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.

(3) Dr Woodcock's point about the effect of the failure rate had been considered. In any experimentation on human subjects missing data from subject loss tend to occur; there is no way of completely overcoming this problem, either clinically or statistically. We believe our analysis provided the most reasoned assessment of the data by (1) analysing between group failure rates and (2) analysing the existing data while explicitly acknowledging the possible effects of missing data. Furthermore, both sets of data are presented and both show small positive effects for antimicrobials, so there is little chance of the reader being misled. At worst he may feel, as Dr Woodcock appears to, that we have shown that antimicrobials are effective.

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¹ Davis, S D, and Wedgwood, R I, *American Journal of Diseases of Children*, 1965, **109**, 544.

² Gordon, M, Lovell, S, and Dugdale, A E, *Medical Journal of Australia*, 1974, **1**, 304.

³ Soyka, L F, et al, *Pediatrics*, 1975, **55**, 552.

Teaching general practice

SIR,—While welcoming your promotion of general practice teaching in medical schools (22 October, p 1042) and agreeing that "academic investment should not be made conditional on service-earning capacity," I must take issue with you concerning "continuing genuine service role" for academic general practitioners.

Few would agree that in any aspect of life—least of all medicine—teaching can be divorced from practice. While all other departments in medical schools acknowledge the need for teachers to be clinically competent and active, let us not deny the same criteria to the developing teaching of primary care. Of course, clinical activity must not be maintained at the expense of providing teaching and research. But all three roles are essential to academic general practice. Sacrifice of the service role will be as damaging to the "academic general practitioner" as it would be to his hospital colleague.

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Indomethacin-induced asthma in aspirin-sensitive patients

SIR,—We have recently had under our care a 43-year-old nursing sister with a two-year history of intrinsic asthma. She was known to be allergic to penicillin (rash) and aspirin (asthma). Her general practitioner prescribed indomethacin for musculoskeletal pains in her left leg. On 17 October at 5.30 pm she took a 50-mg capsule of indomethacin and within an hour started to wheeze. The bronchodilators she had at home (salbutamol inhaler and tablets and sodium cromoglycate) did not help her, so she called her general practitioner. On the GP's arrival at 8.15 pm the patient was found to be extremely short of breath and two repeated subcutaneous doses of adrenaline were given together with 40 units of corticotrophin (ACTH). A little improvement followed and the patient was referred for hospital

admission. On arrival at 9.10 pm her peak flow rate was 170 l/min. This improved to 200 l/min by 10.30 pm after the patient had received a further 200 mg of hydrocortisone intramuscularly and 4 mg of salbutamol by mouth. She continued to improve overnight and by the next morning her chest was clear and peak flow rate was normal at 370 l/min.

This case illustrates the potential dangers of prescribing indomethacin to patients known to have aspirin-induced asthma. This was first described by Vanselow and Smith.¹ The nature of this cross-reactivity between indomethacin and aspirin is unknown; because of the dissimilar molecular structure it is unlikely to have an immunological basis and prior skin testing is known to be unhelpful. It is also important for doctors to remember that indomethacin is not the only analgesic which should be avoided in aspirin-sensitive asthmatics—paracetamol, mefenamic acid, and dextropropoxyphene are also known to induce asthma in this group of patients.²

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¹ Vanselow, N A, and Smith, J R, *Annals of Internal Medicine*, 1967, **66**, 568.

² Smith, A P, *British Medical Journal*, 1971, **2**, 494.

Pathogenesis of osteoarthritis

SIR,—Your leading article on this subject (15 October, p 979) makes no mention of the importance of joint laxity. Although congenital dislocation of the hip,¹ recurrent dislocation of the patella,² and familial hypermobility³ may all predispose to osteoarthritis, attention has traditionally been directed towards repetitive impulsive loading. The most severe example of osteoarthritis in a group of professional footballers occurred in one with abnormally lax ligaments.⁴ Assuming this to be related to collagen structure, which is inherited, rather than muscular hypotonia, which may be acquired, joint laxity, which has a Gaussian distribution throughout the population,⁵ may be a potent factor in the aetiology of osteoarthritis. Moreover, this can be reconciled with Muir's explanation of the predisposition of some people to develop osteoarthritis on the basis of inherited collagen structure.⁶

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¹ Carter, C, and Wilkinson, J, *Journal of Bone and Joint Surgery*, 1969, **46B**, 40.

² Sutro, C J, *Surgery*, 1947, **21**, 67.

³ Beighton, P A, and Horan, F T, *Journal of Bone and Joint Surgery*, 1970, **52B**, 145.

⁴ Adams, I D, *Clinics in Rheumatic Disease*, 1976, **2**, 523.

⁵ Moll, J M H, and Wright, V, *Annals of the Rheumatic Diseases*, 1971, **30**, 381.

⁶ Muir, H, *Annals of the Rheumatic Diseases*, 1977, **36**, 199.

Training posts in medicine and allied specialties

SIR,—The Specialty Advisory Committees of the Joint Committee on Higher Medical Training (JCHMT) has been making steady progress in its task of inspection of senior registrar (or equivalent) training posts in medicine and allied specialties. Most of the posts put forward for consideration have now

been inspected and it is hoped that the remainder will be dealt with in the near future. Lists of posts approved for training after inspection are contained in the Second Report of the JCHMT and supplements thereto (available from the address below, price £1.50).

To assist applicants for a senior registrar post to determine its status in relation to JCHMT requirements the employing authorities have been requested to state in the advertisement for such a post that it has been approved (if this is the case) for training by the JCHMT. This is an additional safeguard to applicants who may not have access to a copy of the Second Report.

Applicants should note that the absence of a positive statement of approval in any advertisement does not necessarily mean that the post has been turned down by the JCHMT. It may be a perfectly satisfactory post that has not as yet been visited by an inspection team or it may be a post that has only minor training deficiencies which are in the course of being put right before final approval can be granted. However, the message to applicants is clear. If the advertisement does not include a positive statement of approval by the JCHMT they should in their own interests carefully scrutinise the further particulars of the post provided by the employing authority and, if necessary, pursue inquiries either before or at the interview to determine its training status.

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Report on first MASC meeting

SIR,—Anyone reading your report (8 October, p 972) of the Conference of Academic Representatives held in Oxford on 26 September would be justified in concluding that the major problem confronting the newly established Medical Academic Staff Committee related solely to clinical academic staff—an impression reinforced by the space devoted (15 October, p 1037) to Dr Robert Lowe's discussion of the remuneration of clinical academic staff. Let there be no doubt that it is in the preclinical field where the most urgent problems lie: unless immediate action is taken to make the rewards of a career in the medical sciences comparable with those in other fields of medicine the effective medical component in many anatomy and physiology departments will have vanished within five years, and, as I write from an anatomy department, the medical science which has over the centuries proved itself concerned with the vocational relevance of teaching will have followed the pathway already taken by biochemistry.

Inquiry reveals that the reason for the failure to report the long deliberations concerning the preclinical problems was that the sole reporter assigned to the activity was available for either the clinical section meeting or the preclinical section meeting but that no way could be found to engage one reporter for each section meeting. The decision made instructing the reporter to cover the clinical debate is likely, therefore, to reflect the priorities of the BMA, which seems to be continuing to pay lip service only to concern for the critical position in preclinical departments while continuing to pursue policies that are