tricyclic and, if that should fail, of an MAO inhibitor. I have been impressed with the good response of about half of these very severely affected patients to such therapy.

Elithorn¹ stated that migraine is "undeniably a hunting-ground for the drug-happy physician." This, of course, is true, but such a statement should not deter efforts to find an effective treatment for this distressing and persistent disorder.

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³ Couch, J R, Ziegler, D K, and Hassanein, R, *Neurology*, 1976, **26**, 121.

⁴ Anthony, M, and Lance, J W, *Archives of Neurology*, 1969, **21**, 263.

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Sex and prognosis in adult acute lymphoblastic leukaemia

SIR,—A relationship of sex to prognosis in acute lymphoblastic leukaemia (ALL) was shown in the last report to the Medical Research Council by the Working Party on Leukaemia in Childhood, the girls faring significantly better than the boys (16 September, p 787). This report suggested that testicular relapse accounted only partly for the observed difference. The same relationship had been observed by Baumer and Mott¹ but was lately denied by Evans *et al.*²

All these studies were concerned with childhood ALL. We would like to add information on the relationship of sex to prognosis in adult ALL based on 137 cases (32 patients treated in our division from 1972 to 1977 and 105 patients reported in detail by others³⁻⁵). The distribution of these patients according to age and peripheral blood blast cell count was similar for both sexes. All patients had been treated for remission induction with vincristine and prednisone and

many of them had also received 2-4 doses of daunorubicin or doxorubicin. Most of the patients who had achieved complete remission had received cranial irradiation and intrathecal methotrexate and maintenance chemotherapy with daily 6-mercaptopurine and weekly methotrexate. The complete remission rate was almost identical for males (69/89 or 77.5%) and females (38/48 or 79.1%). Survival and duration of complete remission were also very similar for the two sexes (see figure). No testicular relapse was recorded in the 89 males during the observation period. These data suggest that at present sex has no prognostic value in adult ALL.

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¹ Baumer, J H, and Mott, M G, *Lancet*, 1978, **2**, 128.

² Evans, D I K, *et al*, *Lancet*, 1978, **2**, 522.

³ Willemze, R, *et al*, *Blood*, 1975, **46**, 823.

⁴ Scavino, H F, *et al*, *Cancer*, 1976, **38**, 672.

⁵ Lister, T A, *et al*, *British Medical Journal*, 1978, **1**, 199.

Minimum information needed by prescribers

SIR,—Mr P W Golightly and Dr D C Banks (11 November, p 1366) make a rather doubtful claim when they state that "the number of drugs in routine use is constantly increasing." Although this was probably true a few years ago, the number of medicines in this country now seems to be falling. For example, *MIMS* lists approximately 1000 commonly used prescription drugs. Last year (1977) they recorded only 43 additions to their list, while at the same time they recorded that 97 of their listed drugs had been discontinued.

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SIR,—The article by Dr A Herxheimer and Professor N D W Lionel (21 October, p 1129) elucidates a problem faced by all health practitioners dealing with drugs. The authors' examination of the present void of adequate sources of drug information should be lauded, but their proposal for a manual of minimum information inadequately fills that void.

If, as the authors point out, the manufacturer's current data sheets (package inserts in the United States) are inadequate in disseminating important clinically relevant material, then the concept of providing practitioners with minimum drug information to supplement the information from the manufacturer perpetuates the problem. For example, in the authors' draft of minimum information on tetracycline why are peak plasma concentrations, minimum inhibitory concentrations, half life, protein binding, and metabolism excluded from the section on pharmacology? Similarly, why is erythromycin not mentioned as a first choice of therapy along with tetracycline for mycoplasma? Other areas could be cited, but the emphasis should be to encourage necessary additions which are important when imparting clinically relevant drug information. But even the lack of data in the draft is not as serious as the omission of

the references used in compilation of the data. Possibly owing to space considerations in the journal the authors found it necessary to delete them and I hope this was the case.

Providing clinically relevant drug information to practitioners prescribing and/or administering medication is a necessity governed by the inadequate data published by pharmaceutical manufacturers. Providing minimum information with lack of suitable references as a substitute for or companion to data sheets (package inserts) is perpetuating the problem.

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Opportunity in health visiting

SIR,—It was with some pleasure that I read the proposed Nursing Bill currently passing through Parliament. There is tremendous need to review the training requirements of those working in the health professions. General practice is half way through that review and nurses have only just started.

May I use your columns to question the assumption that the right basic training for a health visitor is a nurse training course to SRN level? Historically, health visitors started separately and only relatively recently became part of the nursing profession. The present situation often encourages a nurse who, after gaining her SRN, has realised that she has made a wrong career choice to change direction and to train to become a health visitor. This surely must be the wrong reason for entering the profession of health visiting. Perhaps poorly motivated health visitors are in large part to blame for the frequent disparaging remarks made by general practitioners and district nurses about health visiting.

I would like to see health visiting as a separate profession with its own defined area of responsibility. I do not doubt that there may be a need for a basic health/nursing training as a component of a health visitor's course, but there should be the opportunity for young people at school to elect to enter either profession, health visiting or nursing. Thus we might see the emergence of a strong professional body of health visitors, willing and able to work in primary care, to provide a lead in tackling the modern epidemics of accidents, alcoholism, coronary heart disease, lack of exercise, smoking, and over-eating. I for one would welcome the opportunity to work with such colleagues.

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General practice records

SIR,—I would like to congratulate Dr Christopher Maycock (25 November, p 1510) and his partner on their system of record-keeping, but having looked at many general practice records throughout the country I would like to point out that they are enthusiasts and not therefore representative of most GPs. I disagree with Dr Maycock's reasons for preferring the existing medical record envelope (MRE) format to the A4 records. I note, however, that after stating his reasons he adds the rider that the structuring of the MRE records will make any future con-

Life-table analysis of survival and remission by sex in 137 adult patients with ALL.