chart for nearly a year and have found the following advantages:

1. Legibility.
2. Standarized recording of both positive and negative data.
3. Standardized approach to a common problem.
4. Can be used for audit.
5. Occasionally acts as an *aide-mémoire* for some important point omitted from history or examination.
6. The sheet could be used for research purposes, for example, mean time between onset of symptoms to presentation. Indeed the importance of research in general practice is emphasized in a recent College publication.[3]
7. The sheet could provide convenient format for computerization of data.

The disadvantages are:

1. The cost.
2. Suitable at present for A4 files only.
3. Practical problems arise as to where to store in A4 file.
4. Some parts of the chart are restricted in space.

Overall our experience has been favourable and we feel that the advantages far outweigh the disadvantages. Printed sheets of this kind are used extensively in some parts of the USA where I first encountered their use. We are pleased with the limited introduction of our printed sheets and hope ultimately to expand their use to some other common presenting complaints.

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Infant immunization and Reye's syndrome

Sir,

I was interested to see in the current *1985 Members reference book* two adjacent articles on infant immunization[1] and Reye's syndrome.[2]

Like the practices involved in the study on infant immunization, I used to recommend junior aspirin or paracetamol for the minor side effects of immunization. However, the second article on Reye's syndrome reminds us of the possible association between aspirin ingestion in young children and Reye's syndrome.

The drugs and therapeutic bulletin (8 October 1984) contains an article on this possible association and I quote their conclusions:

'The possibility of an association between aspirin and Reye's syndrome has been raised and cannot be ignored, although the case is far from proven. While the issue remains unresolved, it seems sensible to recommend paracetamol rather than aspirin as an antipyretic in infants and children. Further epidemiological and laboratory studies are in progress.'

I would be interested to know what effect this has had on other practices' prescribing habits. My own view in spite of the association being unproven is that it is better to be safe than sorry.

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Report of a case of adder bite with near fatal result

Sir,

This case report is made to emphasize the need for a wider awareness of the management of adder bites.

Case report. The patient, a retired general practitioner in his sixties, was alone at a holiday caravan in the Yorkshire dales on a warm day in July. He knelt in the rough grass beside the caravan and immediately experienced severe pain in his knee. He inspected his knee and saw two tiny adjacent marks in the infrapatellar region. He then looked in the grass but saw nothing. During the following 12 hours his entire leg become grossly swollen and painful, and he felt nauseated, weak and faint. The following morning he still felt extremely unwell and decided to drive home to seek help. Not far from the caravan he blacked out and the car overturned causing severe damage to the vehicle but fortunately no injury to the driver. He was seen by a general practitioner who empirically prescribed hydrocortisone and then by a consultant surgeon at home. Neither doctor nor surgeon suspected the diagnosis of adder bite which was made two days later by a doctor with previous experience of snake bites. Recovery was slow but uneventful, the leg taking two to three weeks to return to normal.

Comment. This patient almost certainly suffered an adder bite to his knee with resulting severe symptoms of envenomation. It is of interest that three different doctors did not initially suspect the diagnosis of adder bite.

Although adder bites are rarely fatal they can be the cause of considerable morbidity.[1] This case demonstrates the need for both general practitioners and hospital doctors to be aware of the symptoms and management of adder bites especially in those areas of the country in which adders may be prevalent. Perhaps this could be achieved by circulating the information contained in an excellent review article by Reid.[2]

There are grounds for introducing a system of notification of such bites so that the true incidence of the problem may be assessed and the distribution of stocks of Zagreb antivenom organized effectively.[2]

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Level of immunity to rubella in several group practices in Ireland

Sir,

Nine trainees in our final year on a three-year vocational training course in Ireland studied the immune status for rubella in females attending our practices in the age groups 14 to 40 years.

Two hundred and thirty-seven women were studied over a six-month period. Our results showed that 94.5% of all the women studied were immune to rubella. This is comparable to previous studies in the UK — for example, Rowlands[1] found 88% immunity and Rose[2] found 96% immunity to rubella. In our survey 4.9% of those who claimed to have had previous vaccination were non-immune.

The women's level of knowledge about the dangers of rubella on the fetus was found to be high and this was so throughout all age and socioeconomic groups. However, in the 14–20 year age