but unmentioned is an identical peak for 0700 to 0900 hours. What is considered to be the significant factor for road traffic accidents in this period? It would have been of great value if further data had been collected (or disclosed)—i.e., (a) evidence of any drugs taken; (b) alcohol levels of persons injured in the road-traffic accidents but not driving, and (c) alcohol levels of persons involved in the road-traffic accidents but not injured.

The basic cause of all accidents is carelessness, and any factor that will cause or is likely to cause a state of carelessness in the majority of drivers should be recognized and, if practicable, excluded. Alcohol is one identifiable factor; it can be excluded.

Blood and/or urine tests should be mandatory on all drivers suspected by police of drunkenness and on all involved in a notifiable traffic accident, and the result be available to the police authorities. This procedure is used abroad and its adoption suggested in this country. The taking of blood or urine samples could at present constitute a trespass against the person, and has given us a reason for opposing such adoption, but the taking of breath for analysis has the same legal defect and also the grave defect that samples cannot easily be kept for independent check analysis.—I am, etc.,

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SIR,—It seems incredible that Britain should lag behind most of Europe because of legal quibbles over compulsory examination of drivers (26 December, p. 1634). We are nearly 40 years behind the rest of Europe in the adoption of international road signs, and over B.C.G. vaccination it was similar. In Scandinavian countries the blood examination of drivers is strictly enforced and acted on. There are few prosecutions because it is generally arranged that the person driving has a low alcoholic blood content.

I can see little hope of effective legislation being passed in Britain, because so many of our legislators are vulnerable.—I am, etc.,

Monte Carlo.

H. R. B. GIBSON.

SIR,—The six-year experience of examinations of drunken drivers in Manchester so ably and clearly presented by Dr. Simon Freeman (26 December, p. 1634) is both authoritative and timely. Of particular value is the analysis of symptoms and signs and the clear emphasis of diagnostic significance. My partners and I evolved a form of examination and report based on the B.M.A. Special Committee Report (1958), which we will now modify to give further prominence to the clinical signs listed by Dr. Freeman.

Urine testing by the Forensic Laboratory was introduced in Gloucester in January 1963, and since this time we have been left with a strong impression that the guilty pleas had increased and our attendance at summary courts reduced. I have examined the results of 14 cases before and after testing (all easily available records in the city cases), and find the number of guilty pleas to have risen from 9 to 11 and total convictions from 12 to 13. Of the three not-guilty pleas in the last group

two did not produce a urine sample on request.

This small survey would seem to support our impression of the value of the chemical test, and it is difficult, therefore, to agree with Dr. Freeman's conclusion that no chemical test is of value unless mandatory conviction at an agreed blood-alcohol level is introduced. After 10 years of limited experience of these examinations and the subsequent sequelae in the courts, particularly the Crown Courts, I am strongly inclined to the view that such legislation is now desirable (as was suggested at the B.M.A. Annual Representative Meeting in 1964).—I am, etc.,

Gloucester.

G. C. MATHERS.

Gas-cylinder Keys

SIR,—I should like to support most heartily Dr. H. Lister Wilson's letter in the *British Medical Journal* of 19 December, p. 1591. The position of the cylinder pressure gauges on the latest B.O.C. Boyle's machines spoils an otherwise excellent piece of apparatus. It is practically impossible to turn a cylinder on quickly without damaging one's fingers. Surely it is not beyond the manufacturers to remedy this defect, as has been done in other makes of Boyle's machine?—I am, etc.,

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Iatrogenic Ulcers of the Small Intestine

SIR,—Your leader (26 December, p. 1611) concludes: "These reports show clearly that the whole issue should be further investigated." As part of these investigations we wrote to 98 doctors, chosen because they held appropriate hospital appointments, and asked them to complete a questionnaire. The extent to which they consulted their colleagues, as suggested, varied considerably, but many said that the circumstances of the reported cases^{1,2} were so unusual that they would certainly have heard of them if any had occurred. To give an order of magnitude to the survey, 82 doctors (84%) replied, representing 80 hospitals and over 35,000 beds. (Total U.K. non-mental-hospital beds: c. 260,000.) All positive, doubtful, or ambiguous replies were followed up personally.

Thirteen reported more or less rare conditions of the small intestine, most of which were clearly unrelated to the syndrome in question. There were, however, three additional cases of interest in the present context and we are grateful for permission to publish the following outlines:

(1) In the autumn of 1964 a man in his early fifties, who had been taking chlorothiazide (not potassium chloride so far as can be ascertained from the hospital and general practitioner), presented with a three-month history suggestive of subacute intestinal obstruction. The histology of a stricture found in the jejunum was compatible with Crohn's disease. There has been no recrudescence.

(2) A female aged 81 underwent laparotomy in July 1964 for intestinal obstruction. A stricture was found in the ileum with ulceration of the mucosa and inflammatory reaction not involving the muscle coat. For 18 months this patient had received digoxin and, 2-3 times per week, enteric-coated thiazide/potassium chloride

tablets. Since the operation this treatment has been continued without further trouble.

(3) A female aged 59 with a long history of valvular heart disease was subjected to valvotomy in 1961 and discharged on digitalis, a thiazide, and potassium chloride. In 1962 she began to take prednisolone, 5 mg. b.d., for a skin rash, and in 1963 spironolactone was also given. In May 1964 treatment was changed to an enteric-coated thiazide/potassium chloride preparation, and she was given A.C.T.H. for two weeks while the prednisolone was reduced. In June 1964 she developed subacute intestinal obstruction and was found to have an inflamed segment of jejunum 10-12 in. (25-30 cm.) long, 2 ft. (61 cm.) beyond the duodenum. This was thought to be Crohn's disease and was left intact. She was anaemic with a high E.S.R. Two weeks later she was discharged but continued to have symptoms until readmission for severe cardiac failure in August 1964. Since then she has had various combinations of drugs and a further admission for cardiac failure in December. At that time she did not complain of abdominal symptoms, although she had a tender congested liver.

These cases are still being followed up. At present it looks as if the last two may be related to the ingestion of enteric-coated thiazide/potassium chloride tablets. In the first case the highly experienced surgeon stands by the original diagnosis of Crohn's disease.

From the replies there was obviously no indication that, regardless of aetiology, disorders of the small intestine of the type recently reported have become noticeably more common in the past three years, during which enteric-coated thiazide/potassium chloride preparations have been in widespread use. (Combined preparations account for about one-third of diuretic prescriptions outside hospitals.) Although other cases of the syndrome may well come to light, it seems improbable, therefore, that any great number is occurring but being incorrectly labelled.

It is interesting to speculate on the apparent relative immunity of this country. A contributory factor may be that there are possibly important differences in the formulation of some of the thiazide/potassium chloride tablets available here and elsewhere. The Committee on Safety of Drugs is being kept informed.—We are, etc.,

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Toxic Insecticides

SIR,—Dr. A. M. G. Campbell's warning (26 December, p. 1658) about the use and abuse of the increasing number of toxic insecticides is most timely. We know that most of these substances are—to some extent perhaps justifiably—described by the makers as harmless or safe after extensive initial toxicity tests, but nothing or little is said about their possible later toxic effects.

Our ignorance about this latent toxicity is due to several factors which unfortunately manifest themselves only after their prolonged use. It is not widely known that in some of them the toxicity is not due to the original compound itself—e.g., sometimes a comparatively small part of the much used organo-