oil). This agent has been implicated in the production of an unusual hyperlipidaemia in patients receiving an intravenous preparation of the antifungal drug miconazole which also contains Cremophor EL.²

We have observed a similar pattern on lipoprotein electrophoresis of the plasma of a 33-year-old man with post-traumatic pulmonary insufficiency who had been sedated for seven days with a continuous infusion of Althesin at the rate of 72 ml/day. The pattern is that of disappearance of the α -lipoprotein band and the appearance of a densely staining abnormal band running in the β -lipoprotein region. The total plasma cholesterol concentration was 4.3 mmol/l (166 mg/100 ml) (normal range 3.6-6.2 mmol/l (140-240 mg/100 ml)) and the triglyceride concentration was 2.6 mmol/l (230 mg/100 ml) (normal range 0.6-1.7 mmol/l (53-150 mg/100 ml)). Bagnarello *et al*² pointed out that this unusual lipoprotein pattern is similar to that seen in dogs during continuous infusion of the surface-active agent Triton, which, over a period of a few months, produces severe arteriosclerosis.

We suggest that patients receiving long-term infusions of Althesin or other preparations containing Cremophor EL should have their plasma lipids monitored and that development of the electrophoretic pattern described could be a justification for discontinuing such infusions unless the benefit of the therapy is thought to outweigh the potential risk. We would also suggest that the transitory rise in plasma free fatty acids associated with the induction of anaesthesia with Althesin³ may be due to its Cremophor EL component.

We thank Mr P M Scott, FRCS, for permission to report this case.

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¹ Ramsay, M A E, *et al*, *British Medical Journal*, 1974, **2**, 656.

² Bagnarello, A D, *et al*, *New England Journal of Medicine*, 1977, **296**, 497.

³ Mehta, S, and Burton, P, *British Journal of Anaesthesia*, 1975, **47**, 863.

Management of children with nephrotic syndrome

SIR,—Your leading article (29 October, p 1103) concerning the treatment of nephrotic syndrome in children requires comment.

A low-sodium diet is traditional and easily prescribed but is unpalatable, tedious for the mother to cook, and unnecessary. A high-protein diet is expensive and illogical: the stimulus to albumin synthesis is hypoalbuminaemia itself and not ingestion of excess protein.

Setting aside these points, the precise indications for steroid therapy are not discussed. The natural history of minimal-change glomerulonephritis is one of relapse and remission. Why should not loop diuretics be used to control oedema until remission occurs? Frusemide and bumetanide are very well tolerated and much less toxic than steroids. Because a condition responds to steroids this does not necessarily imply that steroids are indicated. Is proteinuria per se injurious, provided that oedema is controlled by diuretics? Only a very few nephrotic patients

develop hypoalbuminaemic hypovolaemia of clinical importance.

The place of diet, of diuretics, and of corticosteroid therapy in the minimal-change glomerulonephritic nephrotic syndrome are yet to be evaluated by adequate clinical trials.

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Obstetric audit in general practice

SIR,—I was interested to read Dr G N Marsh's audit of a general practitioner maternity unit (15 October, p 1004). The previously unpublished retrospective figures for our GP maternity unit from 1965 to 1976 cover 3410 births, of which 96.2% were normal deliveries, 2.8% deliveries with forceps, 0.6% breech, and 0.1% twins. Post-partum haemorrhage occurred in a further 2.4% and the flying squad was called out for 1.7% of deliveries. The perinatal mortality was 3.8 per 1000 births, although this is falsely low owing to patient selection, etc, and the maternal mortality was nil. These figures merely show that a GP maternity unit is a safe place to have an anticipated normal delivery.

Between 1965 and 1973 54% of patients were breast-feeding on discharge. It was then decided to improve the combined approach of the primary care team and this involved a setting up of a GP unit booking clinic at which patients were separately interviewed by a midwife and a health visitor, and a clerk and practice nurse were involved in routine blood tests, etc. Also the previously separated hospital and district midwives joined together to become truly community midwives. Our patients are therefore cared for in hospital by their midwife who will follow them up at home, they are informally visited by their health visitors who will follow up later, and supervision is by their GP.

Coincident with this change in approach, the incidence of breast-feeding on discharge has risen to 63%. As the advantages of breast-feeding are now so well documented I wonder how many specialist units can claim such a degree of preventive health care for their normally delivered babies on discharge.

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Advisory Committee on Borderline Substances

SIR,—It is now several years since the Advisory Committee on Borderline Substances (ACBS) in their wisdom classified the powder formulation (but not the tablets) of Optimax (L-tryptophan compound), a drug used currently in the treatment of depression, as a food, creating a situation on which bureaucracy thrives, confusion abounds, and common sense goes by the board.

To the manufacturer who has the same product classified as a drug and as a food it is, to say the least, irritating. One attracts VAT and the other does not. Both are prescribable in hospitals; only the tablet is prescribable outside in family practice. To the committee it must sometimes seem to be a most regrettable classification, involving them in numerous tribunals and a great deal of paper work, not to

mention abuse from general practitioners up and down the country surcharged for prescribing "non-prescribable" medicines. In the case of Optimax powder, after three tribunals and one high court action that involved a great deal of expense and much wasted time, the situation remains unresolved.

Professor Barbara E Clayton in her lucid, informative letter (24 September, p 834) indicates that "the committee is always ready to reconsider any of its decisions in the light of new evidence." What is not spelt out, however, is what constitutes "new evidence." In the early days the clinical efficacy of Optimax was questioned by the committee; accordingly new evidence was generated attesting to the amino-acid's role as a safe, effective antidepressant,¹ etc. Regrettably the ACBS would neither change their mind nor advise on the sort of data they were seeking in respect of our petition to change the status of Optimax powder from food to drug—a classic "Catch 22" situation.

Although the ACBS's recommendations are "never... more than advisory," the implementation of their simple "guidelines" leaves a trail of confusion and frustration for administrators, clinicians, pharmacists, and, not least of all, the patient. However the ACBS sees itself, it is certainly not fulfilling the role of guide and mentor either to the clinician or to the pharmaceutical industry.

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¹ Jensen, K, *et al*, *Lancet*, 1975, **2**, 920.

² Rao, B, and Broadhurst, A D, *Lancet*, 1977, **1**, 460.

³ Herrington, R N, *et al*, *Psychological Medicine*, 1976, **6**, 673.

Matching resources to needs

SIR,—Our resources are finite and our desires to improve health care are not. After an evening spent considering the RAWP Report¹ and "The Way Forward"² I was irresistibly reminded of Macaulay's dictum that nothing is so useless as a general maxim. I must applaud the initiative of the Department of Health and Social Security in attempting to rationalise the planning of the Health Service for the future, but the more I read those documents the more uneasy I became. I appreciate the difficulties of equating the health needs of, say, Yorkshire with those of East Anglia, though it is much easier to contrast Trent with the North-west Thames Region. However, the more closely I study the RAWP formula the more I am impressed by how much we are to depend in the underprivileged areas upon a formula of pseudo-science for our future financial allocations.

"The Way Forward" encourages us to spend more upon community services, and they may be right, though we have no evidence that community health care is either better for the patient or cheaper. It may be both, but we just do not know. I suspect that the DHSS are recommending it because they think it is cheaper. Very large assumptions are being made by such a policy, and to attempt it in the absence of firm information as to its efficacy seems very unwise. Could we not have a trial of it in one region first and see if it is right before plunging the whole Health Service into a course of action which is based upon scant knowledge? We already have the uncomfortable consequences of Sir Keith Joseph's reorganisation to live with—a good