product is effective against house dust mite. It also conforms with all the criteria required by a recent position paper of which he is a coauthor¹: because it is a heavy powder, thorough vacuuming (part of integrated allergen avoidance) is necessary unlike with other acaricidal products except for liquid nitrogen. In addition, Sergeant's Dust Mite Patrol has the least residual action and safest toxicity profile of all acaricides.

Of all the clinical trials quoted by Colloff *et al*, only six resulted in significant clinical improvement in patients, and three of those used some form of acaricide.²⁻⁴ As Sergeant's Dust Mite Patrol kills mites effectively and the necessary vacuuming will remove allergen by removing the dead bodies and mite faeces, the product must offer the possibility of relief of symptoms for people sensitive to dust mites when used as part of integrated allergen avoidance, which we have always advocated.

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Monitoring digoxin treatment

EDITOR,—J K Aronson and M Hardman's article on monitoring treatment with digoxin¹ may cause delay in stopping treatment in cases in which the plasma digoxin concentration is not available rapidly. Newly qualified house physicians tend to send off for measurement of plasma concentrations and wait for the results before stopping or decreasing the dose of digoxin.

If digoxin toxicity is suspected clinically it is much safer to stop the drug at once whether a blood test is done or not. By the next day the patient's nausea, anorexia, or vague ill health is generally much better if digoxin is the culprit. Measurement of the digoxin concentration is often not needed under these circumstances, although it is helpful in more complicated cases, as the article shows.

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Breast feeding and HIV infection

EDITOR,—In the past few years in Nairobi no single issue related to HIV has caused more debate than whether HIV can be transmitted by breast feeding. Should the possibility be tested scientifically in Kenya? Is it valid to carry out research in communities that are unlikely, as William A M Cutting points out,¹ to be able to respond by changing feeding practices if transmission by breast milk is shown? The operational implications seem of clear benefit only to the affluent communities of the industrialised world, where bottle

feeding can easily be instigated. Or is it more important to find out what the level of risk is and then decide how to respond to the problem with hard data?

There are no easy answers to these complex issues, which are common to much of the clinical research carried out in the developing world; it is just that the issue of breast feeding and transmission of HIV is highly emotive and highlights the dilemmas clearly.

Perhaps we are being too academic about the problem. Even if a high risk of transmission is shown and Kenya then decides to recommend and implement a policy of formula feeding for HIV infected mothers, who will actually take it up? It will be almost impossible for most mothers to conceal the fact that they are bottle, not breast, feeding—which will be tantamount to advertising their HIV status. I do not think that many women will be prepared to do this. As Cutting says, poor women will continue to feed their babies in the most convenient, economic, and familiar way. More importantly, they will continue to breast feed because this maintains the confidentiality and privacy of their own diagnosis.

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Role of breast feeding in paralytic poliomyelitis

EDITOR,—Much evidence shows that breast feeding protects infants from infection, but no data are available about its protective effect against poliomyelitis.^{1,2} Human milk can neutralise poliovirus, and limitation of intestinal shedding of vaccine poliovirus by breast feeding has been shown under certain conditions.^{3,4} We investigated the association between breast feeding and poliomyelitis during the last epidemic in Campania region, Italy, which occurred in 1958, by a population based case-control study.

In 1958 there were 114 000 live births, and 942 infants with paralytic poliomyelitis were reported⁵: of these, 634 were admitted to the Regional Hospital for Infectious Diseases Domenico Cotugno. The incidence was 8.3/1000 and the case-fatality rate 15%. We studied all 103 infants aged 0 to 6 months admitted with a diagnosis of paralytic poliomyelitis between 1 January and 31 December 1958. Ten patients, for whom information on feeding was not available, were excluded. One control for each case was selected by systematic sampling of infants admitted to the same hospital with an acute illness during the same period. The controls were matched to the cases by age (within 15 days) and gender; their main diagnoses were seizures, anaemia, and fever of unknown origin. Information on feeding was not available for 14 patients, who were replaced by the next patients in the list for whom information was available from the records.

Breast feeding was classified as a dichotomous variable: never breast fed and at least partially breast fed. Data on background variables and feeding were collected from the clinical charts by a person blinded to the objectives of the study. Information on breast feeding at admission and parental smoking was not available from the records. Confidence intervals for odds ratios were calculated with Cornfield's method.⁶ The number of infants who had ever been breast fed was 75 among the cases and 88 among the controls ($p < 0.01$). Compared with the infants who had received some human milk, those who had never been breast fed had a higher risk of paralytic

poliomyelitis (odds ratio 4.2, 95% confidence interval 1.4 to 14). When we stratified by social class and the number of other children at home the odds ratio did not show any relevant modification.

Because of lack of information in the records our study has some limitations: breast feeding was available only as a dichotomous variable, and the method of feeding at the time of admission was unknown. This may have decreased the strength of the observed association. Moreover, because the data were obtained 34 years ago we could not check their quality (for example, by interviewing the parents). On the other hand, the epidemic of 1958 was the last that occurred in Italy and our study probably has the interest and the limits of a historical study; epidemiology was a young discipline then, and no other studies of dietary risk factors for poliomyelitis have been published.⁷ Our data suggest a protective role of breast feeding against paralytic poliomyelitis during the first six months of life.

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Nedocromil sodium may substitute for steroids in asthma

EDITOR,—J R Hughes and colleagues report a case in which a moderate dosage of inhaled beclomethasone—presumably 500 µg twice daily, not 500 mg as published—caused severe acne in a man aged 77.¹ They were unable to control the asthma without steroid treatment but fail to say whether other inhaled anti-inflammatory treatment had been used.

In a recent study I and colleagues looked at the steroid sparing effect of nedocromil sodium in moderate to severe asthma and found that it was effective in replacing a mean of 330 µg of inhaled steroids yet allowing optimal control of asthma.² That figure hides the fact that 65% of those patients taking high doses (> 600 µg, mean 1100 µg) were able to halve their dosage and 16% to maintain optimal control of asthma on a quarter of the original dosage. High doses of inhaled steroids are extremely valuable in controlling chronic asthma and may have contributed to the fall in deaths from asthma in New Zealand,³ but systemic side effects may occur; if they do, nedocromil sodium may well be useful.

I have recently seen three patients (two men and one woman) who developed skin thinning and purpura while taking 2000 µg of inhaled steroids. The woman developed bilateral rupture of the Achilles tendon, which was then complicated by pulmonary embolus. These patients were given nedocromil sodium, which substituted completely for the steroids with resolution of the skin changes and continuing optimal control of the asthma.

Perhaps Hughes and colleagues should try this management in their patients with difficult asthma.

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GPs and health and safety at work

EDITOR,—R A Cooke and E S Hodgson draw attention to some major concerns regarding health and safety at work in general practice.¹ These have been given added piquancy by the £750 fine imposed on a senior partner of an English practice for contravening health and safety regulations.²

Cooke and Hodgson advise against using glutaraldehyde in the surgery, and we support this view. General practitioners may well consider buying a portable steam steriliser (desk top autoclave) to replace the hazardous, but fairly reliable, disinfectants of the aldehyde group and must be aware of the implications. Steriliser vessels contain steam under pressure and should be insured against third party liability.³ The instruments should be inspected regularly (the statutory interval is 14 months) by a competent person, usually an insurance company engineer. We doubt if an employer's normal liability policy would cover an accident with an autoclave. A recent postal survey of 208 general practitioners in Fife produced a response from 138, 71 of whom owned or were responsible for a portable steam steriliser.⁴ Only 21 of these owners had a specific insurance policy for their instrument.

We strongly recommend that anyone considering buying a portable steam steriliser should consult a document from the NHS Procurement Directorate, which clearly states the requirements.¹ Buying, commissioning, and correctly using an autoclave entail considerable capital outlay, a thorough understanding of the principles involved, and tenacity.

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EDITOR,—I endorse R A Cooke and E S Hodgson's sentiments regarding general practitioners' poor awareness of health and safety regulations.¹ By way of mitigation, though, general practitioners face the same problems as any other small business in this respect—namely, lack of any obvious source of comprehensive advice on health and safety in the workplace. Though occasional articles relating to specific health and safety topics have been published in magazines for general practitioners,^{2,3} these have failed to stimulate general practitioners to give health and safety at work equal priority with some of the more trendy issues, such as practice audit, health promotion clinics, and immunisation

targets, which are both supported by family health services authorities and driven by remuneration.

It is perhaps unrealistic to expect general practices individually to investigate the requirements of disparate health and safety regulations, such as the Electricity at Work Regulations, the Control of Substances Hazardous to Health Regulations, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations,⁴ and First Aid at Work Regulations. A far more effective approach would be for individual family health services authorities to prioritise health and safety issues, issue comprehensive guidelines on all aspects to their general practitioners in an easily read handbook, and encourage the incorporation of health and safety issues into educational meetings approved for the postgraduate education allowance. Such an initiative is currently being developed by Leicestershire Family Health Services Authority as part of the European year of safety and health at work.

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Assisted conception on the NHS

EDITOR,—In writing on NHS funding for assisted conception services M G Chapman rightly highlights the issue of rationing services but misrepresents the way in which purchasing decisions are made.¹ The real questions are about the provision of services within the NHS. Staff working in assisted conception units and infertile couples inevitably consider assisted conception services to be of high priority. Purchasers rank the priority of these services differently since they have to take into account the many competing demands on the health service. Nevertheless, Chapman's assertion that district purchasers "do not see infertility as a priority" is incorrect.

It is not the case that purchasing decisions are taken by a few people behind closed doors. The NHS reforms allow decision making to be made explicit, as illustrated by the debate about public accountability of purchasers and health authorities. Open decision making is surely an advance on the implicit rationing that clinicians made in the past. It is ironic that clinicians had the power to shift resources from relatively ineffective tubal surgery to the more effective in vitro fertilisation but failed to do so. This change is now occurring as a consequence of purchasers' decisions on the relative effectiveness and cost of services.

The idea that patients would have the power to choose and that money would follow them was always just political rhetoric. The NHS reforms are about using resources more effectively—even if that means shifting power from hospitals.

Ours is one of the health authorities that purchase in vitro fertilisation from Guy's Hospital, and this arrangement was not materially affected by the NHS reforms. In a public health authority meeting we recently agreed to purchase cycles of in vitro fertilisation from King's Healthcare, and we will be publishing a consultation document on all subfertility services for our residents.

Others have pointed out that the central problem in subfertility services is how to use resources as effectively as possible in the light of what is known about the effectiveness of different interventions.^{2,3}

To focus on assisted conception techniques alone is unhelpful as it distracts attention from this more difficult task.

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- 1 Chapman MG. Assisted conception on NHS. *BMJ* 1992;305: 772. (26 September.)
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Education is promotion

EDITOR,—The EC directive 92/28/EEC on the advertising of medicinal products for human use will require the BMJ Publishing Group to change its wording relating to sponsored supplements.^{1,2} From next January all industry sponsored symposiums attended by those who prescribe or supply drugs will be classed as promotional, and by extension so too will the publication of such meetings. Accordingly, the permitted line from the sponsoring company will have to read: "Publication of this supplement is made possible by a promotional grant from. . ."

This change in classification will have additional, and perhaps more profound, effects. As such grants are treated as promotional the company will no longer be able to set them against profit targets when negotiating within the Pharmaceutical Price Regulation Scheme, and industry's benevolence in "education" will inevitably shrink.

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Nitrous oxide, nitric oxide, and neurotransmission

EDITOR,—Bernard Dixon seems to believe that nitric oxide is the first simple organic molecule to be shown to have a role in neurotransmission.¹ This has become a popular misconception.

In 1981 Lichtigfeld and I proposed that a simple organic molecule, a gas, could be active in neurotransmission.² This was long before such a role was postulated for nitric oxide.³ Shortly after our suggestion² the endogenous gas oxygen and the exogenous gas nitrous oxide were shown to influence neurotransmission directly at opioid receptors.⁴ These findings were later confirmed independently.⁵

Although it would be incorrect to confuse nitrous oxide with nitric oxide, it seems that they are more similar than Dixon would have us believe.

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