hepatitis was 30,000 cases with nearly 3,600 deaths. No account was taken of the incidence of anicteric hepatitis, and, in general, the accepted ratio is 1 overt case for at least 10 actual infections, although in 1965 it was estimated that the ratio of anicteric to icteric hepatitis after blood transfusion could be greater than 100:1 (based on a small number of patients).⁵ Casting aside for the moment the economics in terms of mortality and morbidity, it would have been quite a useful exercise in economics to calculate the cost of treatment of patients with hepatitis. This indeed has been done in one reported series from the United States.⁶ The "average" patient suffering from post-transfusion hepatitis required hospital treatment for 35 days, incurring hospital costs of £300 to £670.

There are no completely reliable tests available at present for the detection of carriers of the virus of hepatitis, but no matter what method of case finding was used the lowest incidence of post-transfusion hepatitis was seen when commercially supplied blood was avoided.⁷ Mosley⁸ recently wrote that virus hepatitis is now the most important complication of the transfusion of blood and blood products, and it is as well to remember this.

Hepatitis is not generally notifiable in this country, but there is no reason to suppose that we are in any way unique as far as the incidence of hepatitis is concerned, and it would be unwise to ignore the facts collected in other countries. The case for the notification of hepatitis in the United Kingdom and the organization of the follow-up of all patients who receive blood transfusion⁹ can only be made stronger in the light of our ignorance as to the real incidence of the disease. This information should be available well before the economists guide us into the purchase of blood.—I am, etc.,

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Railwaymen and Drug Side-effects

SIR,—The number and variety of therapeutic agents prescribed for the general population continue to increase. Railwaymen, like everyone else in the community, may at times be treated with these preparations, and my railway colleagues and I are concerned at the unwanted effects resulting from the use of some of them. In addition people can and do buy proprietary preparations for various minor ailments which may have similar undesirable side-effects.

Locomotive drivers and other railwaymen have always been aware of their responsibility

for public safety. It is clearly most important, both in the interests of public and personal safety, that they should be made aware of any side-effects likely to arise from preparations prescribed for them and particularly of the danger which could arise if these are taken in combination with even moderate amounts of alcohol. I would therefore be grateful to my colleagues in general practice and in hospitals if they would warn such patients of possible side-effects. I may say that discussions have taken place with the Railway trade unions and they are equally anxious that every step be taken to keep railwaymen informed on this subject.—I am, etc.,

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Factor IX Levels and Oestrogens

SIR,—When reading the disturbing paper by Dr. D. G. Daniel and others (30 March, p. 801) I wondered why they used such large doses of stilboestrol to suppress lactation. I re-read their previous paper¹ and found that even larger doses were used then. In the recent paper a total dose of 180 mg. is given in nine days. The order of dosage discussed by Barnes² has always seemed to me satisfactory. We have used a total dose of 54 mg. over six days (that is, 5 mg. t.i.d. for two days, 3 mg. t.i.d. for two days, and 1 mg. t.i.d. for two days).

Before considering whether we should abandon the use of oestrogens altogether in the inhibition of lactation can the authors tell us whether the same effect on factor IX is found with smaller doses?—I am, etc.,

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Slimming and Sleep

SIR,—I read with interest the report of Dr. Ian Oswald and others (30 March, p. 796) on the effects of diethylpropion and fenfluramine on sleep. While in no way attempting to minimize the theoretical value of these observations, I would question their clinical applicability. We have recently studied in a more clinical setting the effect of an evening dose of diethylpropion (Tenuate) on sleep.¹

I consider that our findings are of greater relevance to the clinical situation than those of Dr. Oswald and colleagues for the following reasons.

We administered 25 mg. diethylpropion, which is the recommended and usual dose, rather than the 50 mg. given by Dr. Oswald and colleagues.

In our trial the tablets were taken at 6 p.m., a time chosen to produce the maximum anorectic effect during the evening when it was most needed, whereas they gave their subjects medication "one to one and a half hours before lights-out."

We examined the effects of diethylpropion on sleep in a group of overweight patients of the type for whom the drug is generally prescribed in practice, not "paid healthy young adult volunteers" as used by Oswald *et al.* In such a clinical setting, under strict, double-blind, controlled conditions, we found that diethylpropion

did not significantly or materially affect the quality of sleep reported by the patients. Whatever the E.E.G. effects might have been, there was no clinical evidence to indicate that our patients' sleep was in any way disturbed by diethylpropion taken at 6 p.m.

I would like to discuss a further point raised by Dr. Oswald and his colleagues in their article. They state that "... it [diethylpropion] has become recognized as a drug which can lead to tolerance, dependence, abuse, and psychotic manifestations..." and quote four references to support their statement. All but one reference refers to a single case, while the remaining reference describes two cases. Thus in the 10 years during which diethylpropion has been widely available only five cases of dependence have been reported; all of these cases had previously abused amphetamine. This, I would suggest, hardly indicates that diethylpropion is particularly likely to produce serious psychological dependence in the very great majority of overweight patients for whom it is prescribed.—I am, etc.,

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Brand Names

SIR,—I write in support of your leading article on brand names (30 March, p. 781). If it had ever been shown that the administration of halothane was associated in some patients with jaundice and more than one firm had been producing halothane, it would have been very important to know whether the incidence of jaundice was related to a particular method of manufacture. To specify a brand name in a patient's notes gives more information than using a B.P. name.—I am, etc.,

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Long-term Corticosteroid Treatment of Asthma

SIR,—Dr. K. Maunsell and her colleagues (16 March, p. 661) have emphasized some of the dangers of long-term steroid therapy in asthma and the importance of keeping a maintenance dose as low as possible. As your leading article (10 February, p. 329) pointed out, this can only be done if patients are followed up regularly with objective measurement of their ventilatory function. The experience of this general practice confirms Dr. G. F. B. Birdwood's belief (9 March, p. 640) that regular measurements of P.E.F. with the Wright peak-flow meter may reveal trends, which indicate deterioration, long before the patient himself is aware of it. Dr. J. L. Struthers (9 March, p. 639) doubts whether this is "relevant to the treatment of asthma as it really affects the asthmatics in the community." However, seeing patients with severe asthma daily, weekly, or monthly, according to their progress, is not as time-consuming as he supposes. In any case, this is amply compen-