the proper analysis to make to get the true relative risk for smoking. There is thus a possibility that the adjusted relative risk for smoking in our paper is too low rather than too high.

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Sensitive thyrotrophin assays

SIR,—The possibility that, because of the normal concentrations found in this condition, hypothyroidism secondary to pituitary disease may be missed if the sensitive thyrotrophin assay alone is used as the first screening test of thyroid function is lightly dismissed by Drs A D Toft and J Seth (12 December, p 1503) on the basis that this condition is rare and can anyway be diagnosed on clinical grounds.

We disagree. Firstly, although rare, the true incidence of hypopituitarism is not known. Our clinic, which serves a population of 250 000, sees on average two patients a year with previously unsuspected hypopituitarism.

The signs and symptoms of hypopituitarism are non-specific, and because of its rarity it is unrealistic to expect non-endocrinologists to keep the diagnosis in mind. Most clinicians do, however, consider a diagnosis of hypothyroidism and in 12 of our last 18 cases the suspicion of hypopituitarism was first raised by the findings of a low thyroxine value combined with a normal thyrotrophin value (sensitive thyrotrophin assay in the last two) (A A Lakhdar *et al*, Caledonian Society for Endocrinology, April 1987). In each case the clinicians (general practitioner, haematologist, and vascular surgeon) had requested the test because of suspected hypothyroidism.

Had the test been reported as "euthyroid" there is little doubt that the next step in the diagnostic process would have been a fruitless investigation of other systems rather than referral to an endocrinologist who might have made the diagnosis. There would then have been delay or even failure to diagnose a potentially fatal condition. In addition many of these patients gave long histories of chronic ill health and had their lives transformed by appropriate replacement treatment.

Because of this and the other diagnostic pitfalls outlined in the leading article our current first tests of thyroid function include both total thyroxine and sensitive thyrotrophin assays.

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Important new treatments for acute ischaemic stroke?

SIR,—Recent studies have examined whether glycerol infusion has a favourable effect on the outcome of an ischaemic stroke. As Dr Peter Sandercock pointed out, a review of the published randomised controlled trials of glycerol in acute

stroke showed that treatment reduced the odds of death within six weeks by about 36% (14 November, p 1224). The review also showed that at four months to one year the initial treatment had no significant effect.

In contrast to the survivors of a myocardial infarction, victims of stroke may remain considerably disabled and require community support. Therefore it is important to know whether glycerol treatment influences not only mortality and neurological deficits but also the activities of daily living.

In a recent study 106 patients suffering from acute ischaemic stroke were randomly treated with intravenous glycerol or saline infusion for six days.¹ In the acute phase the glycerol infusion seemed to reduce the mortality for patients with moderate neurological deficits. After six days 69 patients (mean age 66.2 years) were still alive and followed up to one year. During that time there were no differences in mortality between the two groups.

As well as assessing the neurological deficit we evaluated the patients' abilities in activities of daily living according to established criteria² at the beginning and at the end of the observation time. Nursing care and rehabilitation efforts were the same for both groups. Those patients with the worst neurological deficits died within one year and were not included. The results are shown in the table. The clinical course was not static, and there were shifts to lower levels as well as to higher ones. However, there were no differences between the glycerol treated group and the controls.

Changes in the level of performance of activities of daily living from the acute phase to one year after the stroke

Activities of daily living	No of patients	Level of performance		
		Higher	Unchanged	Lower
Moderate deficit:				
Treated	9	3	5	1
Untreated	6	1	4	1
Slight deficit:				
Treated	9	4	5	0
Untreated	11	3	7	1

Thus glycerol treatment in patients with acute ischaemic stroke does not seem to affect the long term prognosis regarding mortality or performance of everyday activities.

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1 Frithz G, Werner I. The effect of glycerol infusion in acute cerebral infarction. *Acta Med Scand* 1987;198:287-90.

2 Fällström CE. A study on working capacity of persons physically disabled by neurological disease or injury. *Acta Neurol Scand* 1964;suppl 6.

Blood in Scotland

SIR,—I read the Personal View by Dr John Hulbert (12 December, p 1559) with some sadness. A little over one third of the article dealt with the problems the Scottish National Blood Transfusion Service had last summer when the proposal to build a private hospital at Clydebank was first announced. Dr Hulbert has unfortunately failed to brief himself fully with the facts.

The record of the Scottish National Blood Transfusion Service in supplying all private hospitals in Scotland with blood and blood products is one of outstanding success and one of excellent operational relationships between the managers of the private hospitals and the directors of our regional transfusion services. This is due, at least

in part, not to any moral obligation placed on the service, as suggested by Dr Hulbert, but to our legal obligation to supply private hospitals throughout Scotland, provided there is no detriment to NHS hospitals. This obligation and the proviso do not derive from any political leanings of the Scottish directors but are enshrined within the National Health Service (Scotland) Act 1978. The managers of our private hospitals fully understand our position and make considerable efforts to help us meet our obligations. In practice this obligation to the private hospitals has been easily met, primarily because of the strength of support from Scottish blood donors and the relatively small demands (less than 1% of our overall blood input) made by the private sector. The availability of blood and blood products in Scotland has never been and never will be based on whether patients are rich or poor, black or white, or their religious or political persuasion, and Dr Hulbert's implied comments that we may have made these discriminations or will in the future are unfortunate.

It is true that there was controversy after the announcement of the Clydebank Hospital proposals, but Dr Hulbert's suggestion that the Scottish National Blood Transfusion Service may have engaged in "unscrupulous manipulation" must be publicly refuted. The specific problem we had arose as a consequence of genuine professional differences of opinion. These difficulties would have arisen in any country to which the developers had directed their proposals, particularly if that country was self sufficient in blood and blood products and rejected the notion that a voluntary blood donation is a commercial commodity. The difficulties, which arose from these differences in opinion, have now been resolved by actions taken by the Secretary of State for Scotland, and as a consequence the Scottish National Blood Transfusion Service has only to supply a maximum of 7500 blood donations a year and will not be required to supply platelets. But there can be no doubt that at the time the difficulties were unfortunately and inadvertently compounded by the quality of the planning and public relations exercise devised and executed by the Scottish Development Agency. It is my view that this was an error of judgment (which can happen to any of us), but to imply that the Scottish Development Agency or indeed the American doctors were party to some form of unscrupulous manipulation is unhelpful and not founded on fact.

Now that the Secretary of State for Scotland has given his approval to the Clydebank development it is for the Scottish National Blood Transfusion Service to devise strategies to meet this new challenge. Neither my colleagues nor myself require Dr Hulbert to point out to us where our duty lies for it is defined by the law.

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Communication of drug treatment to general practitioners

SIR,—We read with interest Dr David A Sandler and Professor J R A Mitchell's report on interim discharge summaries (12 December, p 1523). We have recently completed a pilot study examining the effectiveness of our policy of prescribing only a three day supply of drugs when we issue a new prescription from our geriatric day hospital. The prescription is accompanied by a message for the patient to contact his general practitioner as soon as possible to ensure that treatment is continued beyond day three. A letter is sent by post to the patient's general practitioner within two days.

Fifty consecutive patients were followed up to