nauseated and vomited. In addition to these well-known local irritant effects of zinc sulphate on the gastrointestinal tract, consideration must be given to potentially toxic side effects of the large and unphysiological concentrations of zinc achieved in human plasma with the recommended zinc sulphate regimen.

In the light of these observations we feel that the current recommendations to treat acne vulgaris with 220 mg of zinc sulphate thrice daily is unwarranted owing to the excess quantity of zinc ion absorbed. There is an urgent need to investigate the dose effectiveness of zinc sulphate supplementation not only in patients with acne vulgaris but also in the various other conditions for which zinc has been recommended. This is being done in this department.

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¹ Michaelsson, G, Juhlin, L, and Vahlquist, A, *Archives of Dermatology*, 1977, **113**, 31.

² Michaelsson, G, Vahlquist, A, and Juhlin, L, *British Journal of Dermatology*, 1977, **96**, 283.

³ Husain, S L, *Lancet*, 1969, **1**, 1069.

⁴ Hallböök, T, and Lanner, E, *Lancet*, 1972, **2**, 780.

⁵ Henzel, J H, et al, in *Proceedings of Congress of the Clinical Applications of Zinc Metabolism*, Cleveland, 1971.

⁶ Petrie, J J B, and Row, P G, *Lancet*, 1977, **1**, 1178.

⁷ Gallery, E D M, Bloomfield, J, and Dixon, S R, *British Medical Journal*, 1972, **4**, 331.

Management of medicines in residential homes

SIR,—It is interesting to compare the advice in DHSS circular 18/69 issued in December 1969 with that in the annex to the "Memorandum of Guidance, Residential Homes for the Elderly," issued in June 1977. I think it shows a rising standard of care in the handling of medicines and I would like to draw attention to particular areas of development so that I can indicate where I think what we do still falls short of excellence.

(1) The 1977 memorandum makes mention of the fact that dispensed medicines are now labelled with details of their contents—that is, NP labelling has been achieved. This is a boon to the staff of homes, who formerly struggled with a chaotic mass of unidentified drug containers bearing unhelpful legends such as "The Tablets" or "The Capsules." The memorandum fails to state that it is now required by law that the date of dispensing appears on drug containers. This is also a most useful advance.

(2) Recording arrangements are described in far more detail in the 1977 memorandum than in the 1969 circular, with provision for a resident's care record document and a medication record. The problem here should not be underestimated. We can have 50 or more residents in a home, most on drugs, many on several different preparations to be administered several times a day. To achieve the prescriber's intentions exactly every day for every patient is a formidable task. Clearly the staff giving out medicines need to be able to see at a glance exactly what is required at each medicine round and the doctor will find it helpful to see the practice records of drug therapy duplicated in the residential home when he attends his patient there. Absolute accuracy is paramount. The care record document and the medication record are the counterparts of the prescribing and recording sheets recom-

mended in the Gillies Report 1970 on "Measures for Controlling Drugs on the Wards," and widely adopted in hospitals since then. There are, alas, important differences between the circumstances applying in residential homes and those in hospital and they all act against the patients' interests.

Firstly, in hospital the nurse works from what the doctor has written. The prescription becomes the instruction to the nurse. In a residential home the drug is prescribed on form FP10 and, if the doctor has visited the resident in the home, the head of the home briefly has sight of the prescription before it goes to the pharmacy for dispensing. If the prescription is written at the surgery, and most are, the head of the home may not see it at all and must enter details on the care record document from the drug container labels. The person giving out medicines works from a twice-transcribed prescription.

Secondly, opportunities for communication about drug therapy between the prescriber and the head of the home are less frequent in the residential home than in the hospital and uncertainty can easily arise as to whether a drug is still current or has been cancelled.

(3) The ideal situation would be for the doctor to see the care record document each time he writes a prescription and for him to enter on it details of the drugs he has prescribed and to make cancellations. This is administratively awkward and the memorandum delegates this duty to the head of the home and suggests meekly that "doctors may consider it desirable to initial these entries." (The author of the memorandum obviously thinks doctors are very fierce creatures and need to be handled ever so gently.) To place the onus of avoiding transcription errors etc entirely on a lay person seems to me surprising. In hospitals the three professions of medicine, nursing, and pharmacy co-operate to the benefit of patients' safety; we should aim to achieve a similar situation in residential homes.

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Breakfast and Crohn's disease

SIR,—Dr A H James (9 April, p 943) reported that 67.6% of 34 patients with Crohn's disease were regular consumers of cornflakes at breakfast when their symptoms began compared with 17 of 68 (25%) controls. The validity of the comparison depends in part upon the control data and as we have collected dietary information in several epidemiological studies we have looked at the prevalence of cornflakes consumption in two of these. The first was carried out in 1966 on a sample (n=220) of the employees of a large pharmaceutical firm¹ and the second over the past two years on a sample (n=142) of the employees of the Greater London Council and Inner London Education Authority. As there were no systematic differences associated with age or sex the results were combined in each case. The proportion of the whole sample eating cornflakes was 24% in 1966 and 32% in 1976-7.

Our results are similar to those in Dr James's control group who were also questioned about current habits. His patient group was, however, asked to recall habits of some years earlier, always difficult to validate. It may also be relevant that dietary advice to patients with Crohn's disease has traditionally been a bland diet, low in roughage—thus from Davidson and Passmore²: "Breakfast—strained

porridge with milk from allowance or small helping of crisp cereal (avoiding those containing bran, nuts or fruit) . . .".

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¹ Boyns, D R, et al, *British Medical Journal*, 1969, **1**, 595.
² Davidson, S, and Passmore, R, *Human Nutrition and Dietetics*, 3rd edn, p 802. Edinburgh, Livingstone, 1966.

Amendment of the Abortion Act

SIR,—Further to the discussion in the Annual Representative Meeting of the BMA, it is clear that although the Benyon Bill is probably defeated, there will, in future, be further efforts to restrict the Abortion Act of 1967. Members of Parliament have been deluged in the past few years with letters from people who are anti-abortion and who are very firm in their views and very well organised. This has, I feel, given most members of Parliament a biased impression about the feelings of the community in general. If patients who are recommended for legal terminations of pregnancy could be told of this by their doctors when recommending such a course perhaps more of them will feel inclined to write to their members of Parliament to tell their views so that these members could get a more balanced impression of the feelings of the community which they serve.

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Breast size and cancer

SIR,—Recently Professor B N Catchpole (19 March, p 776) and Dr A J Robertson and others (14 May, p 1283) wrote letters about the lack of information on breast size in relation to cancer.

We are currently conducting a case-control study of breast cancer in which the women are queried with respect to the size of their brassière. Thus far 85 cases have been compared with 170 controls, matched by age and race. No differences were noted. Thirteen cases (15.3%) and 27 controls (15.9%) had a breast cup size of C or larger with at least a 34-in (83.36-cm) bustline. In two earlier studies^{1 2} the breast sizes of cases and controls were also very similar.

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¹ Wynder, E L, Bross, I J, and Hirayama, T, *Cancer*, 1960, **13**, 559.

² Valaoras, V G, et al, *International Journal of Cancer*, 1969, **4**, 350.

Reversal of sterilisation

SIR,—It is difficult to know what conclusions one can reach in a study of 103 women who asked for reversal of sterilisation (Mr R M L Winston, 30 July, p 305) when there are no data about the numbers and characteristics of the women who were sterilised and have