal and respiratory infections. They were offered an antibiotic without recognising or being told its nature—ampicillin, tetracycline hydrochloride BP, or lymecycline in a randomised order—two unlabelled commercial capsules twice daily for three to four days. The table shows the freedom from side effects of lymecycline as opposed to ampicillin and tetracycline hydrochloride, as shown in previous studies in hospital patients.¹⁻³ In nine later episodes of intestinal or respiratory infection the climbers all demanded lymecycline; one only complained of abdominal discomfort. It thus seems an antibiotic of choice for mountain climbers.

The lymecycline was supplied by Montedison Pharmaceuticals Ltd. The study was helped by grants from Glaxo Research Ltd and Leo Laboratories Ltd.

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¹ Pines, A, *et al*, *British Medical Journal*, 1964, 2, 1495.
² Pines, A, *et al*, *British Medical Journal*, 1968, 2, 735.
³ Pines, A, *et al*, *British Journal of Diseases of the Chest*, 1968, 62, 19.

Successful defibrillation in general practice

SIR,—We wish to report the following case, which may be unique.

One of us (ADS) was called one morning recently to the home of a 49-year-old man with chest pain. He had previously been well but over the previous few days had had chest pain apparently relieved by antacids and attributed by him to indigestion. That morning the pain had been much worse and had radiated to neck and left arm. It had been present for 35 min when ADS arrived, followed 10 min later by JB, the new trainee assistant in the practice.

Physical examination, apart from the obvious distress of the pain, was negative. Following a presumptive diagnosis of myocardial infarction the patient was given 8 mg of Cyclimorph (morphine and cyclizine tartrates) intravenously. Arrangements were made for transfer to the local coronary care unit (CCU) 18 miles away.

The ambulance arrived as we were about to leave some 20 min after first arrival. At that point the patient became unconscious, with a suffused face and no palpable pulse. He was pulled off the couch and external cardiac massage (ECM) and occasional mouth-to-mouth assistance with ventilation were started. The ambulance was despatched to the local cottage hospital for the electrocardiograph and

portable defibrillator, recently acquired with funds raised locally by the Rotarians. The acquisition of the defibrillator had been met with varying degrees of scepticism about its likely usage.

Within 10 min the defibrillator arrived. The patient continued to require ECM, but his colour stayed good and his pupils small. Indeed, the major problem was that he kept surfacing and he had to be given 20 mg of Omnopon-Scopolamine intravenously to sedate him. The first shock produced a steady regular pulse, but it was short-lived and two further shocks were required. On the advice of the consultant in the CCU, relayed over the phone, the patient was given 100 mg of lignocaine intravenously.

We accompanied the patient in the ambulance to the CCU. The journey time was 25 min and the journey started some 40 min after the first onset of what must be presumed to have been ventricular fibrillation. The patient's condition was stable in the ambulance, not unconscious but drowsy enough to be quite relaxed. He is soon to be discharged from hospital, well, with the diagnosis of myocardial infarction confirmed.

This case has two areas of importance. Firstly, general practitioners should not assume that they are never likely to find access to a defibrillator to be of any value. An offer of such a piece of equipment should be seriously considered. Secondary, primary intensive coronary care might be considered to be within the province of interested trained general practitioners who have access to the appropriate equipment. Such a service could complement or in some circumstances take the place of mobile hospital teams.

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When and why are babies weaned?

SIR,—I would like to challenge several of the comments made by Dr Herbert Barrie (26 August, p 633) about the "nonsense" of giving solids to babies before 4-6 months.

Hunger in breast-fed babies is due to an inadequate milk supply, not to a need for solids. It is suggested that instead of feeding the baby more frequently to prevent hunger he should be given solids. However, the disadvantages of possible obesity due to frequent breast feeds must be weighed against the disadvantages of early solids. Two- to three-hourly breast feeding in any case won't necessarily stop the baby crying—he may want to suck more than that and it is ill-advised to put across the idea that breast-feeding should be timed in this way. Babies allowed unrestricted access to the breast suck not according to any schedule but in a random way, sometimes taking extremely frequent feeds or even wanting to suck on and off for several hours on end and sucking for anything from a couple of minutes to an hour or so at each breast. Growth is at its height in the third month and an increase in crying is the baby's way of informing his mother that he wants to suck more and so increase her milk supply by raising her prolactin levels.

It is well proved that the fully breast-fed baby has seven times less allergy in infancy than the baby given foreign protein, partly because the baby's gut lining is protected from damage by, and the ingress of, foreign protein

Comparative incidence of side effects

Antibiotic	No of patients	Total side effects	Diarrhoea for first time	Severe abdominal discomfort appearing or increased
Ampicillin	8	5	2	3
Tetracycline hydrochloride .. .	10	5	2	3
Lymecycline	8	0*	0	0

*P < 0.05.