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Correspondence

Correspondents are asked to be brief.

Hepatitis in Dialysis Units

SIR,—Your leading article (31 October, p. 255) makes two points which we feel require further discussion.

The first is the question of outbreaks of hepatitis and the use of disposable dialysers. It is true that, of itself, the use of disposable dialysers may not reduce the risk; the care with which they are used, for example, may be crucial. However, in a situation (such as our own at Guy's) where all other precautions have failed to prevent spread of a virus already present it seems reasonable to suggest the use of disposable dialysers. There are many examples of the advantages from a cross-infection point of view of using disposable items and these should not be ignored.

The second point is the suggestion that regional units be established for the inpatient treatment of home (or transplanted) patients who are Australia-antigen positive. This is an attractive suggestion, but makes the assumption that in all individual units contributing patients to this central unit the infecting virus would be the same. We think that the epidemiological evidence suggests the opposite. The pattern of outbreaks in different units has been quite dissimilar among patients where the modes of dialysis, degree of uraemia and anaemia, age, general health, and pattern of other infections have been indistinguishable. In some units taking few, if any, precautions in the handling of patients, blood, or equipment the long-term presence of HA-antigen positive patients has not been followed by spread. In others, including our own, even a few days' exposure within the unit even with all precautions so far described has repeatedly led to infection. The similarity between our own outbreak and that in Liverpool and its dissimilarity from that in Edinburgh are striking. We have fortunately had no deaths in 73 cases so far; no patients have suffered more than mild illness and 20 out of 22 patients followed for more than six months have remained HA positive, as in Liverpool. In contrast, the death rate in Edinburgh approaches 30% (personal communication); patients as well as staff have been severely ill with several deaths, and HA-antigen has regularly become undetectable in sera from surviving patients.

The suggestion that we may be dealing with a family of viruses has, of course, implications if immunization is to become available.—We are, etc.,

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Ban on Barbiturates?

SIR,—That it is possible to exist as a virtually amphetamine-free community has already been described (9 May, p. 361). I can confirm, six months later, that no amphetamines of any kind are stocked by Ipswich doctors or pharmacists, and that no cases of amphetamine abuse have been discovered since a voluntary ban on the prescribing of amphetamines was introduced in the town a year ago.

Commenting on this, the *British Journal of Addiction*[1] welcomed such a ban, but considered that a similar ban on the prescribing of barbiturates was not possible because of the much wider legitimate indications for the use of these drugs. Undoubtedly there is greater justification for the prescribing of barbiturates, particularly phenobarbitone as an anticonvulsant, but in view of the increasing evidence of abuse of this group of drugs there is a great need for doctors to tighten their control over them. At the same time, it is now well recognized that barbiturates produce dependence, even in therapeutic dosage, and that they aggravate confusion in the elderly.

Fortunately there now exists an alternative hypnotic which appears to have no attraction for teenage abusers, has only slight risk of producing dependence, and which Matthew and his colleagues[2] confirm is effective and safe in overdosage. This drug is nitrazepam, and it should be possible to transfer to it nearly all patients at present dependent upon barbiturates. Adams and others[3] and Grant[4] suggest that between 1·1 and 4% of the population habitually take barbiturates, and a figure of 2·4% was arrived at for an Ipswich practice, which is in agreement with this.

In this practice we decided to test the theory that barbiturate dependent patients could be transferred to nitrazepam or weaned off hypnotics completely, and over a two-month period this has been successfully achieved in over 80% of cases; it is hoped that there will be total success in due course. By gradually reducing the dosage of barbiturate and increasing the dosage of nitrazepam over a period of four to six weeks the transfer has been made, with sufficient time being given to explain and support the reasons for the change whenever necessary.

The relative ease with which this exercise is being conducted encourages me to exhort other doctors to attempt it. The rapid increase in the abuse of drugs over which doctors do have control must to some extent be due to our own previous ignorance, and, albeit innocent, uninhibited prescribing. Now that we are aware of the hazards of barbiturates to our patients individually, and to our society generally, and now that an effective alternative does exist, it is possible that such a voluntary ban as mentioned above could be applied to these drugs. That it should be applied is for the profession to decide; as an individual member of the profession, I am convinced that it should.—I am, etc.,

FRANK WELLS.

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REFERENCES

1 *British Journal of Addiction*, 1970, **65**, 88.
2 Matthew, H., Proudfoot, A. T., Aitken, R. C. B., Raeburn, J. A., and Wright, N., *British Medical Journal*, 1969, **3**, 23.
3 Adams, B. G., *et al.*, *Journal of the College of General Practitioners*, 1966, **12**, 24.
4 Grant, I. N., *Practitioner*, 1969, **202**, 428.