Contemporary Themes

Three weeks of the limited list

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We asked four general practitioners and one pharmacist to tell us what happened to them in the first three weeks of the limited list. They report below.

Problems within 20 minutes in Scotland

JAMES A GRANT

We were only 20 minutes into the first day of the limited list when Mr McLeod phoned to ask about his Maalox tablets (aluminium hydroxide and magnesium hydroxide). It wasn't because he was upset about the restrictions or because he had run out of his tablets; he just thought he would check with Dr Grant what he would be doing about it when he did run out—in two weeks time.

So it has continued throughout the first three weeks of this "new era" for the NHS. If we thought that we might have escaped the worst effects of Mr Fowler's black list here in rural Perthshire we were sadly mistaken. We even considered ourselves well prepared with practice meetings, letters for the patients explaining changes, and even labels for the pill bottles pointing out that the new pills still had the same effect. At a special meeting with our local rival practice we had the inevitable rumbles: "government by imposition not discussion"; "we must fight to ensure that this is not the thin edge of the wedge"; and "the list is totally unacceptable." I'm sure the same clichés have reverberated from Perth to Penzance—yet to what avail?

Our local chemist was quick to point out at yet another meeting the effect that the restrictions would have on his stock (and profits)—he being the only source of prescribable drugs, potions, and medicaments for 15 miles. Could we possibly keep prescribing Rinurel linctus (paracetamol, phenylpropanolamine, and phenyltoloxamine) as he had just ordered 6 l. (What no Cab drivers' linctus?) Likewise, he was still flush with Actifed expectorant (triprolidine and pseudoephedrine) and Aludrox gel (aluminium hydroxide), but we could forget about Actifed compound linctus

and Aludrox SA suspension—or was it the other way around? No matter, our chemist has faithfully for two weeks sent us small notes informing us as to the demise of yet another winchester of "Dr D E Jough's cod liver oil with malt extract and vitamins—fortified syrup" and the many other potions which he wishes never to gather dust on his shelves again.

But what of our patients. Mr McLeod has finally settled for Maalox suspension night and morning with aluminium hydroxide tablets during the day. We have engaged in heated debate with the Scottish Home and Health Department over whether we can prescribe "paracetamol, codeine phosphate, and caffeine effervescent" instead of Solpadeine for a patient whose chronic pain responds only to this combination. With some sense of triumph we have been informed, after being told the opposite, that we can. Thus the problems continue as we have to deal with many frustrating phone calls and prescription difficulties every day.

Three weeks into one of the most important changes in the National Health Service since its inception it is of course much too early to assess the lasting effects. One gets feelings of patient anxiety and concern yet little sign of hardship or alteration in consulting pattern. A great deal of time and effort has been required to effect the changes needed in repeat prescribing sheets and case notes and to deal with patients' anxieties. Reassurance has been the overriding need of the past three weeks. We are trying to reassure the patients that nothing really has changed, but there is much doctor apprehension that things will never be the same again.

London patient writing to Mrs Thatcher

SALLY HULL

I start Thursday 4 April thinking rather smugly that few changes have been needed among my patients, when Mrs M arrives for her regular consultation. Every general practitioner will recognise this woman; she has a repeat list of eight innocuous but conflicting drugs which she takes ritualistically to ward off the anxieties she does not wish to have probed. On hearing that Disprin (aspirin) is off she gives me an uncomfortable 10 minutes telling me that soluble aspirin upsets her badly and that several eminent consultants have recommended Disprin. My consulting skills evaporate as I weakly agree that her letters to the DHSS and Mrs Thatcher might just change things.

In the weeks running up to the limited list we had a continuous stream of propaganda from the weekly throwaways predicting difficulties. Queues of patients demanding Asilone (dimethicone and aluminium hydroxide), buttercup syrup, or gentian and rhubarb linctus were difficult to imagine, but I was becoming anxious that our practice had made few preparations for the great day: no reception staff training, no extra surgery time, not even a

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printed letter to state that the nearest equivalent had been given. In spite of this on 1 April my log of "list related events" was short: a partner hangs up a poster saying "don't blame your doctor"; reception looks unusually quiet—no reported problems; I make two minor changes to prescriptions—from Panadol to paracetamol and from Distalgesic (dextropropoxyphene and paracetamol) to coproxamol; I reassure someone that antihypertensive drugs will not have to be bought; and two visits from the local chemist. The chemist came to tell us how to prescribe well loved drugs by their generic constituents. He has noted a shift in prescribing habits rather than a drop. We agree that savings will be smaller than if generic prescribing had been introduced.

All in all the clinical impact in our practice has been slight. This reflects our common policy of minimal prescribing for minor ailments, with the aim of diminishing dependency on either drugs or the doctor. The diverse members of the partnership are, however, united in disliking the way the list was introduced. The real importance of this change probably lies outside the clinical sphere. Reforms are certainly needed within general practice, but unilateral action without consent is rarely constructive. I hope that the government will not use this as a model for introducing more important changes in the future.

Inconvenience in the North

ROD SUTCLIFFE

When the limited list was first published I was very concerned at the government's proposals, but when I saw the extended list I realised that the new legislation would have little effect on my prescribing. Many items I was prescribing generically already, and most items I normally used in the affected drug groups were on the white list. I could still prescribe the blacklisted drugs that I wanted to by writing the generic ingredients.

During the last three weeks of March we altered our repeat prescription cards where necessary and handed explanatory leaflets to patients. I took the opportunity of stopping some items that I thought were inappropriate—for example, Limbitrol (amitriptyline and chlorthalidopexide)—or unnecessary—for example, Orovite sachets (thiamine, riboflavine, pyridoxine, nicotinamide, and ascorbic acid). I changed some patients from their constipating analgesics to paracetamol, but I suspect most will soon be back on their old drugs as co-proxamol (dextropropoxyphene and paracetamol), etc. I will continue to prescribe soluble paracetamol (not the Boots product, of course) and also Solpadeine (as "paracetamol, codeine, and caffeine tablets, effervescent"), which controls the bone pain of a woman with metastases from breast cancer. I suspect that many other patients will be asking for their Solpadeine back when they discover that it can be dispensed.

A meeting with the local chemists sorted out a few problems. The receptionists have had to spend time explaining the changes to patients. There has been some anxiety in patients with psychological dependence on their usual preparations. Three of my patients opted to buy their Dalmane (flurazepam) or Valium (diazepam) privately. One patient whose hiatus hernia was controlled for years with Titalac tablets (calcium carbonate and glycine) (£1 per month) was unhappy with Magnesium trisilicate from me, consulted my partner, and is now taking Tagamet (cimetidine) and Gaviscon (alginic acid, magnesium trisilicate, aluminium hydroxide, and sodium bicarbonate) at a cost of about £25 a month.

The introduction of the list has prompted me to review my prescribing, and there has been some inconvenience for myself, my staff, and my patients. There are many loopholes in the list, however, and I doubt if there will be an appreciable reduction in my prescribing costs. So what has all the fuss been about? The regulations are an example of the government's single minded

determination to cut costs in the NHS. Future measures will be more damaging, and I will continue to oppose any measures which threaten to reduce the quality of care the health service can provide.

DHSS not trusted in Somerset

DAVID RAWLINS

We are a dispensing practice with about 4000 patients in north Somerset. We have found two major problems with the limited list: firstly, to ensure that our patients are treated as safely as possible with drugs made by a reputable manufacturer; and, secondly, to ensure that our dispensary is not left with large amounts of costly stock for which we would have to charge the patients direct.

Our preparations started in November as soon as we heard through the media of the decision. We wrote to the DHSS, ministers and our member of parliament and went to see him in Westminster (he turned up 25 minutes late for the appointment). We still await replies to a number of our letters. We explained the implications of the list to our patients. Because we are a rural practice we have always carried large stocks of drugs; these we started to run down, and inevitably we have on a few occasions run out of drugs.

When the proposed black list was published in February after the end of the so called consultations we were horrified to see how much it had been extended—to mucolytics, nose drops, etc. The DHSS had ensured that we would not have any opportunity to comment on its new proposals. The media told us that the new list was being amended. The government informed us at 9 am on 30 March of its final black list—38 hours before it was due to take effect. Only then could we see the size of the problem and learn what we could not prescribe.

We discovered that some valuable drugs are not black listed. Some of these we have run out of; others have been added to the list. Chemists and pharmacists, we learn, are to have a payment of £27m (about £2000 a year for each pharmacy) in compensation for loss of income due to the list. Dispensing doctors were given 62 hours notice that the government was to reduce its payment for the cost of the drugs we prescribe by up to 7.42% (previously it was up to 4.5%). We think that our negotiators have not been very successful. No doubt Mr Fowler and Mr Clarke understand the plight of the pharmacists as they each were paid parliamentary advisers to the Pharmaceutical Society for a number of years.

We have found that very few patients have wanted private prescriptions—and we have not encouraged them to ask. While the National Health Service lasts we prefer to continue to treat our patients inside it. Patients have tended to accept the limitations resignedly and to trust us to try to find an efficacious substitute. The major gaps we have found to date are: a palatable low sodium antacid—Asilone (dimethicone and aluminium hydroxide) was very good; and liquid vitamin preparation—Orovite (thiamine, riboflavine, pyridoxine, nicotinamide, and ascorbic acid) was an extremely palatable liquid preparation as it caused no nausea.

The effect of the gross limitations on benzodiazepines will probably take some weeks to become apparent. The range of analgesics appears to be largely unchanged, and details of the new generic names are gradually filtering through. We are intrigued by the new name for Distalgesic and Cosalgic (dextropropoxyphene and paracetamol)—coproxamol. It is presumably from the Greek *κοπρος*. We hope the new name was not produced with a view to alliteration. We have had little time to institute computer searches for banned drugs—each search may take 30 minutes and then the new name or substitute has to be entered. Computer time would be more usefully employed in our programme for screening for those girls and women who are not immune to rubella, and for hypertensive screening, etc.

Our staff and ourselves have had to check each prescription

several times to ensure that we are not falling foul of the regulations. All this has taken time and energy that would be better devoted to caring for patients. Mr Clarke's statement that the job of the government is to govern and that the BMA and doctors would be wise not to try to enter into discussion make us feel that we are living under an alien government—one that is not interested in our problems and sees us as an unruly section of a subject people. It will be a long while before we trust the DHSS again.

Pharmacist busy reassuring patients in East Sussex

J WINSHIP

All Fool's day turned out to be an unexpectedly slack day for prescriptions, and there were no prescriptions to be returned to the surgery. But I have had a surprising number of prescriptions dated before 1 April for blacklisted products. In some cases I was relieved to see these as stocks of such items were then reduced, but in some cases I had no stock and neither did the wholesaler or other pharmacies in the area, having run down stocks in preceding weeks.

I have spent lots of time assuring patients that the generic product

now available is as good as the equivalent proprietary product and also explaining to other worried patients that their drugs are not black listed. Some patients have not been told by their doctors that the repeat item requested is no longer allowed on NHS, and so they are dispensed a product that is completely unfamiliar. One patient who had previously had Dormonox (loprazolam) (a white tablet packaged in foil) was prescribed Euhypnos (temazepam) (a green capsule in a bottle); her reaction was, "They look lethal." After some explanation, however, she went off quite happily.

Availability of stock has caused problems. Several whitelisted products have not been widely used in the past and are currently out of stock at the wholesalers; as a consequence some patients are having to wait longer than I would like while I contact the wholesaler and then the doctor.

The pattern emerging seems to be one of substitution of non-blacklisted products and a reluctance to issue private prescriptions. The patients are willing to try the alternative drugs—so it will be interesting to see next month if they are satisfied or if there will be an increase in requests for private prescriptions. So far I have had only one private prescription for a blacklisted product.

The second and third weeks presented many more queries from patients, and I have now had to deal with patients who have now found that they are now expected to purchase some of their medicines. These patients were most upset and have made no purchases. There were, too, some prescriptions for blacklisted drugs written by receptionists that had to be returned.

The meeting held locally between doctors and pharmacists before the implementation of the black list seems to have been worthwhile as so far none of the local doctors has inadvertently ordered a black-listed item.

Clinical curio: the imaginary cap

Entering the room, he raised his right hand to his head, then quickly brought it to his side. A folded cap protruded from his jacket pocket. Sitting down, he again raised his hand to his head, immediately returning it to his side. While giving a six week history of facial swelling and headache, he repeated the hand to head movement twice. Asked why he did this, he replied, "I keep thinking I've got my cap on." This sensation had been present one month.

Examination showed superior vena caval obstruction. The chest x ray examination showed a peripheral bronchial carcinoma with mediastinal lymphadenopathy. He left without taking his cap from his pocket, presumably believing that it was on his head. All the symptoms and signs, including the imaginary cap, resolved with radiotherapy.

Symptoms of superior vena caval obstruction include facial swelling, collar tightness, headache, faintness, blurring of vision, and a band like pressure on the head—this presumably due to scalp vein engorgement, which in my patient mimicked the sensation associated with wearing his cap. Signs are differential cyanosis and oedema of the upper half of the body, with distention of neck, arm, and fundal veins. To these might be added attempts to remove the imaginary cap. I thank Dr J M Shneerson for allowing me to report this case.—M S PHILLIPS, senior registrar, Cambridge.

Does a person of average weight who eats an excessive amount of sugar in an otherwise well balanced diet increase his susceptibility to cardiovascular disease and diabetes mellitus?

Rats fed a high sucrose diet develop impaired glucose tolerance, insulin resistance, hypertriglyceridaemia, retinopathy, and nephropathy. The altered composition of the thickened glomerular basement membrane is similar to that seen in rats rendered diabetic with streptozocin.¹ Sucrose feeding has also produced hypertension in rats sensitive to salt, possibly secondary to antinatriuresis.² In man a high sucrose diet (260 g daily) has been associated with a reduced fraction of the protective high density lipoprotein and raised n-acetylglucosaminidase, a marker described in early renal failure.³ In addition, hypertriglyceridaemia has been noted with a high sugar diet, but it is transient and postprandial triglyceride levels become lower than those seen on a diet rich in fat.³ There are, despite this

experimental evidence, no epidemiological data to show that sucrose intake is related to the development of diabetes or atherosclerotic cardiovascular disease. Indeed, an inverse correlation was noted between sucrose intake and blood glucose concentrations in a large group of London men.⁴ Clearly obesity can precipitate type II diabetes mellitus. About 50-60% of obese people have abnormal tolerance or other evidence of diabetes. Compared with normal subjects, diabetic men in the Framingham study had twice the rate of coronary heart disease and five times the incidence of peripheral vascular disease. Therefore, in as much as a diet high in sucrose leads to weight gain it is a risk factor for diabetes and cardiovascular disease.—MARY BRENNAN, research registrar in clinical pharmacology, Dublin.

1 Yudkin J, Kang SS, Bruckdorfer KR. Effects of high dietary sugar. *Br Med J* 1980;281:1396.

2 Hodges RE, Rebello T. Carbohydrates and blood pressure. *Ann Intern Med* 1983;98:838-41.

3 Bierman EL. Carbohydrate and sucrose intake in the causation of atherosclerotic heart disease, diabetes mellitus and dental caries. *Am J Clin Nutr* 1979;32:suppl 12:2644-7.

4 Keen H, Brong JT, Jarrett RJ, Fuller JH. Nutrient intake, adiposity and diabetes. *Br Med J* 1979;i:655-8.

Is weight lifting hazardous for adolescents training for rugby or other sports?

Weight training, including lifting moderate weights to develop upper body strength, is a popular and legitimate activity for adolescents getting fit for rugby football and other sports. Competitive weight lifting, however, is undoubtedly hazardous before full skeletal maturity has been reached. The stresses imposed by this activity on adult joints, ligaments, and muscles are well documented, and they must be all the greater in adolescence. According to the Department of Education and Science, "Medical evidence suggests that there is a risk of spinal injury arising from the lifting of maximal and near maximal weights by growing boys and girls, and such activities, either in training or competition, are not considered suitable for schools."¹ The Medical Officers of Schools Association warns against "the tendency of some sportsmen to try to prove their strength and virility by using heavy weights," and therefore advises that weight training should be carefully supervised to avoid muscle strains, particularly of the back.² Adolescents with backache or signs of muscle strain should not lift weights until recovered.—TREVOR HOSKINS, school medical officer, Horsham.

1 Department of Education and Science. *Safety in physical education*. London: HMSO, 1973. (DES Safety Series No 4.)

2 Medical Officers of Schools Association. *Handbook of school health*. 16th ed. Lancaster: MTP Press Ltd, 1984.