amplitude (mm Hg)/resting IVP (mm Hg) was used. In patients who recovered without dementia, the amplitude indices were high and the frequency of waves varied from about 1 to 4 per min. In patients with a poor clinical course (dementia, vegetative survival and death) the amplitude indices were significantly lower and the frequency was often higher than 4 per min. Thus high amplitude indices imply a good prognosis, and not a poor prognosis as suggested by Turner and McDowall.

GEORG COLD
Virum, Denmark

REFERENCES


SIR,—We wish to apologize to Dr Cold and his colleagues for the mis-quotation of their paper. We should have quoted them as stating that “Low amplitude waves have a poor prognosis, especially if they occur frequently”. The only additional point which we would add from their paper is that the patients in the better prognostic groups had mean ICP values less than 30 mm Hg on the first 2 days after injury.

J. M. TURNER
D. G. MCDOWALL
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EFFICACY OF ANTACID THERAPY

SIR,—The correspondence entitled “The efficacy of antacid therapy” by White, Clark and Stanley-Jones (1976) is interesting. Since Lahiri, Thomas and Hodgson (1973) published their article on 0.3 M sodium citrate as a single- dose antacid, we have been using this regimen. From February 1974 to November 1976 16 456 anaesthetics for patients undergoing obstetric procedures were administered. A single dose of 0.3 M sodium citrate 15 ml was used only before general anaesthesia (1396 cases). Aspiration did not occur in any of the patients delivered during this period.

The administration of an antacid as a single-dose has advantages over the 2-hourly regimen to all patients in labour; the latter policy is a tremendous burden to nursing staff, especially in a busy obstetric unit. White, Clark and Stanley-Jones (1976) have shown that both methods are equally effective, even if the sodium citrate is given immediately before induction of general anaesthesia. Sodium citrate has other advantages. It is a clear liquid devoid of particulate matter, present in many commercial antacids, which may cause pulmonary lesions if aspirated. It is inexpensive and prepared easily by the hospital pharmacy. Its main disadvantage is its unpleasant taste. To make it palatable without changing the pH, we have tried many additives, either alone or in combination—chloroform water, aniseed water, 10% syrup and 20% syrup. The most acceptable mixture was the antacid with 20% syrup. The mixture is prepared in doses of 15 ml in small glass vials and many of these have to be stored. To test if there is any change in pH with storage and if refrigeration is required, we performed the following test. Forty-eight of these vials were divided into two groups, one stored at room temperature (24–26 °C), and the other at 4 °C. Each week, the pH of three vials from each group was examined and the experiment was continued for 8 weeks. The results showed no significant change in the pH of the mixture with storage whether at room temperature or at 4 °C. Thus, 0.3 M sodium citrate in 20% syrup is an acceptable, inexpensive, safe and stable antacid. It is recommended as a single dose before induction of general anaesthesia in obstetrics.

EZZAT ABOULFISH
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REFERENCES

S.I. UNITS

SIR,—I regret deeply your determination to use S.I. units exclusively in future. Clinicians have had this system, with its several practical absurdities, forced upon them without adequate consultation, but this cannot justify its exclusive use in a journal with an international circulation. Have you considered, for example, what the effect will be upon your North American readership and upon the dissemination of information to the less advanced countries? Surely you do not suggest that they should learn the S.I. system or laboriously calculate equivalents. Moreover, you cannot ignore the potentially injurious effects of having European doctors conversant solely with S.I. units. The North Americans well may feel they can support the loss. We cannot. Will you reconsider your decision, and use equivalent values in parentheses for the indefinite future?

ALAN GILSTON
London

We accept the sentiments expressed by Dr Gilston and share his anxieties. The reasons for the change of units was explained in an Editorial note in September, 1975. It is, and always has been our policy, not to pioneer these changes, but rather to reflect the current practice among clinicians in the United Kingdom. The Editor is more aware than most of the anomalies resulting from the changes and these difficulties are shared with most of the other leading general and specialist journals published in this country and elsewhere. Dr Gilston has directed his complaint at the wrong source, but he can be assured that if he wages a campaign to restore the previous hybrid system of units, the Editorial office of this journal will not oppose him.

EDITOR