suggested by Mr Pearson and Miss Weaver, record many fewer movements per unit time than when they record for shorter periods. Presumably this is an effect of fatigue and reduced alertness. Recording during meals, conversation, reading, listening to music, etc, is not reliable. We instruct the women to assess and record each fetal movement for periods of 30-60 min three times a day. If the number of movements is less than three per hour the recording is continued for 6-12 hours in the day. From the sum of the movements recorded the rate per 12 hours—daily fetal movement recording (DFMR)—is calculated. Employing this method for a total of 1.5-3 hours a day the computed DFMR in 114 women with a normal outcome varied between 4 and 1440 per 12 hours. The majority of DFMRs were between 200 and 600 per 12 hours. In addition, the number of fetal movements recorded by an electromagnetic device¹ varied between 25 and 235 per hour. The patients recorded 87% of the movements recorded by the device. These data indicate that DFMRs are higher when recording is made for short periods from which the 12-hour score is computed.

(2) In 17 patients reduced fetal activity was observed, with 4-10 movements per 12 hours, yet the outcome was normal. This fact indicates that there is no significance in the number of the movements recorded provided that they are fairly constant. Only a definite decrease of the DFMR up to the cessation of movements, with normal heart beats, for at least 12 hours should require delivery of the fetus when it is viable.

E SADOVSKY

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¹ Sadovsky, E, *et al*, *Lancet*, 1973, 1, 1141.

Antibiotics for respiratory illness?

SIR,—Your leading article on this subject (4 September, p 550) may be correct for patients without ailments other than asthma, as in these the tendency to spontaneous cure is obvious. However, it is not correct for chronic asthmatics, as in these there is a great chance of the asthma becoming acute when the infection descends into the lower respiratory organs, as is usual. It may even cause status asthmaticus.

As in most cases haemophilus is the infective agent oxytetracycline (2 g/day) should be given at the first sign of an acute respiratory infection. This dose can usually be reduced after a few days. I have used this treatment in chronic asthma for more than 20 years and have given my patients prescriptions in advance for just this eventuality, with excellent results. My controls are those who come only when the infection has taken a hold: their acute phases then last several weeks and often demand corticosteroids or higher doses of them if they had been on them beforehand.

You ought to have added a rider to your advice—"chronic asthmatics excepted."

H HERXHEIMER

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SIR,—In your leading article on antibiotics for respiratory illness (4 September, p 550) an error occurs in the final paragraph, where you refer to the paper by Stott and West which

appears in the same issue (p 556). The antibiotic used in their study was doxycycline. In your leading article you have erroneously referred to the antibiotic as minocycline.

DAVID F TOMLINSON
General Manager,
Lederle Laboratories

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* * * We are sorry to have made this error—it was a simple slip of the pen.—ED, *BMJ*.

Oestrogens for menopausal flushing

SIR,—In his article on the treatment of menopausal symptoms (14 August, p 414) Professor Arnold Klopfer states that vascular instability is a consequence of oestrogen deprivation, and that "treatment . . . should replace the missing oestrogen."

In a recent article¹ Mulley and Mitchell, after a detailed survey of the literature, conclude that "no correlation has so far been established between hormonal changes and menopausal flushing and the rationale for the use of oestrogens to relieve flushing . . . would not seem to withstand critical scrutiny." It is suggested that "as oestrogens carry a significant risk we should stop prescribing them for a condition which we do not fully understand."

Furthermore, Professor Klopfer does not mention the therapeutic role of clonidine hydrochloride in menopausal flushing, yet your experts have advocated this treatment twice within the past three months in the "Any Questions?" columns of the *BMJ* (26 June, p 1584; 7 August, p 357).

I would be interested to read Professor Klopfer's comments on these points, the former of which seems to contradict the rationale upon which his treatment is based.

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¹ Mulley, G, and Mitchell, J R A, *Lancet*, 1976, 1, 1397.

* * * We sent a copy of this letter to Professor Klopfer, whose reply is printed below.—ED, *BMJ*.

SIR,—A good many cherished beliefs could not meet Mr Broadhurst's challenge of direct proof. Such iconoclasm is valuable and I would not wish to counter it with a tedious recital of the data which suggest that there is a connection between oestrogen deprivation and menopausal vascular instability. Let me rest upon one incontrovertible fact which is a matter of such common experience that I need not cite authority in support of it. If a menopausal woman keeping a flush count is treated with oestrogen the number of flushes declines. Depending on which evidence you accept it is also established that the magnitude of the result is dose-related and can be clearly distinguished from a placebo effect. This may not prove a causal relationship but makes the therapeutic point I was concerned to establish. We are not in dispute about the risks of oestrogen treatment, but I don't think Mr Broadhurst reads me fairly about this. Synthetic oestrogens are dangerous and should not be used without good cause. No such case has been proved for natural oestrogens produced by the human ovary during the woman's

menstrual life. As regards clonidine hydrochloride, my intention was to write about endocrine preparations and for reasons of space (the Editor is very free with his red pencil) I did not think it proper to go into the pros and cons of other preparations. It would be interesting to see applied to clonidine hydrochloride the same rigorous criteria of therapeutic efficacy and safety as we now apply to oestrogens.

I think it is important that we should keep our cool. This is an issue in which there is more emotion than reason. I hope the *BMJ* will steer between the Scylla of pharmaceutical houses and crusades in the lay press on one hand and the Charybdis of Mr Broadhurst on the other. At this time there is still a place for certain oestrogens in the treatment of menopausal symptoms. The limits of that place should be watched vigilantly and drawn anew if fresh evidence comes in.

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Dangers of tinted glasses for driving

SIR,—It is a pity that Mr J B Davey, in adding his general support (24 July, p 233) to the warnings which have been raised by Professor R A Weale and myself in your columns and elsewhere on the potential and actual dangers of driving with tinted lenses and windscreens, should have seen fit to add a further red herring to the discussion when he suggests that the wearing of spectacles (with what he suggests might be appropriate photochromic lenses) may add to the physical safety of the wearer by virtue of the tougher glass from which these spectacles are made.

Although, as far as I am aware, there are no specific figures on the subject, it is undoubtedly the experience of many ophthalmologists who, after all, naturally see rather more of these, that in many cases of injury the damage arises from the spectacle frames rather than the lenses.

One would have hoped that, rather than adducing a somewhat dubious further basis for the wearing of tinted spectacles, there could have been further support for our plea that all in the concerned professions put their weight behind an effort to inform the public accurately about the potential dangers and disadvantages of driving with tinted lenses and/or wind-screens.

M J GILKES

Sussex Eye Hospital,
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pH of swimming pools

SIR,—In a letter published a short time ago (3 July, p 47) I emphasised the importance of maintaining the water of swimming pools at the correct pH. In a recent leading article (7 August, p 344) you refer to the danger of pseudomonas infection, but once again the pH of the water was not mentioned. The pH of swimming bath water is perhaps as important as proper control of chlorination. The pH of blood is 7.38 and tears are alkaline. The water should be kept alkaline and the addition of chlorine gas makes it go acid, so this effect has to be neutralised by an alkali. However, in some domestic pools where chlorine gas would be a hazard sodium hypochlorite is used, and this