followed by a dermatologist and receive intensive treatment of the kind we gave when their blisters are active and widespread, even if this means admission to hospital two or three times a year.

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Safety of intermediate doses of pyridoxine

Citing a report by Schaumburg and colleagues[1] on the development of a sensory neuropathy in patients receiving 2 to 6 g/d of pyridoxine, Dr. D. Crawford (*Can Med Assoc J* 1984; 130: 343) recommends that patients taking pyridoxine be warned to avoid increasing the dose without consulting their physician. However, Schaumburg and colleagues' article leaves the medical profession at a loss concerning the safety of intermediate doses of pyridoxine — that is, those in the range of 250 to 500 mg/d.

Even though Baker and Frank[2] reported no untoward effects in six patients receiving 225 mg/d of pyridoxine, Schaumburg[3] responded that, to his knowledge, "there has been no study using systematic quantitative sensory testing of large numbers of people undergoing long-term pyridoxine administration in the 200-to-500-mg range".

Pyridoxine in doses of 250 to 500 mg/d has been found to be effective in patients who have kidney stones secondary to hyperoxaluria.[4] We have followed 22 patients with kidney stones who were treated with intermediate doses of pyridoxine for 8 months to 6 years (average 2.3 years). None has shown any neurologic complication. Furthermore, we performed nerve conduction studies in seven of them (all men, ranging in age from 47 to 60 [average 43.4] years), who were treated with 250 to 500 mg/d of pyridoxine for 1 to 6 (average 2.8) years. The results, shown in Table I, were all within the normal range.

Our findings suggest that the administration of pyridoxine in doses of 250 to 500 mg/d for long periods (up to 6 years) is safe, and we have decided to continue this treatment in our patients.

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Table I—Results of nerve conduction studies performed in seven patients treated with pyridoxine, 250 to 500 mg/d for an average of 2.8 years

Measure and nerve	Mean ± standard deviation	
	Patients	Controls
Motor conduction velocity (m/s)		
Median	58.3 ± 3.2	57.3 ± 4.1
Ulnar	56.1 ± 2.6	60.2 ± 5.3
Peroneal	49.1 ± 2.5	49.0 ± 4.1
Distal motor latency (mm/s)		
Median	3.7 ± 0.3	3.2 ± 0.4
Ulnar	2.7 ± 0.2	2.6 ± 0.3
Peroneal	4.2 ± 0.5	4.2 ± 0.7
Distal sensory latency (mm/s)		
Median	3.1 ± 0.3	2.9 ± 0.4
Ulnar	2.8 ± 0.2	2.5 ± 0.3

Commercial malpractice insurance

I read with interest Dr. C.A. Johnson's letter on commercial malpractice insurance (*Can Med Assoc J* 1984; 130: 672). I agree completely with his sentiments.

However, Dr. Johnson suggests that insurance companies are the cause of the problems with commercial malpractice insurance in the United States. The insurance companies are only a symptom. The problems are actually due to an overabundance of lawyers; the jury system, which not only judges the facts of a case but also sets the damages; no limitation on the amount of damages due to pain and suffering; continuance fees (a percentage of the gross) for lawyers; and patients' attitudes towards physicians.

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Teaching medical students about alcoholism

We read with interest Milan Korcok's article entitled "How can we teach students about alcoholism?" (*Can Med Assoc J* 1984; 130: 305–308). We have no quarrel with his general thesis concerning the importance of integrating meaningful information and practical experience in the area of alcoholism and drug dependence into undergraduate medical curricula. We are, however, dismayed by Korcok's apparent lack of knowledge concerning the training in alcoholism and drug depen-