Identification of tablets

SIR,—I read with interest Dr Anthony Kaiser's letter (16 February, p 485) suggesting the colour coding of tablets to assist in their identification by both the patient and his doctor. On the surface this appears a good idea. There must be over 2000 different preparations currently listed in *MIMS*, not including the various strengths of each one; and if one employs a policy of assigning each tablet a colour and three different coloured bands then, if we assume the use of eight colours, 4096 (8⁴) different combinations are possible.

I doubt, however, whether such an upheaval would be justified. It would probably be more difficult for a patient to remember "a blue capsule with yellow, red, and black bands" as opposed to "red and black capsules." I can foresee many mistakes being made in identification of tablets, by the patients and by hospital staff alike.

If one wishes to improve the identification of tablets, then one should adopt the general medical principle of applying the simple things first. I suggest: (1) All prescribed drugs should have clear labels with the name and strength of the bottle contents *printed* upon them, as opposed to illegibly scribbled. (2) Every bottle should have a sticker stating the use of the tablets—for example, arthritis, water pills, diarrhoea, etc—so that the patient remembers why he is taking them. (3) Manufacturers should be encouraged to christen new products with easily remembered names—this helps the doctor too. (4) One should encourage the use of identification boards. For instance in this hospital the rheumatology clinic has a plastic tray encased in which is a specimen of each of the currently available anti-inflammatory drugs. It is assumed that the forgetful patient recognises the tablets that he has ingested *x* hundred times!

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SIR,—I read Dr Anthony Kaiser's letter (16 February, p 485) with considerable interest and sympathy.

Between 15 and 20 years ago I made the same *cri de coeur* and published some suggestions that a combination of letters and figures should be imprinted on tablets, so that by consulting a list one could identify a tablet, the drug, the dose, and the manufacturer.¹ At that time there was difficulty in imprinting characters on pan-coated and press-coated tablets, and capsules presented a separate problem.

After much discussion between the BMA and the Association of the British Pharmaceutical Industry (ABPI) it was felt that it would be difficult to implement this idea comprehensively on all tablets because of the expense factor (despite the fact that polo mints can be produced with their name on, apparently at such little cost).²⁻⁴ Foreign-produced tablets had also caused complications.

Despite these difficulties the situation is now very much better, and the ABPI compendium includes a description of each fixed dosage form for each product. Many more manufacturers infallibly identify their products, and I suggest that Dr Kaiser should

only prescribe drugs that can be instantly identified on looking at the tablet itself.

It took the profession a long time to accept the principle of *nomen proprium*—that is, putting the name of the drug on the bottle.⁵⁻⁷ When in difficulty I ask patients to bring in their bottles for confirmation of the tablets, but it should also be borne in mind that patients can swap tablets between bottles.

Attempts were also made in the early 1960s to identify tablets and capsules on the basis of colour, but three problems were found: (i) the difference of colour between the tablet and the reproduced colour on a chart; (ii) the difference of colour (albeit slight) between different tablet batches; and (iii) the difference in colour between successive printings of tablet identification charts—for example, by *Chemist and Druggist*. Eight per cent of males are colour blind, and patients can never be relied on to describe a colour accurately.

In order to keep this letter to an acceptable length for publication, I have only briefly touched on a few of the problems that were found. In no way do I consider the present situation ideal, but in fact it is much better than it was.

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- ¹ Whitney JDW. *Br Med J* 1960;i:50-1.
- ² BMA Council. *Br Med J* 1961;iii:69.
- ³ BMA Council. *Br Med J* 1962;iii:36.
- ⁴ BMA Council. *Br Med J* 1965;iii:98.
- ⁵ BMA Council. *Br Med J* 1962;iii:36.
- ⁶ BMA Council. *Br Med J* 1964;iii:99.
- ⁷ BMA Council. *Br Med J* 1965;iii:98.

Bladder cancer as a prescribed industrial disease

SIR,—We wrote our recent paper (23 February, p 540) believing that there is serious under-claiming for PD 39 benefits (including those under the Old Cases Act). Unpublished DHSS tables give annual numbers of new awards of benefit by region, and during 1970-5 awards to Royal Marsden Hospital patients (excluding occupational referrals) appear to have accounted for a third to a half of all those in the South-east region. Yet only about 5% of bladder cancer patients in the region attend the Royal Marsden Hospital; several London teaching hospitals treat as many cases, and various hospitals draw more of their patients from relevant industrial areas.

The Royal Marsden Hospital has long operated a PD 39 claims service, with full occupational histories taken from all patients with bladder cancer, and help given with the claiming procedure—without which we believe that some claims would not be completed successfully. Currently a part-time service is funded mainly by industry, with contributions from some trade unions, since the hospital can no longer finance it. We believe that this service has ensured that virtually all Royal Marsden Hospital patients eligible under the PD 39 prescription have been identified and helped to obtain benefit. The fact that Royal Marsden Hospital patients have proportionately 10 to 20 times as many awards as other patients in the South-east surely suggests that there is serious under-claiming elsewhere in the region where this service is not available.

Our general experience supports this suggestion. Most Royal Marsden Hospital patients are referred from other hospitals; often those with exposure to bladder carcino-

gens have not had this feature of their illness noted, particularly when exposure occurred decades earlier in a job long since left, and this suggests that patients have not been questioned about past occupations. Moreover, when urologists in the London area have identified suspected occupational cases they have often called on our experience and help to evaluate these and assist in the claiming procedure; inclusion of such cases increases the proportion of regional awards in which the Royal Marsden Hospital has been involved to between a half and three-quarters. The degree of under-claiming probably varies in different industries and regions; we note that the West Midlands region had only about nine awards during 1970-5 although it is a centre of the rubber industry.

Doubtless many reasons contribute to the present unsatisfactory position in respect of PD 39 claims, but basically insufficient manpower and expertise are available. Identifying and checking possible exposures to carcinogens after long latent periods can be a complex task requiring time and expertise, and effective help for patients with these uncommon and technical claims demands experience. We hope that our recent paper will be of some help, but it does not provide a solution. How can the present state of affairs be improved?

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SIR,—The article by Sheena M Somerville and others (23 February, p 540) is admirable. There is, however, an omission in the paragraph "What other compensation may be obtained?"

It should be known among clinicians that a financial compensatory scheme known as the "papilloma scheme" was introduced by a number of firms in the dyestuff manufacturing industry many years ago. Clinicians who encounter patients with confirmed diagnosis of papilloma or carcinoma of the urothelium and in whom there is a suspicion of exposure to a bladder carcinogen would do well to advise them to contact the employer with whom they worked at the time of exposure.

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Postgraduate education and the doctor

SIR,—It would be unfortunate if your readers were to deduce from Dr David C Evered and Hilary D Williams's paper (1 March, p 626) that continuing medical education using electronic aids such as videotape recorders was not worth pursuing. The "unacceptability" of such aids, as demonstrated in the limited selection of papers analysed, must surely depend at least partly on the nature of the material available through the medium. It is our experience,