recommendations of the Clinical Pharmacology Committee of the Royal College of Physicians of London that such information should be given by specialised medical staff. Pharmacists are aware of their limitations clinically and would normally refer such inquiries to a poisons centre or to the appropriate medical specialist. I note that a pharmacist is now greatly involved in the provision of drug information in Newcastle and he will refer to clinicians when a clinical opinion is needed. There are so many problems arising with the use of drugs that both factual information and clinical opinion are needed, and such co-operation between pharmacists and clinicians in providing information services is essential if safe and effective use of medication is to be achieved.

I agree with Dr Davies and his colleagues that there is definitely a need for an improved drug information service in its widest context to be available, though not only to doctors who prescribe medication but also to pharmacists for monitoring prescriptions for interactions or overdoses and to nurses and patients who must administer the medication correctly and note possible side effects.

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Principal Pharmacist,
Regional Drug Information Service

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¹ *Pharmaceutical Journal*, 1976, 217, 454.

Future of child health services

SIR,—We write as general practice vocational trainees to resist the recommendations proposed by the Court Committee¹ to establish general practitioner paediatricians (GPPs).

The developing specialty of general practice is in danger of being fragmented by these proposals. A general practitioner will have two choices. He can opt to continue looking after the children on his list, in which case, having successfully completed appropriate training, he would be designated a GPP and his work would take on a more or less heavy paediatric slant. Or he can decide not to become a specialist, to remain a GP, in which case his general practice paediatric work will pass substantially to a colleague, possibly (in a rural area such as this) neither a member of the practice nor even working in the same place. In either case the ideal of family medicine for which we have been specifically trained and to which we aspire, with paediatric as well as geriatric training, will be lost. No doubt once it has become established that paediatrics is too important for an ordinary GP other specialties will make similar decisions.

We intend to be generalists. We have paediatric training and intend to look after children in a primary care setting. Professor Court, himself a specialist, proposes a specialist solution to an undoubted problem. It is now for the generalists, established and aspiring, to demonstrate the general practice answer.

R WESTCOTT
GMSC Trainee Subcommittee
Representative for the South-west

STEPHEN HALL
Chairman,
Exeter Vocational Trainee Group
and 10 others

Essex Postgraduate Medical Centre,
Exeter

¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

Beauty spot or blemish?

SIR,—It is difficult to believe that any pathologist, dermatologist, or surgeon would accept the unqualified statement in your leading article on naevi (15 January, p 126) that "curettage, cautery, or shaving flush with the skin are reasonable alternatives" to excision in managing pigmented naevi. Surely histological confirmation of clinical diagnosis with assessment of the amount of junctional activity and adequacy of excision are essential.

Today a significant percentage of patients are sufficiently well educated on this topic to be aware of the fact that pigmented lesions should not be tampered with. Curettage, cautery, and shaving flush with the skin come under the heading of "tampering" and to encourage this would be a retrograde step.

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. Obviously when the diagnosis and the nature of a lesion are in doubt it would be wise to seek advice of one especially trained in the clinical diagnosis of skin lesions such as a dermatologist before embarking on treatment. It is also good practice to send all pathological material for histological examination, but to insist on full excision of all blemishes for which patients are seeking cosmetic advice would result not only in many ugly scars but also in many dissatisfied patients. Furthermore, apart from anecdotal evidence, there is no scientific basis for the commonly held view that "tampering with pigmented lesions has a deleterious effect on their subsequent course." —ED, *BMJ*.

Snow-shovelling and coronary deaths

SIR,—On Thursday 13 January 1977 there was a considerable fall of snow in Birmingham, starting in the morning and continuing right through the day. That evening five men collapsed and died within minutes outside their homes shovelling or otherwise clearing snow. All of these deaths were reported to the coroner, and at subsequent post-mortem examination they all had considerable atherosclerotic coronary artery disease and associated myocardial fibrosis, together with a varying degree of enlargement of the heart. Their ages varied from 52 to 76 years. All had been well in the morning, but three had a history of previous episodes of ischaemic disease.

After a series of mild winters this was one of the first significant falls of snow in the area. During that day 9 cm of undrifted snow fell and the Edgbaston Observatory in Birmingham reported that the air temperature was -0.2°C at 1500, $+0.2^{\circ}\text{C}$ at 1800, and $+0.7^{\circ}\text{C}$ at 2100. This was not particularly cold, but the wind speeds at the corresponding times were 32, 22, and 20 kph (20, 14, and 12 mph) from a south-easterly direction. It was this cold wind rather than the air temperature which gave a high chill factor that particular afternoon and evening.

It is interesting that, in a report from the United States,¹ there was an association of the incidence of coronary heart disease with a low mean temperature, but this was more apparent when there was a snowfall and it was suggested that the shovelling of snow may have been a relevant factor.

As has been pointed out recently in this journal,² elderly people are particularly liable to succumb to hypothermia. I wish to bring to the notice of readers this other form of sudden death due to coronary heart disease in elderly persons when exposed to the physical rigours of clearing snow. I cannot do better than to quote the pathologist who gave evidence at the inquest on one of these victims. He said, "The problem is that many people over the age of 50 do have unsuspected coronary artery disease and shovelling snow with the combination of severe cold and unaccustomed physical exercise can precipitate a fatal heart attack. I think the clearing of snow should be left to teenagers and healthy adults who are accustomed to strenuous physical activity."

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HM Coroner for District of Birmingham,
West Midlands

Birmingham

¹ Rogot, E. and Padgett, S J, *American Journal of Epidemiology*, 1976, 103, 565.

² *British Medical Journal*, 1977, 1, 336.

Who is at risk of a coronary?

SIR,—The impressive paper on coronary risks by Dr T Khosla and others (5 February, p 341) needs reduction to a quick formula for everyday use. If their risk factors are equated and added rather than multiplied the resulting curves are flattened, but calculation is simplified and the message remains. If an overweight factor is included the relative loadings on the other factors are probably recovered, the effect of any untypical reading is lessened, and an item of clinical relevance is not forgotten.

So perhaps an ASHCO score would be useful, à la Aggar, with 0, 1, or 2 scored for each of age, smoking, hypertension, cholesterol, and overweight, low scores being best. Ranges to count 1 might be age 45-55, smoking 1-20/day, hypertension 130-160 mm Hg systolic, cholesterol 6-7 mmol/l (230-270 mg/100 ml), and overweight 10-20% (say, 6-12 kg or 1-2 stone). Scores over 4 would sound the alarm.

J F WALKER

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Neonatal respiratory intensive care at local level

SIR,—I write to support Drs J M Davies and Janet L P Hunter (25 December, p 1557) and to disagree strongly with Professor J A Davis and Dr Malcolm Chiswick (5 February, p 380). Where the distance between the peripheral unit and the regional centre is over 2½ h it is simply not a practical proposition to transfer newborn infants in respiratory failure. When this has been done from this unit with babies who are suffering from cardiological problems the infants have invariably suffered grievously during the journey (and many die).

Professor Davis and Dr Chiswick refer frequently to babies on ventilators. With early and well-timed intervention with continuous positive airway pressure very few infants require ventilation. If they do require ventilation they certainly would not survive the journey of 2½-3 h to our regional centre.

Professor Davis and Dr Chiswick stipulate various requirements for the treatment of infants with respiratory failure—"staff round the clock, an adequate number of ventilators,"