Particular attention is being paid to patterns of response and our ability to predict not only those patients who will show clear benefit from electroconvulsive treatment but also those who respond to placebo.

We hope that the results of these analyses will soon be available for publication.

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Recommendations for data sheets on benzodiazepines ignored

SIR,—The Committee on the Review of Medicines, in its guidelines for data sheets on 10 named benzodiazepines, "considered that an appropriate warning regarding long-term efficacy be included . . . particularly in view of the high proportion of patients receiving prescriptions for extended periods of time."¹

In conjunction with a survey on prescribing patterns we examined the Association of the British Pharmaceutical Industry's *Data Sheet Compendium 1983-1984*.² We found the 10 named compounds represented by 17 proprietary preparations. Although 16 warn that "prolonged" or "excessive" use may lead to dependence, only one carries a caution regarding long term efficacy (table).

If the pharmaceutical industry is allowed such latitude in the data sheets we can hardly expect higher standards in their advertising literature.

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¹ Committee on Review of Medicines 1979. Systematic review of the benzodiazepines. *Br Med J* 1980;280: 910-2.

² Association of the British Pharmaceutical Industry. *Data Sheet Compendium 1983-1984*. London: ABPI Datapharm Publications Limited, 1983.

* * * We sent a copy of this letter to the Association of the British Pharmaceutical Industry.—
Ed, *BMJ*.

Details of warnings given in data sheets of 10 named benzodiazepines

Benzodiazepines (ref 1)	Pharmaceutical preparations	Specific warning about lack of long term efficacy	Warning about risk of dependence	Recommendation for short term treatment
Diazepam	Atensine	None	Yes*	None
	Valium Roche	None	Yes*	None
	Valrelease	None	Yes*	None
Chlordiazepoxide	Librium	None	Yes*	None
Medazepam	Nobrium	None	Yes*	None
Clorazepate	None			
Lorazepam	Ativan	None	Yes*	None
Oxazepam	Serenid-D	None	Yes*	None
	Serenid Forte			
Temazepam	Normison	None	Yes*	None
	Euhypnos	None	Yes†	Yes†
	Euhypnos Forte			
	Euhypnos Elixir			
Triazolam	Halcion	None	None	Yes‡
Nitrazepam	Nitrados	None	Yes*	None
	Somnite	Yes§	Yes*	Yes
	Mogadon	None	Yes*	None
Flurazepam	Dalmane	None	Yes*	None

*"In general the dependence potential of benzodiazepines is low but this increases when high dosages are attained, especially when given over long periods. This is particularly so in patients with a history of alcoholism or drug abuse or in patients with marked personality disorders."

†"Euhypnos is indicated for short term treatment of sleep disturbances."

‡"As with all hypnotics, long-term use is not recommended."

§"Little is known regarding the efficacy or safety of benzodiazepines in long-term use. It is advisable to review treatment regularly and to discontinue use as soon as possible."

||"Indications: Short-term treatment of insomnia where daytime sedation is acceptable."

SIR,—Dr Murray and Dr O'Leary criticise the ABPI *Data Sheet Compendium* for not following in full guidelines on benzodiazepines issued during the systematic review of this drug by the Committee on the Review of Medicines in March 1980. In a previous letter in your columns I explained how these guidelines should not necessarily be expected to become translated into data sheets.¹ This is because data sheets are required by the Medicines Act 1968 to be consistent with product licences and the product licences cannot be changed other than through the licensing authority. In this process advice may be taken from, among others, the Committee on the Review of Medicines, but manufacturers have the right of appeal against decisions of the licensing authority and we deplored the publication of guidelines for data sheets before this right had been exercised.

In the event, some of these guidelines have been modified in respect of some products during their review so that the data sheets quoted by Dr Murray and Dr O'Leary are the reviewed, approved versions. In the case of other products, new statements have been agreed but not yet incorporated into data sheets. It was misleading for "guidelines for data sheets" ever to have been issued ahead of the process of discussion and appeal and, fortunately, this has not been repeated.

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¹ Snell ES. Systematic review of the benzodiazepines. *Br Med J* 1980;280:1053-4.

Possible method of identifying spotter practices

SIR,—The failure of the statutory notification system for communicable diseases mentioned by Dr William W M McConnell and Dr Vinod K Tohani (11 February, p 455) is not peculiar to Northern Ireland, and effective surveillance cannot be achieved when more than half of general practitioners fail to notify cases.

Since 1980 we have been developing a sentinel practice scheme in the Oxford region. We began by using the "G" book method of Professor Paul Grob at the University of Surrey, which is a simple loose leaf notebook in which numbers of cases are tallied. The conditions studied were the same as those reported by the weekly returns service of the Royal College of General Practitioners research unit at Birmingham and published by the Office of Population Censuses and Surveys. We have modified the method and range of conditions to suit our local needs, but the method has remained simple and inexpensive.

There are now 26 sentinel practices (covering a population of 106 217), which report voluntarily, with materials and postage provided. Most are teaching practices and are not wholly representative of the region. Nevertheless, we are confident that the observations are useful in detecting the timing and scale of local epidemics that are not apparent from national statistics or local notifications.

Each week the records from each general practitioner are sent for regional analysis, and feedback to sentinel practices (and information for other practices, community physicians, microbiologists, and some hospital clinicians) is provided by a fortnightly bulletin *Epidemic Observations*, based on the weekly records.

Participants meet regularly to review the scheme, to discuss the range of conditions and their criteria, and to plan developments. We think that these communications strengthen a local network. In addition, the project has provided a framework for further studies, including microbiological investigation of scarlet fever and a randomised controlled trial of the treatment of cystitis.

The information gained is available for student teaching, general practice training, and health services planning.

The sustained cooperation of the participating general practitioners has been an important feature of the scheme and feedback through the bulletin has undoubtedly contributed greatly to this. We are approaching the end of a three year grant from the Oxford Regional Health Authority locally organised research fund and shall be writing a full account of our scheme. In the meantime, we would encourage the development of such schemes in other regions.

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SIR,—Dr William W M McConnell and Dr Vinod K Tohani (11 February, p 455) raise important issues that go far beyond the subject of notification of infectious diseases, important though that may be. There appears to be a case for a more fundamental review of the purposes served by "notification." No doubt there is still a need for action in the interests of public health, but surely the more pressing need nowadays is for information on all aspects of health problems in the community.

The nettle that needs to be grasped is, of course, the fundamental issue of obtaining first hand information on health problems, morbidity, and use and non-use of services at primary medical care level. Planners need