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

² Michaëlsson, 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

not asked for reversal. And Mr Winston's conclusion that it "seems unwise to sterilise women under 30 particularly immediately after pregnancy or if their marriage is in jeopardy" is therefore difficult to justify and has a disconcertingly paternalistic ring. It also implies that the stability or otherwise of a marriage should be a prime concern of obstetricians when women request sterilisation.

But what disturbed me most about Mr Winston's article was his statement that "most women in this survey had been told that termination would not be undertaken without sterilisation." I wonder if this form of ultimatum, which Mr Winston condemns, is likely to increase now this operation is performed under a fee-for-service system?

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Haematuria

SIR,—The helpful article by Mr P J R Boyd on haematuria (13 August, p 445) omitted one harmless cause of this symptom.

In 1963 a healthy 16-year-old boy suddenly and painlessly passed urine with fresh blood intimately intermixed. There were no other symptoms or clinical signs. Microscopy revealed the expected masses of red blood cells and no organisms, but did show also, unexpectedly, masses of the sharp refractile Maltese crosses of oxalate crystals. It seemed possible that these crystals had cut the urinary tract causing bleeding. Retrospective history-taking then revealed that he had, a few hours before, eaten three enormous helpings of red currants. This clinched the diagnosis, to my satisfaction, of haematuria due to oxaluria and the patient was spared all urological investigations. He has had no symptoms in the 14 years since. This supports Mr Boyd's two priorities in his article of (a) an accurate history and (b) a microscope available to the general practitioner.

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Adverse effects of lithium treatment

SIR,—In recent years major tranquillisers have been used singly or combined with lithium in the treatment of primary affective illness and affective disorders in schizophrenia. Cohen and Cohen¹ and Loudon and Waring² have reported toxic neurological reactions to the combined use of lithium and haloperidol and the latter have recommended caution when using haloperidol in doses greater than 40 mg/day with plasma lithium levels in excess of 1 mmol (mEq)/l. In the light of their reports and your leading article (6 August, p 346) I should like to report the following two cases in patients with long psychiatric histories.

A 48-year-old woman with unstable bipolar psychosis was maintained on lithium carbonate 1000 mg, the serum level being steady at 0.9 mmol (mEq)/l. Over a six-week period she received 75 mg flupenthixol decanoate and a few days after the last dose of 20 mg marked Parkinsonism (especially akinesia) developed. The drugs were stopped and nine days later she was symptom-free.

A 41-year-old woman with mild hypomania was given haloperidol 1.5 mg twice daily and 0.75 mg at noon. On the day the haloperidol was started she

noticed tingling in her fingers and later complained of episodes of marked pallor or cyanosis of the fingers. These changes were noticed by nursing staff and the haloperidol was stopped, when she complained of marked retrosternal pain. She was being maintained on lithium carbonate 1200 mg daily and the serum level was 0.5 mmol (mEq)/l. The symptoms disappeared and have not recurred though other major tranquillisers have been prescribed with the lithium. No evidence of disease associated with Raynaud's phenomenon has been detected and the ECG is normal.

The first case suggests that flupenthixol should also be used with caution in patients receiving lithium. The time relationship in the second between the symptoms and the use of haloperidol suggests that more than chance may be behind the phenomenon, though haloperidol normally inhibits vasoconstriction.³ A further trial of haloperidol has not been given on account of the retrosternal pain.

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¹ Cohen, W J, and Cohen, N H, *Journal of the American Medical Association*, 1974, **230**, 1283.
² Loudon, J B, and Waring, H, *Lancet*, 1976, **2**, 1088.
³ Johnstone, M, *Anaesthesia*, 1967, **22**, 3.

Poor-risk prostatectomy

SIR,—Your leading article (6 August, p 347), reviewing the paper by Sach and Marshall¹ contains many points with which urologists would agree. It is perhaps a little too critical for Sach and Marshall themselves to make the point that "direct comparison between series is difficult because of the number of variables involved and the difficulty of being certain that patients have been graded in a similar manner."

Most urologists would agree with the benefits of endoscopic resection, but a large gland does pose some problems, particularly in the unfit subject. You are a little naive when you talk of careful selection and of the benefits of operating "early rather than late." We all have our fair share of geriatric unfit customers and one can sympathise with our Adelaide colleagues that the majority were admitted in acute or chronic retention. Those urological units accepting all emergencies from a closed catchment area and working on a restricted bed allocation, worsened by nursing shortages, are all too conscious of these difficulties.

Sach and Marshall look for other methods to obtain better results and in the context of the grossly unfit patient may I suggest that greater attention be paid in the future to the use of cryosurgery of the prostate? It is always difficult to assess the numbers of patients condemned to a permanent catheter drainage. Certainly I have performed successful cryosurgery with very good functional results on respiratory cripples condemned to years of catheter existence in centres staffed by competent and enthusiastic resectionists, which I agree, to quote your leading article, is a "counsel of despair."

Properly performed and using quite a simple technique² cryosurgery takes only 10–20 min of total theatre time and can be performed under a short general anaesthetic or local intraurethral or regional anaesthesia. Depending on social conditions the patient may be discharged home within 48 h draining through an indwelling catheter. Good and lasting functional results can be obtained after catheter removal a few weeks later.

I have preferred to use probes using liquid nitrogen and currently we have no experience of lower temperatures with the nitrous oxide probe advocated by Wright.³

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¹ Sach, R, and Marshall, V R, *British Journal of Surgery*, 1977, **64**, 210.
² Green, N A, *Annals of the Royal College of Surgeons of England*, 1977, **59**, 288.

³ Wright, B, *British Journal of Urology*, 1976, **48**, 203.

Occupational scabies

SIR,—Drs R J G Rycroft and C D Calnan (30 July, p 303) emphasise the importance of overcrowding on board ship as an important factor in the spread of scabies rather than the sexual transmission so frequently favoured. It may not be widely known that a perfect control experiment occurred in 1945 to refute the opinion given during the war by the Advisory Committee on Scabies of the Ministry of Health that "the disinfection of clothing and blankets may reasonably be dispensed with."¹

The Third Infantry Division was transferred from Belgium to Egypt after the cessation of hostilities in Europe, half by air and half by sea. Among those arriving by ship after some three weeks large numbers had severe scabies, while none of the airborne troops were affected. Any "fraternising" in Germany and Belgium would have been equally enjoyed by both groups. The seaborne group, however, had slept in very dirty blankets which had previously been used by German prisoners of war, among whom we had seen many cases of severe crusted scabies.

This outbreak fits very well with the susceptible 15–30 age group, the epidemic which ended in 1949, and the overcrowding on board ship mentioned by Drs Rycroft and Calnan. Perhaps we should think of scabies less readily as a venereal condition and more often as a possible occupational disease.

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¹ Mellanby, K, *Scabies*, Oxford War Manual, pp 42 and 50. London, Oxford University Press, 1943.

Liver tumours and the pill

SIR,—In your leading article on this subject (6 August, p 345) you state that hepatic artery ligation will help to control bleeding, a complication of these tumours, and that "in at least one instance arterial ligation led to necrosis of the tumour."¹ In 1974 my colleagues and I reported that hepatic artery ligation combined with portal vein ligation resulted in the immediate shrinkage of a large, unresectable, vascular tumour, enlargement of which may have been due to prolonged oestrogen administration, and permitted complete removal of the tumour.²

Secondly, as you point out, ultrasonography may be useful to diagnose these tumours² and is an established method of diagnosing and differentiating solid from cystic lesions in the liver.³ It is available in most centres. Surely any patient who has sufficient reason to undergo a liver biopsy should now have the benefit of ultrasound, instead of "liver scan first,"⁴ to warn of the presence of cystic or vascular lesions or dilated bile ducts, which are likely to result in morbid complications after