audiograms showed a 60-80 dB neurosensory loss in higher tones in both the ears. After two weeks there was a 30-35 dB gain and a month later his hearing returned to normal in most of the middle frequencies.

Our patient developed auditory symptoms when serum concentrations were not excessively raised. Peak serum concentrations may not be important in patients with renal failure and emphasis must be laid on the area (mg/h/ml) under the serum concentration-time curve.[1] We conclude that our patient was successfully detoxified using the haemoperfusion method.

R AHMAD
N RAICHURA
V KILBANE

Royal Liverpool Hospital,
Prescot Street,
Liverpool L7 8XP

E WHITFIELD

Sefton General Hospital,
Smithdown Road,
Liverpool L15 2HE

[1] Orr JS, Shimmins J, Spiers CP. *Lancet* 1969;ii:771-3.

Double prescribing to opioid addicts

SIR,—There have been articles (27 March, p 972) and correspondence (1 May, p 1335) in the medical journals in the past few months concerning the prescription of opioid drugs (such as Physeptone (methadone) and Diconal (dipipanone and cyclizine)) to addicts in private practice, whether by consultants or general practitioners, or by general practitioners under their NHS contractual obligations.

Drug dependence treatment clinics, as a routine, check with the drugs branch of the Home Office, to which all opioid addicts should be notified, whether a new patient has attended another clinic or doctor outside a clinic. These data (the last doctor or clinic attended) are given on the acknowledgment of notification form routinely sent by the Home Office. On learning that a patient has attended another clinic or doctor, drug dependence clinics get in touch with the previous treater to find out the method of treatment and to make sure that treatment is not still continuing and thus avoid double prescribing (a situation devoutly to be desired by many such patients).

It has recently emerged that some private doctors on learning about previous treatment at clinics or elsewhere do not feel themselves under any obligation to contact the previous treater. They take the view that this would be a breach of confidentiality and that the patient has the right to prohibit such a contact if he so wishes. Furthermore, it seems that the Home Office, which is very alive to such matters of confidentiality, would be unlikely to adopt a system of informing clinics that their patients have gone for treatment elsewhere. It appears to be for the doctors themselves to satisfy themselves that there is no double prescribing.

This situation is unsatisfactory. There is no way by which a clinic doctor can be sure that a patient for whom he is prescribing opioid drugs is not taking amounts of the same drug or drugs prescribed elsewhere. It would be my opinion that any doctor who prescribes opioid drugs to patients whom he knows have attended clinics or other doctors without checking with such doctors that they are no longer prescribing is prescribing irresponsibly. They are thus liable to be dealt with under the appropriate regulations. If I am right in this it might be helpful for the Home Office to alert such doctors to their responsibilities in this field of practice.

P H CONNELL

Drug Dependence Clinical
Research and Treatment Unit,
Maudsley Hospital,
London SE5 8AZ

A-level grades and medical school admission

SIR,—I was very interested to read Dr I C McManus's article on A-level grades and medical school admission (29 May, p 1654), but there seem to be some significant points that he failed to make. There is good correlation between A-level grades and results later achieved in university exams as one would expect since they are both tests of a retentive memory only and not to any significant degree demonstrative of ability, experience, humanity, or compassion. Undergraduate medicine is, of course, a technical college subject rather than a university one, perhaps needing a different approach than hitherto.

The medically required A-level subjects—physics, chemistry, biology—have little or no relevance to clinical medicine other than perhaps indicating a vaguely scientific turn of mind. Regrettably knowledge of these subjects is a prerequisite for understanding the preclinical course, but the latter's relevance to clinical medicine is also highly suspect. The physiology and biochemistry I learnt as a preclinical student some 20 years ago have never been of more than minor fringe value to me as a clinical student, hospital doctor in several different specialties, or general practitioner, and yet the best part of two years was spent on these subjects.

Observation of medical students on GP attachments over the past few years suggests that increased academic prowess does not necessarily go hand in hand with the ability to cope with people. While I would not advocate returning to the old days of boozy rugger players making hearty general practitioners, there is a case for leaving alone the higher A-level grades in searching for a "good doctor." While we obviously need a proportion of high-fliers, to reject two As and a B in favour of two Bs and a C, preferably in non-scientific subjects, might in the end be more appropriate for the public good.

P J HOYTE

Clitheroe, Lancs

Managing cerebral malaria

SIR,—I have been extremely interested in the recent article by Dr Mukesh Kapila and his colleagues (22 May, p 1547) and the leading article by Dr A P Hall (29 May, p 1588) on dexamethasone being deleterious in cerebral malaria.

I spent 10 years in a mission hospital in Rajshahi, Bangladesh, during which time I treated some 50 cases of cerebral malaria. My first case was a shocking experience, the patient dying as I injected him intravenously with quinine dihydrochloride. Manson-Bahr's textbook of tropical diseases,[1] however, advises the prior administration of adrenaline. Using his technique from then on gave our hospital the reputation of having no deaths from this dreaded condition, which is now becoming an increasing menace in this country.

The technique is simple, dramatic, and entirely rational if you consider the pharmacology of adrenaline, a much neglected drug, which cannot be replaced by steroids. For the average adult man 1 ml of 1:1000 adrenaline is given slowly subcutaneously. Five minutes is allowed to elapse, and the dose of about 1 g (according to body weight) quinine dihydrochloride in 20 ml physiological saline is given intravenously at a rate of 2 ml/min. On withdrawal of the needle the patient recovers consciousness "miraculously" and is usually quite rational within 10 to 15 minutes. Follow-up with antimalarials by mouth according to the drug sensitivity of the infecting organism is continued thereafter.

Adrenaline causes vasoconstriction of the peripheral blood vessels, particularly those in the brain, and contraction of the spleen. The parasites driven out from the peripheral vessels are then more safely destroyed by the quinine in the larger vessels where their destruction will not block the vital centres. Adrenaline also reverses the state of shock, which is a feature of this condition, by introducing exogenous adrenalin and not by taxing the patient's adrenals, which, as shown in the interesting necropsy report from High Wycombe, can themselves be exhausted by the use of steroids.

Finally, it is most important *not* to start intravenous infusions of saline as this further increases the cerebral oedema and the risk of the patient dying. It is usually possible to pass a nasogastric tube if dehydration is a problem, but with Manson-Bahr's technique the response is usually so rapid that even this is not necessary.

IAN PATRICK

Aylesbury

[1] Wilcocks C, Manson-Bahr PEC, eds. *Manson's tropical diseases*. London: Baillière Tindall, 1972.

Prevention of doxorubicin-induced alopecia by scalp hypothermia: relation to degree of cooling

SIR,—In their recent paper (5 June, p 1674) Dr R P Gregory and his colleagues discuss the use of scalp cooling to prevent doxorubicin-induced alopecia in patients receiving adjuvant chemotherapy for breast cancer. This seems risky to me: the aim of such treatment is cure and it is entirely possible that micrometastases within the scalp might be protected by this technique. It is our own practice to restrict the use of scalp cooling to patients with advanced breast cancer and other tumours for which the main aim of treatment is palliation.

IAN E SMITH

Royal Marsden Hospital,
London SW3 6JJ

Audit of computerised recall scheme for cervical cytology

SIR,—The approach to screening for cervical cancer advocated by Dr G Philip (5 June, p 1707) is refreshing and sensible. In the computer age there is a real danger that the true objectives of screening will be lost. The tail is beginning to wag the dog.

Most women who develop cervical cancer are parous. Screening at time of pregnancy, especially of those women likely to default from postnatal examination, would be inexpensive