neonate. Apart from these possibly deleterious effects of diazepam several authors[3 5] have questioned its value in labour, and it is therefore difficult to justify its widespread use in the obstetric field.

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[1] Burn, J M B, *Midwives Chronicle and Nursing Notes*, 1974, **87**, 348.
[2] Scher, J, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, **79**, 635.
[3] Lee, D T, *Canadian Medical Association Journal*, 1968, **98**, 446.
[4] Elder, M G, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1969, **76**, 264.
[5] Friedman, E A, *Obstetrics and Gynecology*, 1969, **34**, 82.

Side effects of cyproheptadine

SIR,—Recently cholestatic jaundice was reported (25 March, p 753) as a complication of treatment with cyproheptadine. At present we are evaluating the hypothalamic effects of cyproheptadine in various endocrine disorders and we have administered the drug to 20 patients for periods up to nine months in doses of between 16 and 32 mg daily.

Jaundice has not occurred in any of our patients and liver function tests have remained normal. The only side effects noted have been drowsiness and an increase in weight during treatment. The drowsiness is usually transient and lasts up to four weeks after starting treatment. The increase in weight has affected all our patients with only one exception. With a low dose of cyproheptadine (< 16 mg daily) the increase in weight during a six-month period has been $2{\cdot}9 \pm 1{\cdot}8$ kg. With a larger dose taken for the same length of time the weight increase has been $4{\cdot}2 \pm 5{\cdot}2$ kg. Although Bayliss[1] noted that some patients with Cushing's disease became psychotic when given this drug and it has also been stated[2] that occasionally central nervous system stimulation leading to hallucinations may occur, we have not encountered these problems in any of our patients. In women whom we have observed closely for a period of months the drug has not led to any appreciable mood changes. Dryness of the mouth and other anticholinergic effects have similarly been conspicuous by their absence, but we are dealing with a young patient population of less than 40 years of age.

Our conclusion is that cyproheptadin is generally very well tolerated by patients and that it is associated with remarkably few side effects, a view shared by other workers.[3]

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[1] Bayliss, R, *Quarterly Journal of Medicine*, 1977, **46**, 553.
[2] *Lancet*, 1978, **1**, 367.
[3] Delitala, G, *et al*, *Metabolism*, 1977, **26**, 931.

Alcohol and cirrhosis

SIR,—I wholeheartedly agree with the suggestion of your correspondent (25 March, p 789) that the deleterious effects of alcohol may have been seriously exaggerated, as well as the definite benefits minimised.[1]

I would disagree with him, however, that the differing national cirrhosis rates necessarily imply a specific constituent of wine absent from distilled spirits. One must surely take into account also the varying national alcoholic sex ratios (females being more liable to alcohologenic cirrhosis[2]) as well as possible racial genetic differences. Thus it may well be that some races are more prone to cirrhosis than others, because of genetic predisposition. Recent evidence[3] suggests that certain histocompatibility antigen patterns, so-called genetic markers, may reflect susceptibility to cirrhotic disease (we know that HLA subtypes reflect susceptibility to a myriad of afflictions[4]). Tissue typing may in the future show certain nations with a particular proclivity towards hepatic cirrhosis. This may well apply to the French.

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[1] Kinnell, H G, *British Medical Journal*, 1977, **2**, 1479.
[2] Morgan, M Y, and Sherlock, S, *British Medical Journal*, 1977, **1**, 939.
[3] Bell, H, and Nordhagen, R, *British Medical Journal*, 1978, **1**, 822.
[4] Oliver, R T D, *British Journal of Hospital Medicine*, 1977, 449.

Bronchiectasis and cystic fibrosis

SIR,—The otherwise excellent article on bronchiectasis and cystic fibrosis by Dr Margaret Hodson (15 April, p 971) is seriously marred by the failure to emphasise that the advice on management and drug dosage is directed throughout to the adult and adolescent, and not to the child.

Firstly, tetracycline should not be prescribed for young children for obvious reasons; secondly, the dosage of all the antibiotics recommended is high for infants and small children; it would have been better to specify the amount to be given per kg/day. Oddly, gentamicin 2 mg/kg/day is lower than the dose usually required, which is more commonly 5-7 mg/kg/day; but of course if regular blood level monitoring is carried out as advised by Dr Hodson the amount can be regulated as necessary.

Bronchodilators are not routinely required for children and in fact only occasionally prove useful, but salbutamol 5 mg in 3 ml by inhalation would be an excessively high dose, 0·5-1 ml of 0·5% solution in 2 ml saline being more appropriate.

There are numerous other statements that are unsatisfactory in the context of childhood. For instance, physiotherapy really needs to be carried out three times a day if the child has cough or sputum. Force of circumstances only may cut this down to twice a day—that is, school, mother at work, and so on. Rectal prolapse must be treated by dietary care and increasing the pancreatin extract, or by checking that the latter is effectively used, in order to control the frequency and looseness of the motions. If this is done, resort to surgery is never necessary.

The final paragraph gives a pessimistic impression of an undoubtedly distressing condition by stressing the early mortality of the past and of many of the older patients of today, without noting the effect that early diagnosis—perhaps as a result of neonatal screening—together with more effective treatment may have in the future on the quality of life and length of life. It is highly satisfactory that adult chest physicians are now showing an interest in cystic fibrosis, which in fact reflects the improving life expectancy and the increasing number of young adults requiring their care.

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Hyperbaric oxygen

SIR,—With reference to your leading article (22 April, p 1012) may I draw your attention to the fact that the regional centre for hyperbaric oxygen for the West Midlands region is sited in this hospital? It has been so for the last seven years, and there are therefore four regional centres for hyperbaric oxygen in this country at the time of writing.

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Payment to clinical members of district management teams

SIR,—Certain important aspects of this matter have not been mentioned in recent correspondence on this subject in your columns.

DHSS circular DS 131/74 (paragraph 6), dated 15 May 1974, stated: "The rate of pay is regarded as provisional pending experience of the new management arrangements. The Department and the professions have agreed that inquiries should be made in due course to determine the amount of time clinical members of the DMT/AMT are spending on this work, and that the level of payment should be reviewed in the light of this information at that stage, any revised payment being backdated to 1 April 1974. We shall write to you again about this in due course."

In 1975 DMT payments were increased from £700 to £950 annually, along with the general increase in medical salaries at that time. I think that clinical DMT members believed, as I did, that the DMT increases were in fact just part of that general increase in medical salaries. However, DS 250/75, dated 28 July 1975, stated that "The increases notified in this letter have been agreed on the basis that any future increases related to workload, as envisaged in paragraph 6 of DS 131/74, should not be backdated to before 1 April 1975." Thus it seems that the 1974 agreement regarding the review of time taken on DMT work was revoked, as far as the first year of DMT work is concerned. I wonder how many DMT members were parties to the 1975 "agreement," or even knew about it.

The BMA *News Review* for March 1978 (p 140) states: "The GMSC, together with the Central Committee for Hospital Medical Services, is asking the Department of Health for payments to clinical members of District Management Teams to be based, in future, on two notional sessions per week instead of one." The words "in future" sound ominous to me: do they mean that the 1974 agreement is to be renaged on in respect of the second, third, and fourth years of DMT activity, as well as the first year?

Just what is being done to ensure that the DHSS does honour the agreement to which it was a party in 1974?

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**The Secretary writes: The claim referred to by Dr Penman is now with the DHSS,