items. To know that if they fail to keep up to date with the extensive list of drugs and their respective prices they will suffer financial penalties will indeed further demoralise our pharmacist colleagues. Moreover, it will not avail the druggist to try stocking only the cheaper versions. Not infrequently wholesalers will issue "competitive" lines, a well-known ploy to capture a market. Moreover, let us remember the disturbing example in the past of "cheap" ampicillin and also of penicillamine.

From the patients' point of view ready identification, especially for elderly people, is very important. They are often on long-term medication and frequently on two or more drugs. If the repeat prescriptions are liable to change their appearance the wastage in discarding the previously used (left-over) drugs will outweigh any saving in item costs. The dangers of duplication of dosage and of unused drugs lying around present serious problems. Family practitioners will have to familiarise themselves with a much larger range of products. Not least, they will have to be able to be quite sure that the tablets in the container are consistent with the name on the label. In my experience a surprising number of patients really do change their containers around.

Before this "E" box is adopted the disadvantages must be considered. The "NP" box seemed a good idea, but in practice has increased the numbers of patients who are more or less self-medicating. It has also increased the number of patients who make statements that they are "allergic" to this or that or are suffering from side effects. Any family practitioner who cares to check will soon verify that patients now "look up" their drugs, not infrequently in *MIMS*, a great number of copies of which are circulating in the community. The "child-proof" container has been a mixed blessing; far too high a percentage of drugs are now left around exposed to moist air because of difficulties in opening these containers. On balance, the benefits to the economy of the national drug bill are doubtful. The extra problems resulting are many.

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Modified jejunioileal bypass for obesity

SIR,—I was interested to read Professor A Cuschieri's speculative letter (15 October, p 1028) in which he defined a critical length of residual ileum based upon small-bowel measurements in his own patients.

Backman and Hallberg¹ showed the length of the small intestine in 88 subjects to range from 4.0 to 10.2 m, being longer in obese patients than in their controls. My own measurements in obese patients have been in agreement with their observations and we thus differ considerably from the measurements of Professor Cuschieri. Possibly this is due to different methods of measurement: most surgeons who perform the small-bowel bypass measure the stretched antimesenteric border, as this clearly would be longer than the unstretched mesenteric border. If the latter technique is used it is likely that excessive small bowel would be left "in circuit" and the patient would not lose weight.

When the end-to-side jejunioileostomy technique is used there is often considerable retrograde reflux into the excluded ileum.

Barium meal follow-through examinations carried out one year after the procedure have shown that as much as 60-90 cm may be filled, thereby making a considerably greater ileal absorptive surface available. I doubt therefore whether Professor Cuschieri's measurements are reliable and I do not think they are appropriate in the context of end-to-side jejunioileostomy.

In ileal bypass procedures for hyperlipidaemia 200 cm of ileum is excluded with no problem of liver failure. In small-bowel bypass for massive obesity most surgeons have retained lengths of ileum less than the critical figure which Professor Cuschieri quotes, but the incidence of severe liver problems is low. I feel, therefore, that there is much more to the cause of liver failure after small-bowel bypass than the concept of critical lengths of residual ileum. I am worried that by excluding more jejunum the risk of protein malabsorption and consequent protein-carbohydrate malnutrition is likely to be more hazardous to the liver.

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¹ Backman, L, and Hallberg, D, *Acta Chirurgica Scandinavica*, 1974, **140**, 57.

Analgesia for fractured limbs

SIR,—Having recently sustained a displaced fracture of the neck of the humerus I would heartily endorse Dr K B Queen's experience (Personal View, 15 October, p 1020) of the inadequate pain relief of 100 mg of pethidine (one-third intravenously in my case) for a severe limb fracture. The subsequent lift on and off the stretcher and removal of jacket, etc, in casualty were excruciatingly painful, but oh, the bliss and relief of pain after 15 mg of morphine an hour later, despite its causing vomiting in the evening. The next painful four nights at home were relieved considerably with 15 mg of Cyclimorph subcutaneously without causing vomiting, and I would urge general practitioners first on the scene of a severe limb fracture to give injectable morphine, preferably mixed with an antiemetic, instead of pethidine.

I A CROWTHER

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Donor blood for neonatal exchange transfusion

SIR,—Although the main indication for neonatal exchange transfusion, rhesus haemolytic disease, is now relatively rare, there still appears to be disagreement as to the optimum, or indeed safe, age of the donor blood used.

A brief survey of nine departments of haematology in my own region reveals that, while all provide blood in acid-citrate-dextrose or citrate-phosphate-dextrose (CPD) and partially remove the plasma, there is considerable variation in the age of the blood provided. Two laboratories provide blood four days old or less, four provide blood three days old or less, two provide blood two days old or less, and one is usually asked for fresh donor blood but can often only provide blood up to two days old.

There are well-documented dangers in providing fresh blood straight from a donor before serological testing for hepatitis or syphilis, apart from the other communicable

disease and immunological hazards. However, some paediatricians regard the dangers of fresh blood as less important than those associated with stored blood more than two days old. Standard textbooks quote 4- or even 5-day-old blood as suitable in terms of citrate and potassium toxicity, and the use of CPD as an anticoagulant has improved the known fall-off in 2,3-diphosphoglycerate and therefore oxygen release.

It would be valuable to know, therefore, whether any unpublished definitive information is now available which would indicate that the traditional practice of using serologically tested blood up to four days old is outmoded and that fresher blood should be used.

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Antibiotics for presumed viral respiratory infections

SIR,—We wish to reply to Dr K R Woodcock's criticisms (17 September, p 772) of our paper on the effects of amoxycillin and co-trimoxazole on presumed viral respiratory infections in childhood (27 August, p 552).

(1) Dr Woodcock has misunderstood the conclusions from our study. In contradiction to most similar investigations¹⁻³ our findings show small but statistically significant effects between the antimicrobial- and placebo-treated groups. However, in our opinion the size of these differences does not justify the routine use of antimicrobials in presumed viral respiratory infections in childhood. As we said in our article, had the failure rate for the placebo-treated group prevailed for all subjects in the study this would have resulted in an extra three-tenths of one consultation per doctor per week. The point at issue is not whether antimicrobials have an effect but whether the size of this effect justifies routine prescription. In our opinion the cost of antimicrobials, the risk of sensitisation, the possibility of side effects, and the problems of the development of drug-resistant strains of bacteria in the community far outweigh three-tenths of a consultation per doctor per week and the other marginal benefits shown in our analysis.

(2) Dr Woodcock appears to disavow any statistical expertise and from the table it is easy to see why. He presents a failure score which is the result of summing up the numbers who failed to complete the experiment and the numbers with purulent sputum, sore throat, wheezy chest, or fever on the eighth day of the trial. This summation is arithmetically incorrect, since these numbers do not represent mutually exclusive and exhaustive failure groups. A child could suffer fever, runny nose, and sore throat on day eight; by Dr Woodcock's arithmetic such a child would count as three failures. Leaving aside the basis of the statistic, such a score is misleading, since it combines several different criteria of failure into a global percentage. The purpose of our paper was to avoid this fallacy by analysing individual symptom patterns rather than presenting a single and dubious failure statistic. In reality all that Dr Woodcock has done is to combine some of the individual effects that we demonstrated throughout the paper into an inaccurate score which crudely represents exactly what we were saying.