Follow-up after curative surgery for carcinoma of the large bowel

SIR,—While applauding the common sense of the contribution by Mr John P S Cochrane and others (1 March, p 593), I hope that his argument that the practice of following patients regularly after cancer surgery does nothing to improve the survival rate will not be applied to all malignancies. I feel that what he has to say is true of many sites but it certainly is not true of testicular tumours. With the advent of potent cytotoxic drugs many failures of primary treatment can be reversed by judicious combinations of drugs, surgery, and radiation treatment. The success rate is, however, clearly related to tumour burden. Therefore the earlier a metastasis is detected the better. Most can be revealed by routine or tomographic chest x-ray and the presence of biochemical markers in the serum. It really is essential that these patients are closely followed at least in the initial three years. Late recurrences after this are relatively uncommon, but it is equally important that the long-term hazards of the treatment are sought out.

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Lead and health

SIR,—Your correspondent RS (Medicine and the Media: 12 April, p 1052) might have missed the "gin and vol-au-vents" more than he thought since his lightweight account of my far from lightweight ordeal by press and pressure groups at the press conference launching the report on lead¹ contains some inaccuracies. The entire proceedings were recorded by the BBC so my memory could be checked if suspect.

The questioner who "pursued his victim to the bitter end" was not told that I could not answer his question about whether children attending a play group in Heath Street, Hampstead, were a cause for concern. I told him that he had asked the most difficult question of the session, and after thinking carefully said I thought that there was cause for concern and offered to meet him and any worried parent so that the problem could be investigated. When the meeting was over I wrote to the environmental medical officer of Camden telling him of the matter and arranged for a discussion to plan a detailed investigation. We are to meet soon.

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¹ DHSS Working Party on Lead in the Environment. *Lead and health*. London: HMSO, 1980.

Distalgesic poisoning—cause for concern

SIR,—The article by Drs R J Young and A A H Lawson (12 April, p 1045) on Distalgesic poisoning is of particular interest to the general practitioners at Inverurie Health Centre. In 1976 we started a system for repeat prescribing recording¹ which indicated that Distalgesic was the ninth most frequently prescribed drug at our health centre for males (45) and the fourth most frequently prescribed drug for females (124). For both sexes

Distalgesic was the first drug of choice for analgesics. After we had reviewed the literature it became the policy of the practice to stop repeat prescriptions for drugs containing dextropropoxyphene on the grounds described in the article by Drs Young and Lawson, and this objective we achieved by 1978.

Of the 44 wards at our local teaching hospital, Distalgesic was analgesic of choice in 40 in 1977. Is it then surprising that the annual numbers of Scottish GP prescriptions for analgesic containing dextropropoxyphene rose from 1973 to 1978? From information supplied to the Grampian Medicines Committee² Distalgesic appears to be regarded as the drug of first choice for analgesia by our consultant colleagues.

Before any restriction on the prescribing of these drugs can be achieved a change in the prescribing pattern in our teaching hospital would be required. Only then could we expect any fall in the number of prescriptions for repeat of these drugs in general practice.

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¹ Cruickshank CIT, Moir DC. *Health Bulletin* 1979; 37:180-4.

² Grampian Medicines Committee. *Bulletin* 1978; No 1.

Mebendazole and hydatid disease

SIR,—As physicians dealing with hydatid disease we were interested in Dr A L Macnair's letter (12 April, p 1055).

We also have felt that it is overoptimistic to expect a drug which has been developed purposely to act within the gut lumen to provide effective systemic activity, especially in the sort of cases we see with large, often huge, cysts. Moreover, we feel that the use of mebendazole in such cases could be hazardous by encouraging lysis or fissuring of cyst walls.

We no longer treat new cases of hydatid disease with mebendazole but we consider that routine postoperative use for a few days is a reasonable precaution to prevent recurrence.

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Ketotifen in adult asthma

SIR,—I read the article by Drs A J Dyson and A D Mackay (9 February, p 360) with interest. However, in my opinion, they might have found ketotifen more effective in the sample as a whole if the design of their trial had not resulted in some of the patients receiving the drug for periods of only four weeks at a time.

In support of this contention, I found that ketotifen significantly improved airways resistance, residual volume, vital capacity, and forced expiratory volume (FEV₁) in 20 asthmatic patients treated double blind for a period of six months with ketotifen or aminophylline (between-patient comparison).¹ Moreover, although there was a beneficial effect of the drug at the first check after four weeks, improvement was much greater after a further one to two months of treatment. Other workers have reported similar findings, suggesting that in clinical studies for the evaluation of ketotifen a minimum of eight weeks' consecutive treatment is required.²⁻⁴

As regards the fairly severe drowsiness reported by the authors in a number of their patients, here too more prolonged treatment would appear to reduce the problem. We have also found that ketotifen is appreciably better tolerated if given in a progressive regimen, starting with a single capsule in the evening for the first four to seven days.

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¹ Schubotz R. *Excerpta Medica*, in press.
² Dünemann H, Borelli S, Schiess W. *Munch med Wochenschr* 1980;122:313-7.
³ Goebel P. *Pharmatherapeutica* 1979;2:153-8.
⁴ Craps L, Greenwood C, Radielovic P. *Clin Allergy* 1978;8:373-82.

Training the trainee

SIR,—As vocational training is to become compulsory from next year, is it not time to examine the extent of the trainer's role in the trainee year? At present, the trainees are liable to be used as cheap labour to enable practices to carry far more patients than they can really manage. I wonder how many trainees get full value for the £2000 a year that the trainers receive? I should like to see a minimum commitment laid down in terms of time spent in tutorials or discussion groups or both, and would welcome the views of both trainees and trainers on this.

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Cutting the drug bill

SIR,—The Chief Medical Officer of DHSS and Mr S C Jolly (15 March, p 797) have expectations that the new *British National Formulary* will give guidance towards savings in drug costs. I do not share their optimism, and 1 April might prove very significant if it is thought that the introduction of the prescription charge of 70p has been brought in to contain the NHS drug bill. It is estimated that 330 000 000 items will be ordered on FP10 forms by general practitioners and the cost will, at the present rate of price rises, be in the region of £1000m; but the 70p charge is not the answer and the only solution I can see is generic prescribing. This must be done in a manner acceptable to all, patients and doctors alike.

The safeguards of a scheme like Parcost (Prescriptions at Reasonable Cost), which operates in Ontario, should be seriously considered. Briefly, it functions by publishing a comparative drug index (CDI). This provides a ready reference of comparable pharmaceutical products and relative prices of products which, in the judgment of a therapeutics committee, meet recognised standards of quality. The purpose of the CDI is not only to list drugs of good quality but also to promote good therapy to serve the pharmaceutical needs of patients at the most economic cost, with adequate safeguards. No "on-cost" payment is allowed to the pharmacist, but he is compensated for this loss of profit with a reasonable dispensing fee.

The pharmacist, on receiving a prescription, will interchange the product with the generic,