were representative of a wider group. However, we are grateful to Drs Dally and Grant for underlining this important point.

Unlike Dr Dally we do not find it gratifying that most deaths of notified addicts were due to prescribed drugs. The medical profession cannot control the availability of illicitly imported drugs but is collectively responsible for the drugs that doctors prescribe. Indeed this paper showed very clearly that when the availability of barbiturates was restricted by collective action on the part of the profession the number of deaths among addicts from this cause was dramatically reduced. Although outside the remit of our recent study, there is evidence that prescribed drugs are also implicated in the deaths of non-notified addicts: we have previously studied death due to addiction identified in coroners' courts,¹ where barbiturates caused the deaths of 38% of cases not known to the Home Office. More recently Spear reported, "A further significant trend is the increase in the involvement of dipipanone in the form of Diconal amongst the 'unknown' deaths"—that is, deaths unknown to the Home Office.²

We said in our paper, but in view of the vehement response of Dr Dally and Dr Grant it should perhaps be repeated, that our results do not minimise the problems presented by illicitly imported drugs, problems which are vastly greater now than in 1981, the last year of our study period.

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Mixing short and intermediate acting insulins: effect on postprandial blood glucose concentrations

SIR,—Dr R J Heine and colleagues (19 January, p 204) studied postprandial blood glucose control in insulin dependent diabetics receiving mixtures of short and intermediate acting insulins under carefully controlled conditions. They attributed the observed differences to the precipitation of soluble insulin by insulin zinc suspensions, although the isophane and insulin zinc suspensions used may have different absorption characteristics.¹

We analysed the run in period from a recent UK multicentre study, the aim of which was to compare control achieved with porcine and human soluble plus lente regimens (Actrapid MC; human Actrapid and Monotard MC; human Monotard).² Of the 96 patients entered, 63 were receiving mixtures of twice daily short and intermediate acting insulin. The initial three month run in period with monthly clinic visits allowed diabetic control to stabilise under this new level of intensive care.²

The figure shows the results of the seven point home blood glucose profile, and HbA_{1c} values at the end of the three months, for bovine soluble plus isophane (n=27), porcine soluble (either Actrapid MC or Velosulin) and Insulatard (n=18), and porcine Actrapid MC and Monotard MC (n=18). There were no significant differences between these three groups of patients in age, sex, duration of disease, body mass index, or insulin antibodies. The fasting blood glucose concentra-

Home blood glucose profiles and HbA_{1c} results in groups of patients receiving twice daily short and intermediate acting insulins.

tions were significantly lower with porcine Actrapid MC and Monotard MC than either bovine ($p < 0.01$) or porcine ($p < 0.05$) soluble plus isophane regimens. Within patient comparison (immediately before and one month after transfer from twice daily soluble and isophane regimens to twice daily soluble and lente regimens) also showed significant improvement in fasting blood glucose with the lente preparations, tending to confirm a genuine treatment difference. There was also a tendency for the ratio of short to intermediate insulins in the morning injections to be higher in the lente group than in either isophane group, although total dose per kg was identical in both porcine groups—0.83 U/kg (total daily dose on bovine insulins 0.92 U/kg).

Thus in clinical practice overall glycaemic control, as assessed by HbA_{1c}, is at least as good with a soluble plus lente regimen as with a soluble plus isophane.

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Programmed admissions

SIR,—I was very interested to read the personal view of Mr D D Mathews (16 February, p 552). If more people would use the system that Mr Mathews uses then there might be more satisfaction with the surgical waiting lists in the health service. Many people do not mind a relatively long wait if they can at least plan holidays and time off work around their operation, whereas a long wait to be followed by a few days' notice of admission can cause a lot of resentment.

Could I suggest two additional wrinkles that I use and that might make the system work even better for Mr Mathews? The first is to keep one list regularly empty and I try to keep empty the first list of each month. This list can then be used for those patients with cancer who require urgent major surgery and also (should it be needed) those patients

who have their operation cancelled because of the problems that Mr Mathews mentioned like the redecoration of a ward or upgrading of a theatre. If one list a month is kept free then it means that nobody with cancer and nobody whose operation has been cancelled will need to wait more than a few weeks before the next possible date for admission.

The other suggestion is that a young and healthy person who has been seen in the gynaecological outpatients' clinic within a few weeks of her operation does not need to come into hospital the day before surgery. It is perfectly possible to admit women for hysterectomy on the day of their operation, provided that all the necessary anaesthetic screening tests have been arranged in outpatients. Many women do not like the tension of waiting in a hospital ward on the night before surgery and appreciate the chance to spend an extra day in the comfort of their own homes.

Giving patients dates for their operation in the outpatient clinic does make life so much easier for patients and for the hospital staff that there can really be very few reasons for not doing it.

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Screening for neural tube defects

SIR,—We were disturbed to read Minerva's comments (2 February, p 399) stating that serum α fetoprotein measurement as a screening test for neural tube defects was being withheld from some women in south London purely on financial grounds.

We work in one of the hospitals in south London where serum α fetoprotein measurement is not offered routinely and would like to point out that we reached this decision for several reasons, not all of which were related to funding. The area we serve is one of low risk for neural tube defects (<1:1000 births at St Thomas's Hospital in the past three years). Our present policy is to perform an ultrasound scan on all mothers either at 16 weeks or at booking, whichever is later. When a neural tube defect is suspected high resolution ultrasound scanning is then performed. In addition, mothers with a previously affected infant or a close family history, or who cannot accept the reassurance of a normal ultrasound scan, are offered serum α fetoprotein determination and, if appropriate, amniocentesis.

From 1982, when we adopted this policy, until December 1984 only seven mothers have had pregnancies complicated by a neural tube defect among a population of just over 9000 deliveries. In four of these the infant was anencephalic and the pregnancies were all terminated between 16 and 20 weeks. Three infants were born with a meningo-myelocoele. In one case, the mother transferred her booking in late pregnancy with the diagnosis already established, having declined the offer of termination; in the second the baby was delivered shortly after arrival, to an unbooked mother. The third baby was born to a mother with a history of neural tube defect whose serum and amniotic fluid α fetoprotein concentrations were both normal at 16 weeks. Ultrasound scan suggested a small encephalocoele, which later proved to be correct.

These results confirm that our current policy provides a satisfactory diagnostic service for the needs of our community and agree with those of others who feel that serum α fetoprotein screening is not justified in areas of low prevalence^{1,2} (26 January, p 293). To set up such a screening service in our hospital would be unnecessary and an inappropriate use of our