while the traffic club scheme is being planned. This venture must not become bogged down in protracted negotiations; for ultimately it could have a pervasive influence in reducing death and disability well beyond the age of 5.

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Antidepressants and skin disease

Many patients with chronic skin problems have depression, which may often be unrecognised, and some will improve when treated with antidepressants. Itch and sleep disturbance, for instance, are common in those with chronic skin conditions and may be helped by antidepressants, particularly trimipramine. Recently, however, it has become apparent that antidepressants may help in some skin conditions even when the patient is not depressed.¹ They have been used with some success to treat chronic urticaria, angioedema and dermatographism, idiopathic cold urticaria, nocturnal pruritus in atopic eczema, postherpetic neuralgia, and the pain of diabetic neuropathy.¹

Imipramine was discovered in the search for antihistamines, as was chlorpromazine. Tricyclic antidepressants, benzodiazepines, and phenothiazines are closely related—like car keys with small variations. How they work is still not clear, but they inhibit uptake of noradrenaline and so potentiate sympathetic activity. They can reduce skin blood flow, lower skin temperature, and reduce sweating. They also are sedatives, antiemetics, muscle relaxants, and local anaesthetics.

So far as the individual drugs are concerned patients with chronic urticaria and dermatographism may benefit particularly from doxepin²⁻⁵; those with postherpetic neuralgia from pimozone and trimipramine⁶; and those with chronic aphthous ulcers from phenelzine.⁷ Emotional factors are important in these conditions. Amitriptyline has relieved unilateral itch after strokes,⁸ and naloxone helps the pruritus of cholestatic jaundice, illustrating that endorphins may have a central modulating effect on itch.⁹

Epiphenomena are part of all chronic illnesses, and when they are not readily explained they are often assumed to have psychological origins. Sometimes this is true, but doctors may overestimate the number of problems that have psychological origins.¹⁰ Nevertheless, antidepressants may often be indicated in patients with skin problems. They may also be indicated for patients whose problems are purely dermatological,

particularly for the urticarias, pruritus, and other pain related syndromes.¹

Antidepressants do, however, have many side effects, and they may interact with other drugs. They should not therefore be used as a substitute for thought and proper evaluation, especially when "waiting and seeing" is an option.

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Drug regulation: evolution or revolution?

The history of drug regulation in Britain has been one of evolution.¹ From the Arsenic Act of 1851 to the Medicines Act of 1968 each legislative step has been prompted by parliamentary, professional, or public concern over particular aspects of the manufacture, promotion, prescription, or sale of medicines. The Medicines Act, stimulated by the thalidomide disaster, created the licensing authority (represented for human medicines by the health ministers) with powers to grant (or revoke) product licences for the sale or supply of medicines and made it an offence to market a drug without such a licence. In discharging its responsibilities the authority obtains advice from committees established under the act, of which the Committee on Safety of Medicines is the most widely known. Although the Committee on Safety of Medicines is only advisory, the licensing authority has rejected its views only very rarely. The committee is thus extremely influential in deciding which drugs should be available on the market.

Recently radical proposals have been put forward by Dr David Green, director of the Institute of Economic Affairs' health unit, who believes that the British licensing system has failed.² He claims that current regulatory requirements impose important additional costs and delays in drug development; preclinical toxicity studies have not proved a wholly reliable indication of safety in man; the licensing system fails to take enough account of the true nature of the risks and benefits of new medicines; and as a result some drugs that might have been effective have been rejected while others have been approved and later found to be toxic.

Green therefore suggests that our licensing procedure should be abandoned and replaced by systems whereby the decision whether a drug should be marketed would rest