after another is potentially hazardous; it is better to stick to the devil we know than to flirt with one we don't know.

New drugs are often presented as having therapeutic advantages or less toxicity than their predecessors, yet a critical appraisal of the research undertaken does not usually justify such claims. Statistically significant differences between drugs or between one or more of the numerous variables measured, even in a meticulously conducted trial, can occur by chance alone. The skilful presentation of these should not be accepted as the cue for adopting a new fashion in prescribing. Neither should we be intoxicated by our own clinical impressions because if it requires a large sample and sophisticated methodology to demonstrate differences between drugs it follows that none of us has the mental apparatus to elicit these differences in routine clinical practice.

It is therefore sound practice to (1) use those established drugs that have been in use for the longest period of time, as any longer-term unwanted effects are more likely to have been recognised; (2) learn the difficult task of using them skilfully; (3) adhere to these principles until at least two or three meticulously conducted trials, fulfilling those criteria that have become well established in pharmacological research, have shown unequivocal advantages, including less toxicity, of the new drugs over the old; and (4) resist the pressures that will be put upon us to try the new drug for ourselves.

Paradoxical though it may sound, the main danger of "trying it for yourself" is that good results will probably follow. When dealing with conditions that run a fluctuating course or that are influenced by numerous non-specific factors, including changing drugs and the enthusiasm of the physician, the laws of chance will guarantee that good results will follow in a number of cases. The danger is that they are then attributed to the pharmacological action of the new drug as a post-hoc error of thinking and a stimulus is thereby given to the spread of a new fashion—perhaps with a drug that eventually turns out to be as toxic as its predecessors.

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¹ Brewer, C, *British Medical Journal*, 1975, 4, 409.

"New" operations for cataract extraction

SIR,—Wide publicity has been given recently to reports from a congress and elsewhere of "new" procedures of cataract extraction. Through the mass media assertions have been made of their facilitating the playing of golf and other games within 24 hours of operation. These procedures have also been the subject of a leading article in the *BMJ* (25 June, p 1616), which perhaps did not emphasise sufficiently that no one method is generally applicable to the surgical treatment of cataract.

Regrettably, this publicity has given rise to widespread anxiety and apprehension on the part of patients, who are unable to understand why their personal professional advisers are often less than enthusiastic when asked about the "new" operation for their own individual problems. The fact is that these procedures have been in use for a number of years and are by no means free from their own specific complications and difficulties. They have been discarded by some

surgeons who had used them for an appreciable time.

Your assistance in underlining the undesirability of wide publicity in the mass media which may lead the public to demand of its doctors inappropriate treatment and procedures would render signal service.

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Compulsory wearing of safety belts

SIR,—We would suggest that those who oppose the compulsory wearing of safety belts on the grounds of interference with the freedom of the individual should be given freedom of access to an accident and emergency department late at night and at the weekends, when an appreciable part of the time of the medical staff is spent suturing wounds of the face inflicted by shattered windscreens in patients who were not wearing safety belts. Much has been made of the reduction in mortality which can be achieved by the introduction of compulsory safety belt wearing. This is indeed important but represents only a small proportion of the total morbidity and the accompanying physical, social, and psychological misery which follows accidents in which car occupants have omitted to fasten their safety belts.

The records of all patients involved in road traffic accidents who attended the accident and emergency department of this hospital in July 1977 were studied. Of the 41 patients, 70% were not wearing safety belts and of these, 50% required surgical toilet for the repair of lacerated wounds (mostly to the head and face). Of the 30% who were wearing safety belts, only 15% required surgical toilet for lacerated wounds.

More detailed studies would be required to ascertain the cost in terms of time and money expended by the NHS. Sadly such surveys would give no idea of the distress caused to those on whom these wounds had been inflicted. If the politicians are genuinely looking for economies in the Health Service, this is one area of many where enormous savings could be effected without in any way jeopardising other essential services.

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Campylobacter-associated diarrhoea in Southampton

SIR,—We have investigated the occurrence of campylobacter infections in Southampton over a four-month period from April this year. A total of 860 faecal samples from patients with acute gastrointestinal symptoms were examined for microaerophilic vibrios using a selective blood agar containing vancomycin, polymyxin, and trimethoprim (VPT agar) and incubated at 43°C under microaerophilic conditions as described by Dr M B Skirrow (2 July, p 9). Campylobacters of the *C. coli-C. jejuni* group¹ were isolated from 36 patients (4.2%) and two healthy carriers. Twenty-two specimens were from adults and

16 from children under 15. Routine techniques for detection of faecal pathogens on the 860 samples gave 24 isolates of salmonellae (2.8%), eight of shigellae (0.9%), and six (0.7%) of enteropathogenic *Escherichia coli*. These figures suggest that during four summer months in Southampton gastrointestinal infection with campylobacter was as common as the combined total of the commonly reported faecal pathogens. Our figures represent more than 15% of the 253 campylobacter isolations reported during the same period in England and Wales (PHLS Communicable Disease Reports).

Detailed histories based on a questionnaire used by King² were obtained from patients. Diarrhoea was the main complaint in 32 out of 36 of the isolate-proved cases. (Of the 38 stool samples received 8 were liquid and 14 semiformed.) The duration of the diarrhoea was ascertained in 27 cases. Twelve patients had severe diarrhoea for more than three days and two gave a history of chronic diarrhoea; in one of these the diarrhoea had started 2-3 months ago and lasted five weeks and the other had had several episodes over a year. All the patients except two complained of general malaise and 19 out of 25 had temperatures between 39 and 40°C. Five patients complained of sore throat, two had bad coughs, one presented with urticaria, and one with swollen lymph nodes in the neck. Nine of the 36 patients were in hospital at the time of diagnosis: four were children with abdominal pain who had been admitted to the paediatric surgical unit, and at appendicectomy two were found to have acutely inflamed appendices and two had acute mesenteric adenitis; three others were children who had been admitted to the paediatric wards with diarrhoea and abdominal pain; the remaining two were adults in whom the infection was an incidental finding one being a 73-year-old woman who had presented with a stroke and diarrhoea and subsequently died and the second a 28-year-old woman who had been admitted because of recently diagnosed diabetes during pregnancy. This last patient was transferred from the antenatal ward to an infectious disease ward, where she was treated with oral neomycin. Faecal cultures were negative five days later and a normal baby was delivered by forceps after induction at 37 weeks. No cases of diarrhoea occurred in the admission ward or among the staff.

In addition to ascertaining clinical information the questionnaire was aimed at discovering factors of possible epidemiological significance. Four people gave histories suggestive of the infection having been contracted abroad. One patient associated the onset of her diarrhoea with eating fresh chicken in Spain and another with the eating of a water-grown vegetable; eight out of 12 people who had had the same vegetable were similarly affected. We assume that in the remaining 32 cases the infection was acquired in the United Kingdom. Campylobacters of the *C. coli-C. jejuni* group have been isolated from chickens in England, but in three family outbreaks (eight cases and two carriers) and in questioning 13 out of the remaining 19 patients chickens could not be directly implicated, though one patient had handled fresh chickens. Five children, however, gave histories suggesting that they could have acquired their infection from environmental sources; two had dug worms for fishing bait, two had been on biological field courses, and one had been camping in the New Forest. Sea-water samples collected from the Solent coast were filtered through 0.45-µm Millipore membranes and the latter incubated on the selective antibiotic media for 16 hours at 43°C. Six out of 13 samples gave campylobacter-like colonies on the VPT agar. Dark-ground and electron microscopy showed organisms which were similar to the human isolates. Five of these six strains were agglutinated by human sera from two people previously infected with campylobacter. Two patients with diarrhoea gave a history of contact with cage birds; in one case the bird had died, and a second patient bred canaries and a campylobacter strain was isolated at 43°C from the canary pen, but all the birds were healthy.