printed name and number (for example, 40 or 80) on the pack and label, ignoring colour as an indication of either. It would be advisable to keep an empty pack or vial to check the identity of repeat prescriptions.

HARRY KEEN
Chairman, Medical
Advisory Committee

PETER WATKINS
Secretary, Medical
Advisory Committee

ARNOLD BLOOM
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Photocoagulation and diabetic retinopathy

SIR,—I was fortunate enough to be invited to a Guy's lecture on photocoagulation and diabetic retinopathy and heard Professor H Keen—like Mr B L Hercules and Dr I I Gayed (23 June, p 1710)—refer to the urgency of the need for photocoagulation in proliferative eye disease.

I understand that most such cases come from eye rather than diabetic departments and that roughly 3% in eye departments will have the condition. This is a serious matter because, whereas appointments for diabetic clinics are more or less immediate, for the eye departments six or seven months is a standard waiting time unless urgency is recognised. This is about the time for all to be over and done with so far as saving the sight is concerned.

A possible solution could spring from the patient with an eye complaint placing homatropine in the eye before attending a GP's surgery. The recognition of the condition is not difficult.

G P WALSH

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X-ray examination of acute ankle injuries

SIR,—Drs Gerald de Lacey and Shirley Bradbrooke suggest that if there is no swelling over the malleoli it is not necessary to x-ray a twisted ankle (16 June, p 1597).

Even for excluding a major fracture their advice is not entirely foolproof, as their figures show. However, x-rays should be taken in such patients' ankles not merely to exclude fractures but also to exclude a torn lateral ligament of the ankle. It is the localisation of tenderness as well as the presence or absence of swelling which provides the solution to this problem. If there is neither swelling nor tenderness over the malleoli there will be no major fracture. And if there is tenderness over the lateral ligament, forced inversion pictures should be taken.

While the absence of swelling and tenderness excludes serious pathology, their presence does not prove its presence. But exclusion of the possibility is then impossible without x-rays.

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SIR,—Drs Gerald de Lacey and Shirley Bradbrooke (16 June, p 1597) merit our thanks for

reminding us of the direct association between fractures round the ankle and soft tissue swelling. I have found this association useful for many years and indeed it was standard teaching at St Thomas's 25 years ago. Careful radiography will show the base of the fifth metatarsal in ankle films, and this is the only likely bony involvement with rotation strains in the ankle.

Incidentally, has anyone reviewed the damage suffered by patients we have failed to x-ray?

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Injuries to boys who scramble

SIR,—I would like to thank Drs R H Jackson and A W Craft for their comments on this topic (16 June, p 1625) and for pointing out an apparent error in my computation. In the explanation of my figures I did not make clear that the figure of 24 races includes the initial five practice races, but these were not included in the rider races calculation and there was an average number of 19 races per event.

I can only agree with the observation that children of this age are not suited physically or mentally to take part in such sports. In many cases I feel that the parents are encouraging the child not for his enjoyment but for the feelings of displaced pleasure that they experience. Injury to their children does not diminish their enthusiasm, and I must say I was expecting a much greater frequency of serious injury when we embarked on the study.

The implication of Drs Jackson and Craft's letter is that a medical presence at such events not only condones them but positively encourages the competitions. Sadly, the experience in other areas is that events take place irrespective of the medical cover provided, since there are no safety rules by which they must be governed. This organisation attends many functions in the interest of offering help to the "sick, wounded, disabled, or suffering" and unfortunately our personal attitude to them is not a consideration; our first concern is for those in pain. We hope our continued presence at such events will help to reduce the suffering of those injured or unwell, and that in our small way we can influence the organisers to pursue their interest in the safest possible way. Scrambling is increasing in popularity nationally, and regulations on the conducting of meetings are urgently required.

M PLACE

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MRC treatment trial for mild hypertension

SIR,—In a paper given on 13 June at the sixth scientific meeting of the International Society of Hypertension, the management committee of the Australian National Blood Pressure Study reported results which have led them to stop their randomised controlled trial for the treatment of mild hypertension. Some of your readers may want to know how this will affect the somewhat similar MRC trial in Britain.

The entry criteria in the two trials differ in an important way. The Australian trial included men and women aged 30-69 with

screening pressures within the 95-109 mm Hg diastolic (V) range. Randomisation for active or placebo tablets was determined after blood pressure measurements had been recorded at a subsequent entry examination, when all with pressures of 95 mm Hg or over were eligible. At that stage 16% had pressures of 110 or over, and these were included. The Medical Research Council's trial includes men and women aged 35-64 with diastolic (V) pressures found at screening to be within the 90-109 mm Hg range but only if their pressures are confirmed *within that range* at the entry examination.

In the Australian study pharmacological treatment conferred benefit only in those whose pressures at the entry examination were 100 mm Hg or greater; in this group treatment significantly reduced the incidence of fatal terminating events ($P < 0.05$) and of all terminating events ($P < 0.01$) compared with control subjects receiving placebo tablets. But among the 2056 subjects with pressures above 100 mm Hg at entry were 530 (25.8%) with diastolic pressures of 110 and over who would not have been eligible by the MRC trial criteria.

The Australian trial therefore deals with a higher blood pressure range than the MRC study, and it was within the upper part of the range that significant benefit from treatment was demonstrated. Nevertheless, on hearing of the Australian results the MRC trial monitoring committee examined the data in a similar way and submitted them to the chairman of the trial's ethical committee, who advised continuation of our trial, urging us to state publicly that "the data to hand are too few to justify any comment."

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Depot neuroleptics in a community mental health service

SIR,—I was most interested to read Dr Ernest Bennie's letter (7 April, p 958) commenting on his preliminary experience with cisclopenthixol decanoate (Clopixol). I would like also to give my impressions of the use of this drug in a catchment area of 85 000 people, as compared with the more familiar depot neuroleptics fluphenazine decanoate (Modectate) and flupenthixol decanoate (Depixol).

My experience of the use of depot neuroleptics began with the introduction of fluphenazine enanthate in 1964 and the subsequent development of fluphenazine decanoate in 1969. Fluphenazine was an excellent drug for controlling many of the symptoms of the major psychoses and was largely responsible for the increased numbers of patients who were able to live their lives outside psychiatric hospitals.

Other depot neuroleptics were introduced, but were less satisfactory for the sustained control of psychotic illness. Flupenthixol decanoate was the one exception, and in patients with simple schizophrenia who were