know whether there was an increase in creatinine clearance at any stage in pregnancy. A lack of increase indicates decreased renal reserve, which might possibly reflect subclinical cyclosporin toxicity. It is possible that cyclosporin may blunt the renal haemodynamic effect of various hormones in pregnancy, raising both glomerular filtration rate and effective renal plasma flow. Several studies have shown a decrease in plasma creatinine concentration and increases in glomerular filtration rate and effective renal plasma flow in renal transplant recipients on conversion from cyclosporin to azathioprine and prednisolone. Many such patients had lower blood cyclosporin concentrations than in the authors' patient. We consider that 959 µg cyclosporin/l whole blood is high, particularly 11 months after transplantation. It is not clear whether the drug was given once or twice daily.

It is prudent to maintain plasma concentrations as low as possible. This can be achieved without compromising the immunosuppressive effect by dividing the daily dose into two or three.¹ When cyclosporin is given as a single oral dose patients will be exposed to very high concentrations two to six hours after the dose. The postabsorption peak could be five times higher than the trough concentration. This may generate a huge concentration gradient between the maternal and fetal circulations. The fetal liver may not be able to metabolise and eliminate the drug as efficiently as the maternal liver.

At 12 weeks after transplantation most of our patients receive 2.5 to 6 mg cyclosporin/kg in a divided twice daily dose, and we adjust the dose to keep 12 hour trough plasma concentrations around 75 µg/l. At this concentration toxicity is rare. It may become necessary to give cyclosporin in divided doses to pregnant women who have received transplants.

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Insulin for the non-insulin dependent?

SIR,—Not all will agree with Dr Roy Taylor (9 April, p 1015) that recent advances have removed many of the problems for the clinician on when to advise insulin treatment in maturity onset diabetics. The (still imperfect) evidence derived from studies on young insulin dependent subjects that "good control" of blood glucose concentration delays or prevents complications cannot necessarily be transposed to the late middle aged or elderly type II diabetic. Doctors treating a 70 year old newly diagnosed diabetic should remember not only that life expectancy for the normoglycaemic is 10-14 years but also that diabetes diagnosed over the age of 70 does not alter that life expectancy.¹

Most importantly, however, Dr Taylor joins the longstanding conspiracy of reviewers in this subject not to consider the initial weight of the patient. Where weight is normal or moderately increased the need for insulin treatment, where others means have failed, is not in dispute. What, however, of those subjects who remain obese by the criteria of the Royal College of Physicians report?² Such subjects may not have complied completely with diet, but dietary compliance may be "as complete

as the patient can achieve." Where is the evidence that insulin treatment improves the outcome in these patients? Indeed, what evidence is there that better glycaemic control will be maintained over years as opposed to months in these patients? Will the initial 2 kg weight gain over 1 year (4.2 kg in six months in Peacock and Tattersall's study³) be confined to the first year? Is glycaemic control more important than other factors such as lipid state, hypertension, smoking, and obesity itself in determining the outcome in this group? The necessary long term studies in a group selected for initial obesity have not been performed. Until they have, it may prove prudent to consider the advice of the European non-insulin dependent diabetes policy group⁴ that "Insulin treatment is irrational in a patient who achieves reasonable blood glucose control during hospitalisation but is unwilling or unable to cope with therapeutic recommendations on an outpatient basis." In the individual patient the decision for or against insulin is likely to remain difficult.

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Eye pain with nifedipine

SIR,—Dr David Coulter reported an association between eye pain and treatment with oral nifedipine (16 April, p 1086). Although only nine out of 757 respondents taking nifedipine had their intraocular pressure measured, and all were normal, glaucoma was cited as a possible adverse effect of nifedipine.

We found that systemic nifedipine had no effect on intraocular pressure in six normal volunteers.¹ There were no adverse ocular symptoms, although headache occurred in four subjects. Schnell found that a single 20 mg dose of nifedipine given sublingually reduced intraocular pressure in patients with glaucoma, while repeated oral administration had no effect in them or in normal subjects.²

Nitrendipine also lowers intraocular pressure in patients with essential hypertension and normal intraocular pressure.³ Typical verapamil lowers intraocular pressure in normal volunteers.⁴ Nifedipine causes a transient rise in intraocular pressure and ocular blood volume in rabbits, possibly due to ocular vasodilatation.⁵ Ocular vasodilatation might be beneficial in humans with open angle glaucoma if it improved optic nerve perfusion without increasing intraocular pressure. Visual field loss might be reduced. Further investigations of the effects of calcium antagonists on human ocular blood flow are needed.

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Health care of physically handicapped young adults

SIR,—Dr Martin Bax and others (23 April, p 1153) illustrate the detrimental effects on health care that can result from a lack of information and coordination of services for the disabled school leaver.

There is an urgent need for the establishment of multidisciplinary teams to act as a focus for the disabled school leaver. Sections 5 and 6 of the Disabled Persons (Services, Consultation, and Representation) Act 1986 have now come into force and these require the local authority, in liaison with the local education authority, to identify all disabled school leavers, or at least those who are the subject of a statement in terms of the 1981 Education Act, and offer them a full assessment of their needs.

Finance, at least in the short term, for the implementation of these sections has been made available from central government funds. At last we have the opportunity and financial backing for the establishment of multidisciplinary assessment teams. Joint care planning teams and others should take this opportunity to establish teams in their area. In Newcastle upon Tyne plans have been made for establishing a small multidisciplinary unit which would facilitate and coordinate all available services in the health, local authority, voluntary, and employment sectors for the disabled young adult.

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Minerva wrong about yellow cards

SIR,—Perhaps it is some time since Minerva reported a suspected adverse drug reaction to the Committee on Safety of Medicines or even saw a yellow card (7 May, p 1334)? Had she done so she would have seen evidence of the business reply service, which she advocated we arranged, prominently displayed.

Occasionally we receive adverse reaction reports on old yellow cards, printed with our previous address in Finsbury Square. The post office usually forwards these, though the business reply service licence was transferred when we moved here eight years ago.

We are striving to encourage reports of suspected adverse drug reactions to the CSM. The prepaid yellow cards are widely available for this purpose, and recently yellow slips, which can be sent FREEPOST, have been distributed in the *British National Formulary*, in the Association of the British Pharmaceutical Industry *Data Sheet Compendium*, and in FP10 prescription pads. Doctors with older yellow cards addressed to Finsbury Square should discard them.

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** We apologise for this mistake.—Ed, *BMJ*.