we believe that the trial is worthwhile. We have also found that many parents starting subcutaneous infusion at home have acquired new hope and a greater personal involvement in the care of their children. The main obstacle to routine home treatment, apart from the psychological difficulties, is the cost of a subcutaneous infusion apparatus (including the syringe driver, still half the price of a colour TV set, and a scalp vein needle for each infusion).

In conclusion, our short-term experience is encouraging: if its efficacy is confirmed by long-term trials, subcutaneous infusion therapy promises to be a reliable, convenient method of preventing or reducing iron overload in transfusion-dependent patients.

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Naming of drugs

SIR,—The explosion of drugs on to the market is disturbing, and the dangers were emphasised by Sir Richard Doll in Oxford six years ago. Not only do drugs have chemical and proprietary names, but the same preparations are often marketed under different names. The prescriber finds it difficult to remember these and to distinguish one drug from another. When the names of the drugs are very similar errors are likely to occur. For this reason the name Molivate was changed to Eumovate. Other drugs, such as Movelat and Motival, are easily confused. The biochemical effects of Sinthrome and Sintisone or of Optimax and Optimine are very different, but again the names are very close. Can many of these names not be simplified before more accidents occur?

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*. *Since all the names mentioned by Dr MacGregor are those of proprietary preparations his letter provides one more good argument in favour of using BPC approved names. These are carefully devised not only to avoid confusion with other names but also to indicate, wherever possible, the pharmacological group to which the drug belongs.—Ed, *BMJ*.

How to appear on television

SIR,—May I comment on the article about appearing on television by Mr Karl Sabbagh (21 October, p 1145)? His thesis is that a doctor who is approached to appear on TV should "trust" the producer in deciding whether or not he should appear on TV. What Mr Sabbagh fails to say is what the position of the doctor is if the producer misuses that trust.

Several years ago I was asked to contribute to an article in a national newspaper on a medical theme currently of public interest. I placed my "trust" in the journalist involved—much to my subsequent chagrin. The article was not in the form that the journalist informed me that it would be; and it contained material that I specifically wished to be excluded. The result of my willingness to give my services "as a person who does have something to contribute" (to use Mr Sabbagh's

phrase) was that I received the inevitable letter from the GMC, paid over £160 for a legal opinion on whether I had a case to sue for libel, and had several weeks of letter writing—and throughout all this time very much aggravation.

During the past year I have been approached twice to appear on TV for the purpose of contributing to a discussion on a subject of current public interest. My immediate reaction was a very definite "no," and I strongly recommend any doctor similarly approached to think twice about the proposition, despite Mr Sabbagh's comments. The question the doctor should ask himself is whether he can envisage medical colleagues who were not invited to appear on the TV programme watching their television sets with notebook in hand, having already looked up the GMC's address in Hallam Street, and just waiting to send off the letter of complaint. If such a scene can be imagined, then I suggest that he forget the invitation—the decision not to appear may not be "particularly good for medicine," but it will definitely be very good for one's own peace of mind.

J SLOME

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SIR,—Mr Karl Sabbagh in his interesting piece on appearing on television (21 October, p 1145), while offering some useful hints, omits some of the unexpected hazards.

The person who phones has, in my experience, rarely been the producer but a research assistant. Well-informed, courteous, and seductively persuasive she briefs you well, tells you of an eminent colleague who may be participating and what line she thinks you ought to take. She omits to say that there will be at least five others on the panel and that if you are lucky you may have 20 seconds of talking time. And that's after you have rearranged, with great difficulty, all your other commitments and suffered the concern and the anxiety that appearing on television entails.

Or what's worse is when you accept, at very short notice, a pressing invitation to be on the programme the following evening which you consider worth while, only to be told half an hour before the car arrives that "owing to unforeseen circumstances" this part of the programme has had to be postponed. Fair enough, but what of the indignity when they put the programme on a week later with another colleague in your place and neither explanation nor apology?

Even worse is to be invited to take part in a programme in a few hours' time, and because it is all so rushed nobody in the studio has time to talk about it and before you realise it either you are in the studio about to appear in somebody else's slot or, what happened to me, somebody else was about to do your bit.

But there are innumerable well-timed, carefully thought out programmes in which it is a privilege to participate and which enable you to "say something important about your own specialty in minutes."

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Day hospitals

SIR,—Having had a research interest in geriatric day hospitals for the last three years, I was very interested to read of the work of a Nuffield-funded day hospital mainly for pre-

terminal cancer patients (14 October, p 1053). Though not documented, some geriatric day hospitals have carried out similar supportive work in elderly cancer patients, with benefit both to patients and to relatives (if any).

Professor E Wilkes's day hospital also caters for those with "chronic disease" and here there is even more overlap with geriatric day hospitals since the conditions treated are very similar (strokes, arthritis, Parkinsonism), as are the therapy and diversions used. Although geriatric day hospitals cater mainly for those in their 70s and 80s, about 13% of their work is with younger disabled patients with strokes, multiple sclerosis, etc; and this group is similar to those treated in the Sheffield unit.

It would seem very desirable, as Professor Wilkes suggests, that any new day hospital function should be grafted on to existing units, to avoid duplication of staff and skills and to avoid worsening of transport difficulties. If the physicians and surgeons who first care for these cancer patients will continue their care in the day hospitals, enlarging and sharing the facilities with geriatric physicians, this would be a further and desirable move in the integration of general and geriatric medicine.

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Drug treatment of psychiatric patients in general practice

SIR,—I am disappointed that your correspondents look on my survey (7 October, p 1008) as destructive academic research. I had hoped that the "practical help and advice on how to help our patients" asked for by Dr D C Hogg (28 October, p 1228) would be detected in the article. If, as a result of reading it, doctors now prescribe benzodiazepines singly, for short periods at a time, and in flexible rather than fixed dose schedules, and recognise that low dosage of antidepressants is adequate for sedation but inadequate to produce antidepressant activity, they will help their patients a great deal.

Dr I H McKee (4 November, p 1296) claims that my conclusions cannot be justified as I was a participant in the consultative process, and as my sample was a psychiatric outpatient one the results are not applicable to general practice. He is right in assuming that general practitioners did receive feedback about their prescribing habits—I hope this was recognised as much from the clinical response of their patients as from any ex cathedra pronouncements I may have made—and in the last two years of the study there was less incorrect prescribing than in the first. This is likely to reduce errors in prescribing in those patients referred to an outpatient clinic, but Dr McKee nevertheless suggests that those who are treated by general practitioners alone might show fewer prescribing errors. This cannot be answered from the study, which, as its title indicated, was concerned with patients seeing a psychiatrist. However, as the survey was concerned with prescribing habits rather than response to treatment I have no reason to believe that the practitioner's general prescribing principles differed for other patients. Of course not all general practitioners refer patients to psychiatric outpatient clinics, but from my experience of the generally high quality of care given to the patients I saw I doubt whether the doctors who did not refer

were superior in their prescribing habits. Dr McKee also queries the dosage level of antidepressants regarded as inadequate. Nortriptyline is prescribed in lower dosage than amitriptyline and 18 tablets daily (37.5 mg) was taken as equivalent to amitriptyline 50 mg daily. Dr C H Gill (4 November, p 1296) points out that often a drug is prescribed for psychological rather than pharmacological reasons. Whatever the merits of this practice, and many would question it, drugs prescribed in this way are incorrectly prescribed on pharmacological grounds. I hope that most prescriptions are given for their ingredients rather than as tokens.

I am sympathetic to the difficulties of general practice but do not accept that they are so great that psychotropic drugs must continue to be prescribed incorrectly. Although individually such errors may appear small, nationally they are large, no matter whether viewed from the ivory towers of academe or the grass roots of general practice.

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Mortality and morbidity of reusing dialysers

SIR,—Dr A J Wing and others (23 September, p 853) demonstrate that dialysers are widely reused in the UK. However, as they rely on a co-operative study they can hardly quantitate the loss of dialyser efficiency and the morbidity associated with reuse: the latter data can be obtained only for a specific technique utilised by a well-trained staff.

In 1977 we reported our experience of reuse.¹ Two parallel-flow dialysers (RP 6—2100 dialyses; Gambro Major GM—1500 dialyses) were reused up to 10 times in our centre. Rinsing of the blood compartment is achieved with hypochlorite 10% (five minutes) followed by deionised water (five minutes). Sterilisation is subsequently achieved by filling the dialyser with either hypochlorite 10% (that is, 11 000 ppm) for RP 6 or formalin 4% for Gambro Major GM. More recently RP 6 dialysers have also been sterilised with formalin 4%.

Loss of dialyser efficiency is minimal: no difference for small and middle molecules' dialysance is noticed between new RP 6 dialysers and those used 10 times. A 20% fall in small molecule dialysance, but no change in middle molecule dialysance is noted in Gambro Major dialysers used seven times. Efficiency of reuse is significantly better if the dialyser is rinsed within 10 minutes after the end of dialysis. The technique is fully automated and requires about five minutes of a technician's time.

Blood leaks are rare: none for Gambro GM and 6.7% for RP 6. More recently this latter figure has fallen to less than 1% when hypochlorite was replaced by formalin as the sterilising agent for RP 6. Neither septicaemias nor pyrogenic reactions have been observed in 23 patients followed for an average of 16 months. The incidence of anti-N antibodies is the same (4 out of 23) in patients treated with reused dialysers as in patients treated without reuse (2 out of 12) for the same length of time.

This technique has been successfully adapted for home dialysis. The blood compartment is rinsed with sterile hypochlorite 5% (that is, 5550 ppm) and filled with saline. Sub-

sequently formalin 1.25% is introduced in the dialysate compartment. From there it diffuses towards the blood compartment, where saline is continuously recirculated. Equilibrium between both compartments is achieved within three minutes.² Sterilisation of both compartments is achieved after eight hours of storage. The whole procedure is fully automated as a result of a small adaptation of the individual monitor's program (Gambro AK 10).

From our experience we conclude that reuse is indeed safe provided that a meticulous technique is applied. It is not time consuming with adequate equipment and results in an important financial saving, well documented by Wing *et al.*

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¹ Vandenbroucke, J M, Stragier, A, and van Ypersele de Strihou, C, *Proceedings of the European Dialysis and Transplant Association*, 1977, 14, 598.

² Stragier, A, and Beelen, R, *Proceedings of the European Dialysis and Transplant Nurses Association*, 1974, 2, 21.

Children with small stature

SIR,—Having just seen yet another 11-year-old girl for "small stature" without any previous height measurements (at school or elsewhere), can I please make a plea for *all* children to have height measured on entry to school and for yearly measurements thereafter whenever they are below the third centile? Most parents of children with Turner's syndrome and growth-hormone deficiency are small—we expect it—therefore small parental height when the child is below the third centile is rarely the sole explanation for the child's small stature and all require to be investigated.

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Paraldehyde and plastic syringes

SIR,—Mr V I Fenton-May and Felicity Lee (21 October, p 1166) do not say how they exposed their syringes to paraldehyde and what signs of damage they observed.

We used 10 Gillette 10 ml disposable syringes. Immediately after starting a stopwatch 5 ml paraldehyde BPC was drawn up into the syringe through a Sabre 19 g × 2 in disposable needle. The syringe was ready for injection within 15–25 seconds of beginning to draw up the paraldehyde. 1 ml of paraldehyde was ejected from the syringe through the needle at one-minute intervals and the syringe was observed for signs of damage over a five-minute period.

Of the 10 syringes used five appeared to be totally unaffected. In two there was slightly increased resistance to injection, beginning at 2 min; but in neither was the sticking such as to preclude further injection. In one syringe a hairline fracture of the shaft and the plunger was seen at 2 min, but it did not progress any further. In two syringes the shaft broke apart. One developed a hairline fracture at 4 min and broke at four min 45 s, and the other broke suddenly at 5 min. The needle hubs were not affected.

It should be possible to complete an intramuscular injection well within two minutes of beginning to draw up the paraldehyde. Our

observations therefore confirm that it is possible to inject paraldehyde from a clear plastic syringe provided that it is drawn up immediately before injection.

The question of toxicity from dissolved plastic in the paraldehyde is one which we are pursuing further. Although concern has been expressed about possible toxicity from the plasticisers added to some plastics to make them supple, the Gillette syringes have not contained such additives since 1974. We believe that the risk from intramuscular injection is small and outweighed by the advantages of paraldehyde in the emergency treatment of the child in status epilepticus at home, where to forbid the use of plastic syringes is in effect to ban the use of the drug.

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Breast-feeding as protection against respiratory syncytial virus

SIR,—The report of the Medical Research Council Subcommittee on respiratory syncytial virus (RSV) vaccines (16 September, p 796) is a welcome reminder of the importance of RSV as a cause of illness and admission to hospital in infants. The report mentions briefly the well-documented protection offered by breast-feeding in early infancy.¹ In 24 proved RSV-positive cases of bronchiolitis admitted to our unit in the winter of 1977–8 only two infants had been breast-fed, and one of these had been breast-fed for two weeks only and the other had never been fully breast-fed.

While we agree that preventive measures such as vaccines or other antiviral substances should be developed, we feel that these uncontrolled figures of ours underline once again that the protective effects of breast-feeding have not been sufficiently emphasised to the community at large. Specific protection against RSV infection should be publicised as another reason why "breast is best." Perhaps if breast-feeding were the rule rather than the exception four deaths a year from RSV infection could be avoided and expensive immunisation campaigns become unnecessary.

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¹ Downham, M A P S, *et al*, *British Medical Journal*, 1976, 2, 276.

Duodenal ulcers

SIR,—If Dr John Bennett (21 October, p 1147) had suffered from a duodenal ulcer himself, as I have, he would perhaps attach more importance to the relief of his patients' symptoms than he appears to do at present. He finds "no place for a preparation midway in effectiveness between antacids and cimetidine," although he admits that "the various liquorice preparations and also De-Nol have been shown . . . to be superior to standard antacid regimens," because, he says, "after all, a painful ulcer exacerbation is uncomfortable but it's not medically dangerous."

Should doctors merely be concerned with medical dangers? Many patients come to me