## Debendox

SIR,—In his Letter from Westminster (3 May, p 1213) Philip Johnston states that there is evidence linking Debendox with deformities in children. This is not the case, and 30 epidemiological studies have failed to show any connection between the drug and deformities.

Debendox has been reviewed by many regulatory authorities around the world, including the Committee on Safety of Medicines, and in July 1984 the Minister of Health, Kenneth Clarke, in a debate in parliament declared, "After the most exhaustive examination of all the evidence, all the major regulatory drug authorities in the Western world have failed to find any causal link between this drug and deformities in children. No regulatory authority has even withdrawn the licence, because it is the opinion of the experts in every country that on the scientific evidence available to them there is nothing to show that the drug is unsafe."[1]

There was no finding of illegality in respect to the proposed settlement but procedures were found to be faulty under US law and, as a result, the common issues trial involving 1180 plaintiffs took place. This was won in March 1985 by Merrell Dow, when it was found that Debendox did not cause malformations. The British plaintiffs were not "thrown out" of the US courts; the US courts said that the UK courts were the more appropriate venue for these people to make their claims.

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1 Clarke K. Debate on Debendox. *House of Commons Official Report (Hansard)* 1984 July 25;**64**:cols 1165-179 (no 201).

## Emergencies at sea

SIR,—If Dr W R P Bourne's letter (26 April, p 1133) is of only marginal interest to your readers, it should prompt the BMA to take more than evasive action. The shipboard doctor is not an anachronism, as my experience taught me.

Between January 1982 and December 1984 I served with the Royal Fleet Auxiliary, mostly in the South Atlantic, where distances from shoreside hospitals can be outside helicopter range. The cases in the table illustrate the call for urgent and essential action in isolation. The patients were all men. I hasten to add that ships' doctors are not alone in having to act without hospital support, but because they have the platform that is no reason to deprive them of equipment.

All the patients survived, though the final outcome in the patient with the head injury is uncertain: his repatriation was to the other side of the Iron Curtain. The use of helicopter transport facilitates evacuation to a hospital within 400 miles; it also enables a patient to be transferred 200 miles (there and back) to a ship with a doctor. If the doctor is to be useful he must be well equipped.

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*Details of patients*

| Case No | Date | Distance from surgical support (miles) | Age of patient | Diagnosis | Management |
|---|---|---|---|---|---|
| 1 | 18 June 82 | 50 | 29 | Spontaneous pneumothorax | Observation only, evacuation by air to SS *Uganda* (delayed for 48 hours) |
| 2 | Dec 83 | 800 | 21 | Acute appendicitis | Conservative treatment (Fowler's regimen+ antibacterials), air evacuation on 18 Dec for removal of gangrenous appendix |
| 3 | 2 Jan 84 | 800 | 24 | Strangulated inguinal hernia | Stomach washout; surgical reduction under thiopentone, gas and oxygen, and lignocaine; 4 l intravenous fluids; antibacterials; air evacuation and repair of hernia on 3 Jan; patient recovered |
| 4 | 2 Feb 84 | 800 | 24 | Extradural haematoma with depressed fracture | Trephine under gas and oxygen and local lignocaine 20 ml; intravenous fluids (3 l); air evacuation on 3 Feb; fracture raised; patient repatriated on 1 March with residual right hemiplegia |

## Low serum C4 concentrations and peripheral neuropathy in type I and type II diabetes

SIR,—Dr Mark E Cooper and colleagues (22 March, p 801) reported low serum C4 concentrations in 25% of type I diabetics independent of the presence of microvascular disease. This is in contrast to the previous findings of Barnett *et al.*[1,2]

We examined 20 diabetic patients (12 women and 8 men; 14 insulin dependent and 6 non-insulin dependent) during their stay in hospital. Four of the 14 (29%) type I diabetics had low serum C4 concentrations without any correlation with the duration of diabetes, the age of the patient at the time of study, or age at diagnosis. There was also no difference between type I and type II diabetics. Six of the 14 type I diabetics showed retinopathy, two of them proliferative retinopathy, while only one of the type II diabetics had retinopathy. Six type I and three type II diabetics had proteinuria. We confirm the findings of Dr Cooper and colleagues that there was no significant difference in C4 concentrations between patients with and without microvascular complications in type I or type II diabetics.

Each patient was also studied by physical examination, electromyography, and electroneurography for diabetic neuropathy. Ten of the 14 type I diabetics and three of the six type II diabetics had abnormal findings on electromyography and electroneurography. Likewise, we found no significant difference in C4 concentrations between those with and those without peripheral neuropathic complications. Only three type I diabetics with symptoms of autonomic neuropathy and abnormal findings on electromyography and electroneurography had low serum C4 concentrations (mean (SD) 0·19 (0·04) g/l *v* 0·28 (0·09) g/l (normal 0·2-0·5 g/l)).

Low serum C4 concentrations are obviously not markers for either retinopathy and nephropathy or peripheral neuropathy in type I and type II diabetes.

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1 Barnett AH, Mijovic C, Fletcher J, *et al.* Low plasma C4 concentrations: association with microangiopathy in insulin dependent diabetes. *Br Med J* 1984;**289**:943-5.
2 Vergani D, Johnston C, Abdullah NB, Barnett AH. Low serum C4 concentrations: an inherited predisposition to insulin dependent diabetes. *Br Med J* 1983;**286**:926-8.

## Epidemic of AIDS related virus infection among intravenous drug abusers

SIR,—Mr Gary Webb and others (3 May, p 1202) conclude from their data on drug abuse habits in south London that if the Edinburgh experience prevailed by now half the intravenous drug abusers should be seropositive for the human T cell lymphotropic virus type III/lymphadenopathy associated virus antibody. Since this is not the case they conclude that there must be some other protective factor operating in south London drug abusers which needs elucidating.

I would suggest, however, that the most likely protective factor operating is a relative lack of needle sharing compared with that in Edinburgh drug abusers. Of 78 intravenous drug abusers attending the City Hospital screening clinic in Edinburgh 49 (63%) shared needles at least weekly while 33 (42%) shared daily. By comparison in south London only 14 (31%) of 45 drug abusers had shared needles within the past three months. In our patients there was a significant relation between seropositivity and the frequency of needle sharing ($\chi^2=4{\cdot}24$; $p<0{\cdot}05$). Data collected from health care workers show that the risk of acquiring the virus from a single inoculation injury is less than 1%.[1] Increasing the frequency of these incidents is therefore the most likely method of increasing the frequency of virus transfer.

*Relation between frequency of needle sharing and incidence of HTLV-III antibody*

| Frequency of needle sharing | HTLV-III antibody status | | |
|---|---|---|---|
| | Positive | Negative | Total |
| At least weekly | 32 | 17 | 49 |
| Monthly or less often | 12 | 17 | 29 |
| Total | 44 | 34 | 78 |

$\chi^2=4{\cdot}24$; $p<0{\cdot}05$.

Frequent needle sharing with many individuals is analogous to the high rate of sexual activity among homosexuals. At present prevention is our only viable option for controlling the spread of this virus. A health education campaign similar to "safe sex" is required now, to promote "safe shooting" to contain the spread of this virus among the drug abusing community.

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1 Anonymous. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. *Morbidity and Mortality Weekly Report* 1985;**34**:681-95.

## Universities squeezed to brink of financial disaster

SIR,—You were commendably swift to report the address by Mr Maurice Shock, the chairman of the Committee of Vice Chancellors and Principals, to the BMA which followed this year's conference of medical academic representatives (7 June, p 1542). I would like, though, to have on record Mr Shock's response to a question relating specifically to preclinical medicine—a response which, as I recall, was unequivocal and delivered without hesitation. It was, he said, the wish of the government and of the community at large that resources