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.

D J BETTERIDGE

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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Nevertheless, it was withdrawn and the symptoms abated.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.

DAVID SCOTT

Fleet,
nr Aldershot, Hants

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

EDWARD MATHEWS

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Queen Elizabeth Hospital,
Birmingham

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

Paul de Haen Inc,
Drug Information Services,
New York, NY

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.

ANNABEL PEATMAN

Staff Pharmacist,
Cheshire Area Information Service

Department of Pharmacy,
City Hospital,
Chester

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

retina and the cortex. The problems and responsibilities arising from this established fact are so great that, by comparison, the matter of vision screening in older children (8 October, p 958) is trivial. Certainly refractive errors appear in older children so long as body growth continues. Almost all of the 7.4% of children with later developing significant visual defect, found by Drs Peckham and Tibbenham, are myopes whose near vision is normal and whose distance vision will always remain correctable to normal even if undetected until adult life.

I do not think that sufficient emphasis has been placed, in this correspondence, on the one essential point: by 8 years plasticity in visual development is lost and eyes that have never learned to see centrally remain blind to discriminating vision.

R M YOUNGSON

British Military Hospital,
Hong Kong

* * * This correspondence is now closed.—Ed, *BMJ*.

Hospital appointment procedure

SIR,—May I be allowed a brief general riposte to the sharp responses to my letter (3 September, p 645)? All your correspondents work in hospitals and see things, understandably, solely from the hospital viewpoint. I was not surprised to have raised their hackles in drawing attention to a clumsy hospital procedure which undoubtedly lends itself to abuse.

In general practice—when it runs well and the hospital co-operates—if the GP considers a consultant opinion necessary his secretary can immediately type the referral letter. She then telephones the hospital, indicating the degree of urgency. (An estimation best made, surely, by a doctor who has examined the patient outside, rather than by one who has examined a piece of paper inside a hospital.) The date and time of the appointment are typed on the envelope and the letter given to the patient. This arrangement is immensely appreciated by the patient, who is spared anxiety and suspense, and by the GP, who knows what is happening to his patient. Time is saved; so is the cost of postage.

It is a bit tough that, whereas constant criticism of the GP from inside and outside the profession is a currently acceptable pastime, criticism by him is castigated as rocking the boat. My letter was not directed at the Middlesex Hospital, which provides an admirable district hospital service.

BENJAMIN LEE

London WC2

Obstetric audit in general practice

SIR,—Dr G N Marsh's audit of the pregnancies in his practice (15 October, p 1004) and his sensible plea for GP obstetricians to be given more realistic consideration in the planning and execution of future maternity services caused me to have a sad feeling of déjà vu. A similar review of the pregnancies in my previous practice, in Ayrshire, between 1958 and 1960¹ had almost identical results and conclusions.

Now, almost twenty years later, the trend towards more and more specialist hospital

confinements, often with obstetrical interference, is gaining pace. If the reason for this is that the drop in the birth rate necessitates a high specialist hospital confinement rate for teaching and training purposes, then this should be stated. If not, then is it not time that the argument that it is always safer to have a baby in a specialist hospital be refuted and the place of the GP obstetrician be reassessed?

Most GP vocational training schemes now include a six-month period of training in obstetrics. Is it right to allow the obstetrical skills of these young general practitioners to atrophy, by depriving them of the opportunity of looking after carefully selected patients in childbirth? Dr Marsh thinks no; and I would agree with him.

J S K STEVENSON

Department of General Practice,
Edinburgh

¹ Stevenson, J S K, *British Medical Journal*, 1961, **1**, 1673.

SIR,—The report by Dr G N Marsh (15 October, p 1004) on the experience of a GP maternity unit was interesting, but I cannot agree with his implied conclusion that perinatal mortality is lower in a GP maternity than in a consultant unit when patient selection has been taken into account. The number of deliveries was too small and the survey not designed in such a way that one can draw such conclusions.

When will someone answer this question by designing a prospective controlled trial in which women assessed as suitable for confinement in a GP unit are randomly allocated to either consultant unit or GP unit care?

R M DARLING

Harrogate, Yorks

Oestrogen:creatinine ratio in all pregnancies?

SIR,—We were interested in the recent article by Dr L G S Rao (1 October, p 874) on the value of measuring the urinary oestrogen:creatinine ratio (OCR) in pregnancy. He advocates extending the test to every patient rather than confining it to those thought by the obstetricians to be at special risk. Using the data in this paper, we have drawn up a table to show the incidence of fetal and perinatal mortality for those patients monitored for fetoplacental function compared with those in whom the OCR was not measured.

	No	Mortality (%)	
		Fetal	Perinatal
OCR monitored ..	5429	1.25	1.90
OCR not monitored ..	10 179	0.96	2.15

With the χ^2 test the difference between the groups for either mortality classification did not reach statistical significance ($P > 0.05$). This implies that the selection of patients for OCR determinations is ineffective. One must conclude that either new selection criteria are required or that all patients need to be monitored. We believe this finding is crucial to the argument for widening the scope of the OCR test, but before facing the technical and staffing problems of extending the laboratory service it is necessary to know whether the above results were biased in any way.

We therefore wish to ask Dr Rao on what basis patients were selected in his study both for OCR monitoring and for exclusion from measurement. In contrast to Dr Rao we are concerned about coping with the increased work load.

A T HOWARTH
P RISDON
DAVID P SMITH

Biochemistry Department,
Royal Infirmary,
Bradford

* * * We sent a copy of this letter to Dr Rao, whose reply is printed below.—Ed, *BMJ*.

SIR,—In reply to Dr Howarth and his colleagues, the selection of patients for oestrogen assays was made by our obstetricians and the criteria for selection were the usual criteria which are used throughout the country for the identification of high-risk patients. The lack of a significant difference in the number of fetal deaths between those who had their pregnancies monitored by oestrogen assays and those who did not would make it appear that the selection of patients for this assay is ineffective. This conclusion is not strictly true, because many of the fetal deaths occurred in patients who did not receive any antenatal care, including oestrogen assays. Most of these patients were from a poor socioeconomic background, had failed to attend any of the antenatal clinics, and came to hospital in labour. To that extent the results are biased.

There is also a category of patients who had fetal deaths without any clinical signs of high risk, and this category has been termed "cause unknown" in the classification by clinical cause of perinatal deaths used in Glasgow.¹ Your leading article (15 January, p 123) on the prediction of fetal death has stressed the difficulties of the obstetricians and is worth quoting: "The obstetrician's second patient (who is the one most at risk) is buried in the maternal tissue, so that the predicament is like that of a physician asked to assess a patient in full winter dress and refusing to take off even the greatcoat. In consequence obstetricians are relying more and more on scientific techniques to give them insight about the hidden fetus." Therefore I feel that every patient must be monitored at least thrice weekly, if not daily. I know that it will be a considerable effort for the laboratory, but I do not see any real alternative at the present time.

L G S RAO

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Maternity Hospital,
Bellshill, Lanarkshire

¹ McNay, M B, *et al*, *British Medical Journal*, 1977, **1**, 347.

The perilous skateboard

SIR,—Your correspondent Dr A R Rogers (15 October, p 1026) seems to be displaying in his attitude towards skateboards the kind of holier than thou elitism that is so common in the medical profession. The research to date refutes his impression. Certainly my series of 70 suggests that the majority of injuries are relatively minor—Colles's fractures and sprained wrists contribute about 70% of all accidents, and we have had no serious head injuries. Only three children required admission and they were overnight stays only. It is true that according to the press¹ 13 people