them making some attempt to reduce their intake.

If this small group of adolescents attending a diabetic summer camp is at all representative of the adolescent diabetic population as a whole, then these findings would suggest that control of hyperglycaemia in our young diabetics is far from satisfactory. It is pertinent to note that of the 10 patients who preferred persistent glycosuria on urine testing, six felt that their hospital doctors were satisfied with these tests. If the incidence of distressing complications of diabetes is to be reduced, then it would seem necessary to lay the foundations of good diabetic control in our young diabetics, as in the adult clinics it is often very difficult to change long-standing habits of maintaining persistent glycosuria or even to transfer patients previously on one injection to two injections of insulin a day.

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¹ Crofford, O, *Reports to Congress of the National Commission on Diabetes* (DHEW Publication No (NIH) 76-1018). Washington, DC: Government Printing Office, 1975.

² Job, D, *et al*, *Diabetes*, 1975, **24**, suppl 2, p 397.

³ Cahill, G F, Etzwiler, D D, and Freinkel, N, *New England Journal of Medicine*, 1976, **294**, 1004.

Another beta-blocker causing eye symptoms?

SIR,—I would like to report the events following the administration of metoprolol (Lopresor) to a patient of mine. She was started on 100 mg of metoprolol daily to control her tachycardia. She started this in December 1976 and the dose was subsequently increased to 200 mg daily. In April of this year she reported pain and soreness in both eyes and was seen by a cardiologist and an ophthalmic surgeon, both of whom felt that the symptoms were unrelated to the drug.

Nevertheless, it was withdrawn and the symptoms abated. She was given a different beta-blocker to control her tachycardia, but this produced other undesirable side effects and because of this she asked me if she could be restarted on metoprolol, which she had found very satisfactory. I started her again on 100 mg twice daily and within two or three days she suffered from very dry eyes, which were painful and sore, and she had difficulty in opening her lids.

In view of the recently reported eye problems with practolol I feel that this matter should be given some publicity.

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Names of drugs

SIR,—Your second defence of the long-standing policy of using only non-proprietary names for drugs (15 October, p 980) shows how your use of an approved name can be very misleading.

"When I use a word," Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean—neither more nor less.'

"The question is," said Alice, 'whether you can make words mean so many different things.'"¹

When you use the word "prednisolone" in

your leading article it means just what you choose it to mean—not what it means in the *British National Formulary* on my desk. Your list shows that by the approved name prednisolone you have chosen to mean drugs for which the *BNF* uses no fewer than five approved names: prednisolone, prednisolone sodium phosphate (Codelsol), prednisone (Di-Adreson), methylprednisolone, and methylprednisolone acetate (various methylprednisolone preparations), plus some aspirin and steroid compounds (Cordex, Cordex F) and prednisolone steglate (Sintisone).

The question is, sir, whether you can make one approved name mean so many different things. Is this an example of the small effort required when once the decision is taken to "think generic"?

In practical terms the use of generic equivalents in this hospital led to the supply of ampoules of thiopentone injection which on analysis were shown to have variations of 33% in drug content. This analysis was carried out as part of the Birmingham Drug Testing Scheme, which included both "standard" and proprietary preparations. The analyst reported "a most disturbing situation. . . . We found manufacturers who did achieve near-perfection . . . we found others whose products left much to be desired. . . . Faulty formulations again showed that an original preparation is frequently superior to its imitations."²

I hope you are not leading us along the road to Afghanistan, where only generic drugs may be prescribed and the inclusion of a manufacturer's name in a prescription leads to a fine of 500 Afghani (£6).³

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¹ Carroll, L, *Through the Looking-glass*, chapter 6.

² Report of the Medical Officer of Health, City of Birmingham, 1963, p 63.

³ *Lancet*, 1977, **2**, 602.

SIR,—Your leading article on this subject (15 October, p 980) interests me very much. In our work with the manipulation and extracting of data of drug information we are constantly confronted with discrepancies in the nomenclature of drugs. Our various indices contain extensive cross-references to the various names that may be used for one compound, either trademarks or generic names employed in various countries.

For a number of years I have, unfortunately unsuccessfully, been battling with various editors of the *Journal of the American Medical Association* to change their custom and discontinue listing the names of trademarks of a drug that has been studied in a given paper. These listings appear at the end of the article. In my opinion they are completely misleading because they do not tell the reader the name of the manufacturer whose product was used by the investigator. This is most important today because of differences in bioavailability which may apply to drugs sold under generic names or trademark names.

What I would like to see done is to require every investigator to state, in a footnote to any paper describing experimental work with a drug, the name of the manufacturer if the drug was identified only by generic name or the name of the trademark if it had one and, if he so wishes, also the name of the manufacturer of such compound. If this practice were followed one should see over a period of years

whether there are any real differences in the therapeutic action and bioavailability of compounds made by different companies. At the present time the situation is completely confused.

In the United States a number of the larger manufacturers are now selling a large line of products under generic names which are sometimes called standard products. Unfortunately, however, not all of these drugs are made by the manufacturer whose name appears on the label but is listed only as distributor.

If my suggestion appeals to you I would hope that one of these days you would make reference to it in one of your announcements, because whatever comes from the *BMJ* carries a great deal of weight. I think that some years from now many drugs will be sold under their generic names, such as meprobamate-Glaxo, indicating that Glaxo is the manufacturer of the compound. The use of generic names is, of course, not new, and has been a common practice as long as drugs have been on the market.

PAUL DE HAEN

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SIR,—I would like to draw the attention of your readers to the existence of the "Drug Names Glossary" published by Cheshire Area Health Authority.

This booklet is published every four years, with yearly cumulative addenda, which are included in the initial cost of £1.75. It provides a rapid cross-reference of approved and brand names, each name appearing in alphabetical order with a complete list of its equivalent names, which is repeated on each occasion to give a complete cross-reference. Approved names appear in capitals, and trade names in small letters. For example,

CEPHALEXIN ≡ Ceporex ≡ Keflex.
Ceporex ≡ CEPHALEXIN ≡ Keflex.
Keflex ≡ CEPHALEXIN ≡ Ceporex.

The constituents of compounds are also listed. For example,

AMILORIDE ≡ Midamor (Present in
Moduretic)
Moduretic ≡ AMILORIDE +
HYDROCHLOROTHIAZIDE.

In order to present a complete record names of obsolete products have been retained in the glossary and, where possible, product name changes have been indicated. For example,

PRAMINDOLE ≡ Prondol ≡ IPRINDOLE.

It does not contain any foreign trade names, but a few of the common USA approved names have been included.

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Screening children for visual defects

SIR,—By the age of 7 or 8 the functional maturation of the visual system is complete. Any visual acuity deficit at that age resulting from earlier stimulus deprivation (squint, astigmatism, inequalities of refraction, cataract, ptosis, unavoidable occlusion, etc) is irremediable. No subsequent treatment can establish unmade functional connections between the