fully informed donor and recipient couples desire this.

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1 Porter IH, Hook EB, eds. *Human embryonic and fetal death*. New York: Academic Press, 1980.

Antiemetic effect of nonabine in cancer chemotherapy

SIR,—The well conducted randomised double blind cross over study of Dr C B Archer and others (29 January, p 350) suffers from the disadvantage that only twelve patients were studied. The chemotherapy used (CHOP—cyclophosphamide, adriamycin, vincristine, and prednisolone—and MOPP—mustine, vincristine, procarbazine, and prednisolone) usually causes considerable vomiting despite standard antiemetic treatment. While the antiemetic efficacy of chlorpromazine has been proved in placebo controlled trials[1] its effect is best seen in drugs that cause mild or moderate vomiting. The complete control of vomiting in over 80% of those patients who received CHOP and over 50% of those patients who received MOPP on either nonabine or chlorpromazine is surprising. It is possible that this small group of patients were unusually resistant to vomiting due to cytotoxic drugs.

Only the minority of the courses of chemotherapy (37 out of 139) were associated with any vomiting, and it seems likely that this was confined to a few patients. To conclude on a sample of this size that the antiemetic effect of nonabine is similar to chlorpromazine seems premature. We would suggest that the only conclusion that can be drawn is that nonabine alone in the dosage used produced only minor side effects and would be suitable for further investigation. Larger studies designed to assess the efficacy of nonabine would now seem desirable.

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Intestinal anastomosis

SIR,—It was disappointing, but predictable, that your leading article on bowel anastomosis (26 March, p 1002) made no reference to the contribution that regional anaesthesia can make in helping to solve some of the problems mentioned.

The quiet contracted bowel and perfectly relaxed abdomen have long been advocated as advantages of spinal anaesthesia for intestinal surgery,[1] but more recently Aitkenhead *et al* have shown that both colonic breakdown and subsequent mortality are reduced with high spinal anaesthesia.[2] These workers have shown in dogs that spinal anaesthesia produces a significant increase in colonic blood flow and a decrease in colonic oxygen consumption,[3] results that might be appropriate in man and might explain their former findings.

Other advantages of epidural anaesthesia in these circumstances are the avoidance of the detrimental effects of neostigmine,[4] lowered blood loss[2] (and transfusion is related to breakdown[5]), and increased bowel tone owing to the avoidance of opiates.[6] Other more general advantages are the lower incidence of deep vein thrombosis and pulmonary embolism,[7] the abolition of the stress response,[8] and better postoperative analgesia.[9]

It is a pity that a technique that has so much to offer in diminishing some of the problems associated with intestinal surgery received no mention in such a prominent leading article.

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Immunisation policies

SIR,—Dr C G D Brook's impassioned plea (2 April, p 1082) for support of our immunisation policies is laudable, but some of his statements about rubella vaccination deserve comment.

A recent report from this country[1] has shown that a programme of screening 1000 pregnant women for rubella antibodies and then vaccinating the seronegative patients after delivery had an overall efficacy of 83%, with no less than 98·2% of the whole population being immune at the onset of their next pregnancy. Five cases of natural rubella infection occurred in the initial 1000 pregnancies of these women, but none occurred in their subsequent 1000 pregnancies. Since 56% of women in this country delivering babies congenitally infected with rubella virus have had a previous pregnancy[2] such programmes should be encouraged as a means of helping to control congenital rubella infection.

Thus rubella vaccine has been shown to protect women of childbearing age, but only those who have agreed to be vaccinated. The weak point in the British approach to rubella vaccination is, therefore, not the strategy being used but human nature, since our population shows a perverse reluctance to volunteer themselves for vaccination. Hinman *et al*[3] do not indicate how their new vaccination strategy could improve vaccine uptake, and Dr Brook does not address this central problem either.

The current complacency towards vaccination represents a twentieth century form of "survival of the fittest," which could be modified by making vaccination a prerequisite of some desirable event in the way that admission to school is used in the United States. Such mandation, however, would inevitably be tied up in the general debate of how patronising official agencies should be towards the general public. We, and the public, know that vaccines, seat belts, and crash helmets are good for us, but we need to be able to cajole the public into increasing the uptake of these prophylactic measures without infringing their civil liberties. This problem is not solely medical since it requires a political commitment, but it is one which is surely not beyond the ingenuity of our legislators.

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SIR,—Dr C D G Brook draws attention to official complacency about immunisation against disease (2 April, p 1082). Parents are willing to cooperate, and their apparent lack of interest in preventive medicine springs from fear of such measures. They have heard of the dangers of vaccinations but have little understanding of the dangers of neglect. It is the parent who is out—at work perhaps—when the health visitor calls who often objects to inoculations. There is an inherited tribal folk memory related to the past when vaccination was officially enforced; the public vaccinator, however, had to present the parents with a form allowing conscientious objection to the vaccination. All this has to be corrected by education.

The situation is dynamic, and an occasional campaign or the odd feature on television often does more harm than good. Information becomes garbled with the lapse of time. Each year around a third of a million parents need regular information. The detergent salesman knows this and regularly advertises his wares monthly, weekly, or even every day. Static notices on public noticeboards are not adequate. The facts need wide and effective publicity comparable to that for washing machines or motorcars or Danish bacon.

The facts on pertussis or measles are not well remembered even by doctors. Try asking any colleague, consultant or junior, the vital statistics for 1982; quite a few will not be too sure. How can we expect a lay person to be able to judge the risks of immunisation on too little accurate information.

As a start perhaps the birth certificate should be accompanied by a statement of the data about measles, pertussis, rubella and so on. Another time to alert the parents is when they register their child at school. Intervals between programmes on television could be used, and regularly. Even the cold statistics might be adequate, but I would think that short advertising cartoons or similar sequences would be preferable.

One of my reasons for this letter is to advertise Dr Brook's campaign to those readers who missed his article. I do not, however, think we should move to compulsory immunisation as currently practised in the United States. In a democracy freedom can be sustained by information and education.