cardiovascular disease, and patients who have had upper abdominal or thoracic surgery or prolonged nitrous oxide anaesthesia are among those who, you suggest, should be given routine oxygen postoperatively. Should this large group of patients have arterial PO_2 and PCO_2 measurements before, during, and after oxygen therapy? This would necessitate repeated stabs or an indwelling arterial line. Although Nunn¹ felt there was no alternative to arterial puncture and direct measurement of PO_2 , we² have shown, using paired radial artery samples and arterialised capillary blood from the ear lobe, a highly significant correlation between both methods for PO_2 determination. Respiratory care in the surgical unit would be improved by more frequent blood gas analysis, and arterialised capillary blood, when carefully collected, gives as accurate results as arterial blood.

For how long should oxygen be prescribed after general anaesthesia? Many surgical units routinely treat selected patients with oxygen for the first 24 h postoperatively. However, we³ have shown that the mean percentage decrease in PO_2 following upper abdominal surgery was greatest during the second and third postoperative days, remained greater than 20% for the first four days, and tended to return to preoperative values towards the end of the first week. This suggests that when oxygen is indicated during the first postoperative day it is illogical to stop it after 24 h unless cessation is accompanied by serial observation of PO_2 levels. Further treatment with oxygen should take into consideration the necessity for early mobilisation, oxygen-induced pulmonary toxicity, and the need to keep the arterial PO_2 above 8 kPa (60 mm Hg).

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¹ Nunn, J F, *Applied Respiratory Physiology*. London, Butterworths, 1969.

² Parfrey, P S, et al, *British Journal of Surgery*, 1977, **64**, 384.

³ Parfrey, P S, et al, *British Journal of Surgery*, 1977, **64**, 390.

Naming of drugs

SIR,—I heartily agree with Dr G A MacGregor's (18 November, p 1433) view that the multiplicity of names for one and the same drug is fraught with dangers. I do not, however, believe with you that the advice to use approved rather than proprietary names when prescribing drugs provides a satisfactory solution. This is a losing battle. After all, it is the proprietary name that appears in large letters on the bottle of tablets we get from the drug house, that appears in our medical journals and on the advertisements that come daily through our letterboxes, whereas the approved name is in tiny print and often difficult to find. Furthermore, in *MIMS* drugs are listed according to their proprietary and not according to their approved names. Approved names, especially when attempts are made to indicate the pharmacological group to which they belong, become clumsy tongue-twisters like chlorthalidopoxide or tranlycpro-

mine, which makes them difficult to remember and to use when communicating with the nursing staff, not to mention the patients. A further hazard in these days of world travel lies in the fact that even some of our approved names are quite unknown abroad, including the USA, so that a patient travelling to a foreign country might be in real trouble if he has left his tablets behind and tries to get them replaced abroad.

To my mind the best, if utopian, solution would be an international agreement: one single name for each drug. It should be simple, easily remembered, and universally understood. Should the prescriber be anxious to have a particular brand he should put the manufacturer's name in brackets behind the drug's name. It has worked so well for so long with insulin; why not for other drugs too?

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Successful defibrillation in general practice

SIR,—Drs A D Shaw and J L Baird (30 September, p 958) suggested that their experience of resuscitation after cardiac arrest in general practice was unique. We are glad to say that it is not unique as we are able to report a further case.

The patient, a woman, suffered cardiac arrest in our surgery. External cardiac massage was started, an intratracheal tube was passed, and an intravenous line inserted. One of the partners went to the GP hospital and collected the electrocardiograph, which took well over five minutes; once attached it showed ventricular fibrillation. She was given 1 g of procainamide with no effect. At about this point the ambulance arrived, but unfortunately it did not have a defibrillator on board and was therefore sent to the district hospital to collect the recently donated portable machine, which naturally took a considerable amount of time, say 10 minutes. Luckily the casualty sister arrived with the defibrillator and a box of emergency drugs so that we were able to give the patient some bicarbonate. After problems with ventricular tachycardia, asystole, a total of four defibrillations, and a mixture of drugs she was dispatched to the coronary care unit in sinus rhythm. She has now returned home to live alone with a minimal amount of residual cardiac failure.

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Collaboration between GPs and pharmacists

SIR,—As a pharmacist working in retail pharmacy I am very concerned by the lack of co-ordination between general practitioners and retail pharmacists. Although I have no problems with my particular local practice, I find that if I have to refer back to other prescribers for various reasons I am not accepted as being able to discuss drug therapy on a level with them.

I do not wish to use your journal merely to voice my moans, but I do feel that both GPs and pharmacists are the poorer for this

lack of communication and, more important, the service either group is able to give the patient is therefore impaired. I strongly feel that medicine has now become such a vast subject that there is a greater need than ever for each group, expert in its own particular branch of the science, to work with the other groups to provide an effective health service. Although the prophets of doom foretell the imminent destruction of the NHS, I look forward to an improved service in which I will be able to utilise my pharmaceutical education to its full potential to the benefit of the rest of the medical profession and the patients.

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Terminology of enuresis

SIR,—The introduction of the term "recent-onset enuresis" by Mr Paul H Abrams and others (4 November, p 1258) to describe nocturnal incontinence due to chronic retention requires comment. At the recent meeting of the International Continence Society in Manchester an attempt was made to clarify the meaning of the term "enuresis" with little success. Enuresis simply means incontinence of urine, but by common usage has come to mean bed-wetting in children. It is a symptom and not a disease entity. During the time a child is "learning" bladder control incontinence is normal, only becoming abnormal when delay in gaining control is prolonged beyond 5 years of age. Keith Turner¹ has defined nocturnal enuresis as persistent involuntary micturition during sleep in the absence of demonstrable pathology. It is probably true that children who gain control both by day and by night and then become incontinent in the absence of demonstrable organic disease have a psychological basis for the incontinence.² This group has been termed secondary or "onset" enuresis. Neither of these terms gives a clear description of the suggested aetiology. To clarify the situation it would seem that the term enuresis should be used in children or adults who fail to gain bladder control and as evidence of this have persistently wet the bed all their lives and have no demonstrable organic disease. I feel the introduction of the term "recent-onset enuresis" to describe nocturnal incontinence of known cause is a retrograde step and will add further to the confusion.

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¹ Keith Turner, R, in *Bladder Control and Enuresis*, ed I Kolvin et al, p 196. London, Heinemann, 1973.

² Kolvin, I, and Tauch, J, in *Bladder Control and Enuresis*, ed I Kolvin et al, p 170. London, Heinemann, 1973.

Deficiencies in parenteral nutrition

SIR,—Your leading article (30 September, p 913) wisely stresses that the advantages and disadvantages of parenteral feeding need to be carefully balanced, and jaundice and cholestasis are mentioned among the hazards associated with this form of therapy. The author of the reference cited concluded that cholestasis and jaundice occurring in the patients whom he studied were produced by the intravenous amino-acid solution Travasol.¹ In Great