antibody decline in this subject was similar to that of maternal antibody in infants. We have infiltrated monkey serum into the distal phalanx of the thumb of a person bitten by a monkey from a colony in which B virus was known to have been circulating. This was done under ring block local anaesthesia; the only reaction was severe pain during the night after the anaesthesia had worn off. Though this was not unexpected with such a sensitive area as the pulp of the thumb, it makes the procedure less than ideal for wounds in these areas unless the risk of infection is high—as it was on that occasion.

If immunoprophylaxis is to be used for monkey bites or similar trauma it is essential that antisera or immunoglobulin should be held in laboratories where monkeys are used. Stocks of monkey sera are held by us at Porton Down and at the National Institute for Biological Standards and Control, London. We hope that these stocks will be converted into immunoglobulin and made available as freeze-dried preparations.

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Requests for reprints should be sent to Dr B Thornton.

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Smoking and drinking by middle-aged British men: effects of social class and town of residence

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Abstract

In 7735 men aged 40-59, selected at random from general practices in 24 towns throughout Britain, pronounced differences were noted in the prevalences of smoking and drinking between the social classes. Social class differences also existed for frequency and quantity of drinking, type of beverage, and several aspects of smoking behaviour. Increasing amounts of smoking were associated with higher prevalences of moderate to heavy drinking, particularly in daily rather than weekend drinkers. Between drinking groups, however, the relation with smoking was more U-shaped, with light and heavy drinkers smoking more than moderate drinkers. The lowest rates of moderate to heavy smoking were observed in frequent light drinkers, particularly in the non-manual workers. The proportion of moderate to heavy drinkers was no higher among ex-cigarette smokers than among current smokers. When the data were examined by town of residence social class differences persisted. Controlling for social class still showed pronounced differences between towns in both smoking and drinking behaviour.

These data confirm that town of residence and social class have independent effects on smoking and drinking. The established regional and social class differences in cardiovascular disease may be due in part to the independent influences of town and social class on smoking and drinking behaviour.

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Introduction

The pronounced regional differences in mortality from cardiovascular disease in Britain have interested observers for decades and led to several studies.[1 2] The British Regional Heart Study is a further effort to investigate the problem.[3 4] Researchers have noted associations between cardiovascular diseases and cigarette smoking and, to a less extent, drinking alcohol.[5 6] Cigarette smoking has been positively associated with the prevalence and incidence of ischaemic heart disease,[7] light drinking has been associated with lower blood pressure[8] and less cardiovascular disease,[9 10] and heavy drinking has been associated with both higher blood pressure[8 11] and more ischaemic heart disease.[12 13] Probably at least part of the well-known regional variation in mortality from cardiovascular disease may be explained by regional variations in these two risk factors of smoking and drinking.