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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Mortality of pathologists and medical laboratory technicians

SIR,—Dr J M Harrington and Mr H S Shannon (8 November, p 329) report an increased mortality from suicide among pathologists and medical laboratory technicians compared with all medical practitioners and all laboratory technicians respectively, as well as with the general population.

Although it will not have escaped the attention of those engaged in clinical medicine, it should perhaps be put on record that while there has been in recent years a large increase among the general population in suicide attempts by the use of drugs, fatalities are exceptional among those who reach hospital alive. It seems likely, therefore, that the excess mortality noted among laboratory workers is due to more efficient suicide attempts, based on greater knowledge of what is likely to be effective, as well as to the ready access to poisonous chemicals suggested by the authors. Implications that laboratory workers are less likely to use other methods of self-destruction may not be untrue but are unnecessary, since in the general population failed suicide attempts with the use of drugs must far outweigh successful suicide from all causes.

Other unexplained excess mortality figures reaching levels of significance in small subgroups, such as lymphatic and haemopoietic neoplasms in English male pathologists and aortic aneurysm in male pathologists, probably need no other explanation than the normal range of variation in the ratios of observed to expected deaths among subgroups, which is predictable in a survey wherein large numbers of valid comparisons are possible. It must be remembered that $P=0{\cdot}01$ represents the chances that a particular event *will* happen as well as those that it will not.

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Ocular reactions to beta-blocking drugs

SIR,—I read with dismay the short report by Mr R B Cubey and Dr S H Taylor (8 November, p 327) suggesting a link between a beta-adrenoreceptor antagonist and transient ocular symptoms and signs. Since the initial publication (15 March, p 595) which described an oculomucocutaneous syndrome as an adverse reaction occuring in a very small percentage of people treated with practolol there have been scattered reports of non-specific ocular symptoms and signs without any real evidence to suggest that they might be considered as an adverse reaction to any drug. This most recent report deprecates the circumstantial nature of the evidence of earlier authors but offers yet more tenuous evidence rounded off by inaccurate references.

The only abnormal findings appear to have been reduced tear flow and some vessel changes in the conjunctiva. In the age group 50-70 years about 5% of patients will have evidence of reduced tear flow without any specific cause,[1] while very variable hyperaemia and vascular engorgement is the normal finding in any dry eye. Such non-specific changes without any scientific evidence to support the claim can in no sense be said to justify the title of an ocular reaction to a drug.

It is very desirable that doctors should report their suspicions concerning any adverse response to a drug, and this service is admirably provided by the Committee on Safety of Medicines. Meanwhile, many workers are endeavouring to discover the mechanism underlying the adverse reaction to practolol and will report their findings in due course. As part of this, my group has had the opportunity of examining most of the cases reported to the committee as having adverse ocular symptoms or signs to beta-blockers other than practolol. To date we have not seen a single case in which there was evidence to support the suggestion of an adverse response and all had other adequate ocular causes for their symptoms. Additional details will be published in due course, but so far there is no reason to believe that any beta-blocker other than practolol causes an adverse ocular reaction.

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1 Whaley, K, *et al*, *Age and Ageing*, 1972 **1**, 197.

Treatment of meningitis and encephalitis

SIR,—The article by Dr C C Smith (8 November, p 335) raises some points worthy of discussion.

We would agree that meningococcal meningitis should be treated with penicillin but do not feel that there is any justification for intravenous therapy except on the grounds of causing less discomfort to the patient. Intravenous therapy in general is more hazardous than intramuscular injection; as stated in the article, it has special hazards such as the possible production of ventricular tachyarrhythmias and also, with the sodium salt, problems of fluid retention, and it is treatment which cannot be given other than