completely to ignore the diversity of conditions loosely termed depressive and the clear need for matching the pharmacotherapy to the case. We regard the suggestion that either of two drugs of which there is limited experience should be the "antidepressant of first choice" as ill-founded and irresponsible.

P DALLY
J GOMEZ

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SIR,—I found the views expressed by Dr C L Brewer (20 August, p 523) concerning antidepressant prescribing interesting and challenging, as no doubt they were to other doctors and the pharmaceutical companies. Dr Brewer expresses the view that either mianserin or flupenthixol should be the antidepressant drug of first choice in general practice, but he makes no mention of hospital prescribing.

Large numbers of patients receiving antidepressants from their GP have been started on them in hospital; surely these patients are also at risk from taking an overdose—indeed the risk is probably greater since their depression is likely to have been more severe, necessitating hospital referral in the first place. Dr Brewer should therefore have carried the logic of his argument through to hospital practice, and not limited his strictures to general practice alone.

CLIVE STUBBINGS

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Fatal agranulocytosis attributed to co-trimoxazole therapy

SIR,—Professor D H Lawson and Dr D A Henry (30 July, p 316) suggest that we could have expected a "major increase" in the frequency of fatal blood dyscrasias if, as I suggested (11 June, p 1500), a substantial proportion of deaths from agranulocytosis were causally related to the use of co-trimoxazole. They point, quite rightly, to the difficulty in distinguishing cause from effect in patients in whom a blood dyscrasia, particularly agranulocytosis, is so closely associated with infection and its treatment with anti-infective drugs. If such therapy was coincidental, however, one might expect antibiotics such as ampicillin or the tetracyclines, some of which are used even more frequently than co-trimoxazole, to have been noted more often in the "drug history".

It is true that the frequency of fatal agranulocytosis has not changed since co-trimoxazole was introduced in 1968, ranging from between 19 and 38 deaths in each year (from 1960 to 1974). If co-trimoxazole was not a cause of agranulocytosis one might have expected a reduction in frequency to have dated from about this time because of the diminished use of at least one other drug known to be a frequent cause of blood dyscrasias.

Although adverse reactions are seriously under-reported, deaths attributed to chloramphenicol were reported to the (then) Committee on Safety of Drugs at an average rate of one per month up to the time of their publication of a pamphlet reminding prescribers about the dangers of this antibiotic (Adverse Reactions Series No. 4, 1967). This had a profound effect on the use of systemic

chloramphenicol and, apart from isolated deaths of travellers returning to the United Kingdom after treatment abroad, deaths from chloramphenicol-induced dyscrasias have virtually ceased to occur. Other changes in the past 10 years include a reduction in the use of thiouracil and a trend towards the use of co-trimoxazole in place of other sulphonamides. Thus the fact that there has been no change in mortality since co-trimoxazole was introduced may simply reflect a change in pattern of use of drugs liable to cause blood dyscrasias rather than the absence of cause-effect relationship. It is perhaps reassuring that the total mortality among the many patients receiving this mixture of drugs appears to be so small.

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When do we stop vaccinating against smallpox?

SIR,—With reference to your leading article on vaccinating against smallpox (13 August, p 413) it is felt that you have been slightly unjust to the armed Forces. While not disputing in any way the tenor of the arguments against routine smallpox vaccination, it does seem that insufficient account has been taken of the special position of the armed Forces. In the Army we do train or have training teams in African countries adjacent to the last known smallpox area. We have military attachés in most foreign countries. The spearhead battalion stationed in the UK, a task which rotates between different infantry battalions, is ready to move at very short notice to any part of the world. The services are always ready to meet the call for assistance in a disaster situation in any area. The Royal Navy and the Royal Air Force have similar commitments. In order to meet these commitments there may not be "plenty of time to immunise them before departure."

For the moment we tend to side with Espmark's view, but we are flexible and certainly we have no intention of continuing routine smallpox vaccination any longer than we consider to be necessary. Junior soldiers and apprentices are no longer vaccinated against smallpox until they reach man's service. Dependents are vaccinated only if it is required by the country to which they are proceeding.

The present policy may, if you like, be described as an insurance policy. In your leading article you agree that the country needs an insurance policy. At present the services prefer to be "paid-up members," already immunised, rather than depend on the stockpile principle.

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Arc flash and the contact lens wearer

SIR,—There has been considerable correspondence between individuals, company management, and union officials on the one hand and general practitioners, ophthalmologists, and the optical profession on the other asking if a person's eyes are at risk if, while wearing contact lenses, he is subjected to an arc flash,

the normal precautions of wearing protective glasses being taken.

It is amazing that such a simple question should be asked so frequently when an ophthalmic surgeon¹ involved in this problem has gone on record as saying, "It is extremely likely that the contact lens, whether it be made of glass, plastic, or soft lens, would reduce the penetration of ultraviolet light, if not eliminate it completely, so that a person wearing contact lenses might be regarded as more protected than one not doing so. If he was wearing micro lenses the sclera and conjunctiva would not be covered, but even so protection would be given. On the other hand there is no doubt that if a micro contact lens wearer did sustain a flash burn he would have some degree of ultraviolet keratoconjunctivitis and this might be further irritated by the lens. I certainly do not regard this as a serious problem and would not dream of suggesting that anyone should stop wearing his contact lenses if he were likely to have an arc-welding flash. Now, on balance, I would be rather in favour of them."

A second statement has been made in an open letter from another ophthalmic surgeon²: "We have had advice and conclude that heat from an arc weld flash likely to affect the plastic of the contact lens would have the same effect on the plastic used in the protective goggle. There is no evidence that the goggle is affected by this degree of heat and therefore the plastic of the contact lens would likewise be unaffected. Furthermore the power correction in the contact lens will not concentrate the radiations more than the normal eye. Therefore the safety goggle, when worn, gives adequate protection to the contact lens wearer exposed to flash."

The question of the safety of the contact lens wearer exposed to arc flash continues to be asked because of statements published over the past 10 years. These statements, believe it or not, generated from a single incident misquoted and requoted since 1967. Such emotive statements as "When he later tried to take out his contact lens large areas of dried cornea came off his eyes with them. . . doctors were unable to save his sight"³ and "Contact lens hazard—contact lenses should not be worn even under spectacles in any area where an arc flash could occur"⁴ have been made.

The real story, as given by the Medical Director of the Bethlehem Steel Corporation in July 1972, is as follows. The injured employee was a welder, an employee of the Bethlehem Steel Corporation, working in a shipyard in Baltimore. On 26 July 1967, while he was plugging welding units into a 440-V service line, the electrical switch box "exploded." Witnesses describe "brilliant lights" accompanying the blow-up. The injured man was wearing contact lenses at the time and industrial safety glasses. He had no complaints following the incident and did not report any injury until the following day, at which time he reported the above facts and admitted that he had not removed his contact lenses for at least 12 h after the incident. He had large corneal ulcerations and was referred to an ophthalmologist as an emergency consultation. The two ophthalmologists who carried out the examination and treatment advised that in retrospect they believed that the electric flash had no part in the causation of the corneal injuries but that these resulted from neglect by the patient, absence of elementary precautions, and over-wear of the contact lenses. Within a few days his vision had returned to normal.