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

determine when the patient received a prescription from his general practitioner. Of the 24 patients staying with a relative or spouse, 21 (88%) received a prescription from their general practitioner within three days. Of the 19 patients who were living alone, however, only eight (42%) received their general practitioner's prescription within three days.

Our results therefore confirm that postal communication is a relatively inefficient method of passing fairly urgent information to general practitioners, but they also identify a group of frail elderly patients who are dependent on relatives, friends, or statutory services to deliver any necessary communication. Perhaps telephone communication to the general practitioner is the best way of ensuring adequate continuity of care for this group of patients most in need.

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Fiddling while tobacco burns

SIR,—In the light of Dr Simon Chapman's pessimism about tobacco promotion in the Third World (2 January, p 39) may I bring to your readers' notice the fact that we in Bangladesh, although belatedly, have formed an organisation named ADHUNIK. This is a Bengali word composed of the first letters of a sentence meaning "we prevent smoking." This is registered with the Ministry of Social Welfare and is the only organisation of its kind in Bangladesh. During the first year of its existence, in 1987, it has been able to achieve: (a) a total ban on advertisements for tobacco on radio and television; (b) the inclusion of a section on smoking and health in a school textbook; (c) separate compartments for smokers on trains; and (d) reservation of seats for non-smokers on domestic air flights.

The organisation undoubtedly has a great responsibility in waging a successful campaign against tobacco. In doing so it needs moral, educational, and financial support. May we therefore take this opportunity of appealing to all who are interested in tackling tobacco to join us in any way they can to strengthen our hands.

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Diagnosis of ophthalmia neonatorum

SIR,—Although a Gram stain is an essential investigation in any infant with ophthalmia neonatorum, it has no place in the United Kingdom for the diagnosis of *Chlamydia trachomatis* infection (Dr Joseph Wincelhaus and others, 28 November, p 1377). Such infection in the newborn indicates that at least one parent has a sexually transmitted disease; the physician treating the parents and infant needs to be certain that *C trachomatis* is the cause of the infection.

Appropriate treatment of the newborn should include a topical antibiotic such as tetracycline and a course of oral erythromycin. Although chloramphenicol eye ointment is inappropriate for the management of chlamydial ophthalmia, blood dyscrasias after this form of treatment are so extremely rare that it should be used in preference to neomycin once *Neisseria gonorrhoea* and *C trachomatis* infection have been excluded.

Even in developing countries it may be more

economical to make available a cheap diagnostic test for chlamydial infection than have to dispense expensive antibiotics (four courses for each index case) for the appreciable number of false positive diagnoses which will be made using a Gram stain.

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AUTHORS' REPLY.—We disagree with Dr Rudd's contention that the Gram stained conjunctival smear has no place in the United Kingdom for the diagnosis of chlamydial ophthalmia neonatorum. It is useful for the presumptive diagnosis of chlamydial ophthalmia because the sensitivity is 100% and specificity 92%. Accordingly, local treatment, and in severe cases systemic treatment, can be started immediately while essential confirmation is awaited. When confirmation has been obtained systemic treatment can then be started or continued and the parents and their sexual contacts investigated as we outlined. In very special circumstances, such as when the baby has already received antichlamydial treatment, it may be necessary to test the mother (after explanation) before the correct diagnosis can be established.

We recommend neomycin eye ointment for the treatment of presumptive bacterial conjunctivitis before chlamydial ophthalmia is fully excluded because chloramphenicol can suppress *C trachomatis* and vitiate tests for that organism. Treatment with neomycin eye ointment is promptly effective, is very trouble free, and has no antichlamydial effect. It also facilitates the culture of *C trachomatis* by controlling local bacterial infection. Although blood dyscrasias after local treatment with chloramphenicol are rare, they have been reported¹⁻⁴ and the risk is best avoided. Moreover, it is unknown what happens to the adult who receives local chloramphenicol again after having received it and possibly become sensitised by the drug in childhood.

False positive results of only 8.8% using our Gram stained smear criteria for diagnosing chlamydial ophthalmia do not lead to Dr Rudd's "many courses of unnecessary antibiotics." We also would like to see cheap, simple, and rapid diagnostic tests become widely available for *C trachomatis*. Until they do and are generally used we believe that the Gram stained smear gives a useful presumptive diagnosis of ophthalmia neonatorum.

Dr Rudd states that where *C trachomatis* is the cause of the infection the treatment should include "a topical antibiotic such as tetracycline and a course of oral erythromycin." The use we have for tetracycline eye ointment is as a case holding measure until systemic treatment is started. We know of no evidence that local treatment adds any benefit once erythromycin by mouth is given in adequate dosage.

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Death by inches

SIR,—We would like to add an international dimension to Dr Andrew Robinson's study of longevity (19-26 December, p 1599) by reporting the results of our survey of the factors affecting the appearance and length of announcements of deaths of doctors in Britain and Sweden.

Figures were obtained from the *BMJ* for 1986. The length of each obituary was measured to the nearest 0.5 cm, and this was correlated with age at death and specialty. When age at death was not stated it was calculated by assuming an age of 24 at the time of the qualification. Doctors were divided into the following specialties: physicians; surgeons; obstetricians and gynaecologists; radiologists; radiotherapists and pathologists; anaesthetists; psychiatrists; general practitioners; and others.

The data are summarised in the table. During 1986 there were 433 obituaries, with a total length of 69.71 metres. The average length was 16 cm. The average age at death was 73 years. The mean age at death among surgeons was 74 while that among physicians was 69 ($p < 0.05$). Excluding the physicians, there were no significant differences among the ages of the other groups. Surgeons and the combined group of radiologists, radiotherapists, and pathologists obtained the longest obituaries, while general practitioners received the shortest ones ($p < 0.0001$). No correlation was found between age at death and length of obituary.

Numbers of doctors mentioned in obituaries in *BMJ* in 1986 with age at death and length of obituary

	Total No of doctors	Mean age at death (years)	Mean length of obituary (cm)
Physicians	59	69	17.5
Surgeons	42	74	19.5
Obstetricians and gynaecologists	22	75	18.5
Radiologists, radiotherapists, and pathologists	29	75	19.5
Anaesthetists	14	72	16.0
Psychiatrists	26	75	18
General practitioners	168	73	13
Others	73	75	17
All doctors	433	73	16

We compared these overall figures with the announcements of deaths of doctors appearing in the journal of the Swedish Medical Association, *Läkartidningen*, for the same time period. In 1986 163 deaths of Swedish doctors were recorded at an average age of 71 years. This was 37% of the number appearing in the *BMJ*.

To our knowledge there has been no previous study of the factors influencing the length of obituary among doctors. The total number of doctors in Sweden is only about 23% of that in the United Kingdom. A Swedish doctor was therefore 61% more likely to have his death recorded than a British doctor. The average age at death of Swedish doctors was also two years younger. We thus advise our British colleagues to visit Sweden only if they are in search of fame rather than longevity. They should also not become physicians if they wish to avoid an early demise or general practitioners if they wish to avoid obscurity.

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