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CORRESPONDENCE

Correspondents are asked to be brief

Outmoded Barbiturates

SIR,—Your leading article (7 December, p. 552) was timely and helpful. Our aim is to prevent the opportunities for drug abuse as well as to supply health education in this field, so we are concerned that all doctors in general practice should fully appreciate the points you made. Firstly, the work in Ipswich referred to by Dr. Frank Wells, showing that the prescribing of barbiturates can be reduced by 65%, could be a prototype for all the medical profession. But only a few doctors prescribing less carefully can undo a great deal of good work. When the limitation of prescribing for amphetamines was accepted by most general practitioners it did not take drug-abusing groups of young people long to find doctors willing to prescribe methylphenidate, and now Drinamyl is around in fair quantities because some doctors have been "conned" into prescribing it.

Almost any drug with psychotropic qualities can be abused. Hence if an applicant unknown to the doctor applies—usually with elaborate excuses—for a supply of drugs which could possibly be used for the alteration of mood or as a drug of abuse, caution is essential. One certain way of limiting abuse is for the doctor to prescribe a maximum of five tablets, carefully writing in full in block letters to avoid a skilful alteration. This would aid a genuine patient. In the more likely case of the prescription being destined for the black market it would be almost useless and might never reach the chemist's counter. That particular doctor would not be troubled again by the wide circle of the applicant's drug-abusing friends. The consulting-room of a doctor who prescribes drugs on request is often filled in only a matter of hours by a queue of young hopefuls, and there have been cases of elderly doctors being intimidated by aggressive and threatening "temporary patients" demanding prescriptions. Where prescribing can safely be limited we appeal to doctors to find the time and enthusiasm to give the patient confidence in a weaning process and never to prescribe more than minimal quantities of any drugs which can be abused. Many youngsters start their drug experiments from that over-stocked family medicine cupboard.—I am, etc.,

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Polio Vaccination for Travellers

SIR,—In his paper on imported infections Dr. L. Roodyn (14 December, p. 648) states that it is still prudent to give a reinforcing dose of oral polio vaccine to children before departing to countries in which poliovirus is still endemic. However, we feel it particularly important to ensure that oral polio vaccine is offered not only to children, but also to adults if they have not previously had a full course of vaccine, if details of their polio vaccination status are in any doubt, or if they received a course of inactivated vaccine many years ago, for inactivated vaccines may not always induce persistent immunity to all three serotypes of poliovirus (personal communication from the Public Health Laboratory Service).

During the past four years we have seen five adults with poliomyelitis, one of whom died, while the others experienced severe and disabling disease resulting in permanent confinement to a wheel-chair. All contracted infection while abroad on holiday or business and none had ever been immunized against poliomyelitis. In addition, general practitioners must remember that an increasing number of persons now travel on "package" holidays to non-tropical countries where poliovirus may still be prevalent—for example, parts of North Africa, Turkey, and Spain. We also feel that attention should be drawn to the need for immunization against poliomyelitis in brochures issued by travel agents, which at present is generally not done. Should there be insufficient time to provide a full course of polio vaccine, we recommend that travellers be given at least a single dose of oral vaccine before departure which, though not intended to provide adequate immunity, might prevent colonization of the gut by virulent poliovirus. The full course can then be completed either abroad if the visit is prolonged or on return.—We are, etc.,

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Dangers of High-solute Infant Feeding

SIR,—The Department of Health and Social Security has recently published a very welcome report[1] which lends support to our continued efforts to encourage breast-feeding of the newborn. It was further suggested that where breast-feeding was not possible a "low-solute" artificial feed should be used. Some excellent breast-milk substitutes are available but are relatively expensive—up to 70p for an average of five days' feeding. One might further hope that such expense would help to persuade the impecunious, at least, to breast-feed. This would be too naive a supposition however.

I have recently cared for an infant who has suffered brain damage as a direct consequence of the high cost of artificial feeding. An eight-week-old infant was admitted with severe hypernatraemic dehydration and convulsions. The precipitating cause was