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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Post-marketing surveillance of drugs

SIR,—I read the article by Dr A W H Marcus and his colleagues (21 July, p 163) with interest. These workers have shown that at the instance of the Committee on Safety of Medicines it is possible for a pharmaceutical company to identify a selected cohort of over 9000 hospitalised recipients of a new injectable drug and record brief details of its efficacy and toxicity for periods of several hours after the injection. Regrettably they did not give full details of the cost of the study, but from the information given it would seem unlikely to be less than £50 000. Thus, as a pilot study for a post-marketing surveillance programme of a new compound, this project seems to have been successful in its limited aims. It is important, however, to emphasise that it does not give much useful information on what is seen to be the main problem with new drugs—that of detecting reasonably common delayed adverse drug effects or effects arising only after long-term use of the new compound. For this purpose one requires to look to some of the proposed developments recently discussed in the *British Medical Journal* and elsewhere.¹⁻³ These studies all aim to identify a large cohort

of patients receiving a new drug and follow them for periods of up to one or two years. As yet none of the pilot studies currently under way have reported their results. Until they do it is important not to conclude, as Dr H Marcus does, that post-marketing surveillance studies are unlikely to add much to the knowledge and understanding of new drugs already gained from preregistration clinical trials.

Finally, I would take issue with Dr H Marcus and his colleagues when they state that “monitored release, however large the cohort size, without a suitable (randomised?) control group is a methodological impasse when rare effects are considered.” The objective of the proposed studies is to look for common (up to 1 in 500 recipients) serious events which may be drug related.⁴ If such events are noted in an uncontrolled screening programme such as carried out by Dr H Marcus then more detailed studies with different methods and incorporating appropriate controls are required to elucidate whether the event is truly drug related or not. The original screening studies can only be hypothesis-generating projects which, if successful, will require further

detailed studies before any outcome is accepted as being truly drug related.

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¹ Inman, W H W, in *Drug Monitoring*, ed M Gross and W H W Inman. New York, Academic Press, 1977.

² Dollery, C T, and Rawlins, M D, *British Medical Journal*, 1977, 1, 96.

³ Lawson, D H, and Henry, D A, *British Medical Journal*, 1977, 1, 691.

⁴ Lawson, D H, *British Journal of Clinical Pharmacology*, 1979, 7, 713.

Drug information and cost effectiveness

SIR,—The randomised controlled trial analysing the relative merits of buprenorphine and diamorphine by Dr M J Hayes and others (4 August, p 300) for the treatment of chest pain in suspected myocardial infarction is most interesting, but incomplete.

It is unfortunate that the authors of the study did not complement their careful analysis with an appraisal of the full economic costs of the different drugs. Buprenorphine is uncontrolled but more expensive to buy. The full costs of controlled and uncontrolled drugs can be estimated—see, for example, Culyer and Maynard’s analysis of the cost effectiveness of Fortral and morphine¹—and doctor decision makers should be given evidence not only of clinical efficacy but also of costs if we