dystonia, are not uncommonly seen in the affected limbs of patients with reflex sympathetic dystrophy²⁻⁴—a fact not mentioned in the review.

The appearance of the limbs in the author's figure 3 is similar to that of patients with the causalgia-dystonia syndrome (figure).⁵ Such patients have fixed dystonic posturing of the affected limb in addition to the other typical features of reflex sympathetic dystrophy. The dystonia either occurs at the same time as or follows the symptoms of causalgia.¹¹ Interestingly, the patient shown in figure 3 in the review is said to have had similar symptoms in the other foot and in one hand previously. This was also seen in the patients we described previously, in whom the causalgia and dystonia would spread from the affected limb to other limbs.⁵ Such spread suggests that central mechanisms play a part in the pathogenesis of the syndrome.⁵

It is important, for two reasons, to recognise this subset of patients with reflex sympathetic dystrophy who have additional dystonia or other movement disorders. Firstly, from the prognostic point of view, in our experience these patients seem refractory to most forms of conventional treatment for this condition.⁵ Secondly, because such dystonic muscle spasms may dominate the clinical presentation these patients may be referred to many different specialists, including orthopaedic surgeons, rheumatologists, neurologists, and physiotherapists, who need to know the different manifestations of this difficult condition.

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Has been renamed complex regional pain syndrome

EDITOR,—Elisabeth Paice's review of reflex sympathetic dystrophy¹ omits to refer to two important recent publications. In the second edition of its taxonomy on pain the International Association for the Study of Pain has replaced the term reflex sympathetic dystrophy with a new term, complex regional pain syndrome type I.² Sympathetic involvement and dystrophy do not occur in every case of reflex sympathetic dystrophy. Causalgia becomes complex regional pain syndrome type II. Pain that is maintained sympathetically may coexist with either of these syndromes. The diagnostic criteria for complex regional pain syndrome type I are ((b) to (d) must be satisfied): (a) the presence of an initiating noxious event or a cause of immobilisation; (b) continuing pain, allodynia, or hyperalgesia, with the pain disproportionate to any inciting event; (c) evidence at some time of oedema, changes in skin blood flow, or abnormal sudomotor activity in the region of the pain; (d) the diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction.

Jadad *et al* conducted a systematic review of the literature and a randomised controlled trial of the use of intravenous regional sympathetic blockade for pain relief in so called reflex sympathetic dystrophy.³ Neither element of their report sup-

ports the use of intravenous regional blocks with guanethidine in this condition. In the light of this finding Paice is right to call for a critical evaluation of all the treatments used to manage reflex sympathetic dystrophy.

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Leeds students were angry with the university, not each other

EDITOR,—In Luisa Dillner's news item about the medical students in Leeds who had to resit a multiple choice paper in their final examinations, Frances Ledgard, the university's information officer, is quoted as saying, "The students...are angry and upset with each other—those that had seen the paper were cross with the ones that complained."¹ This is both inaccurate and disingenuous. The students were not angry with each other but were united in their annoyance with the medical school and university authorities at the error. This solidarity was shown by the fact that the students themselves arranged a meeting to discuss the problem.

Ms Ledgard's statement is disingenuous because it implies that some of the students had cheated or were otherwise to blame. This is untrue, and the university has accepted full liability for the mistake. Aside from the factual inaccuracy, I find it insensitive that Ms Ledgard should obliquely suggest underhand behaviour by the students. Enough anxiety had already been caused by the university, with students having to resit this difficult paper.

Secondly, the provision of multiple choice questions as a learning tool is well recognised. The provision of past questions from these papers is analogous to that of past essay papers and should be routine. The events at Leeds should provide the stimulus for a much needed re-evaluation of the standard and structure of the final year exam in medicine, as pointed out by Andy Smith, the students' representative.

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New equities of information in an electronic age

EDITOR,—Christopher Zielinski's editorial "New equities of information in an electronic age," is an excellent summary of the many problems faced by developing countries in receiving and supplying health information. Since 1977 the Appropriate Health Resources and Technologies Action Group (AHRTAG) has worked with partners in developing countries to disseminate relevant and accurate information on health and to develop information systems to meet local needs. The group is an independent non-government organisation and has no corporate links with commercial providers of information.

AHRTAG publishes four newsletters—on child health, HIV infection and AIDS, disability, and

primary health care management—and distributes them free in the developing world. The newsletters seek to balance biomedical information with a community perspective and provide a forum for readers to exchange experiences and views. Authors are from, or have worked in, developing countries. Subjects tackled range from dealing with infectious diseases, through changing community attitudes about disability and HIV infection, to developing strategies for management and health education.

AHRTAG's partners in developing countries translate or adapt the newsletters for regional distribution. In 1994 the newsletters had a total circulation of 600 000 in 11 languages and an estimated three million readers worldwide.

AHRTAG's resource centre in London houses a unique collection of over 19 000 books, journals, training manuals, slides, and videos focusing on practical aspects of primary health care. The emphasis is on material from developing countries. Few of these resources reach medical or academic libraries. AHRTAG has continued to develop systems to make information in the resource centre more accessible. Bibliographic databases can be an effective way of improving the flow of information to and from developing countries. AHRTAG is working to make its databases more easily accessible through increased circulation of the printed list of its resources and through the Internet. To be successful, however, this depends on well developed communications systems, which are often unavailable in areas where information needs are greatest. Therefore we are working with our partner organisations to establish their own resource centres, based on local needs.

Like all charities, AHRTAG must raise funds to cover the ever increasing demands for its services. Yet many vital areas of its work, including the resource centre and the new child health newsletter, *Child Health Dialogue*, are currently underfunded. Equity in information requires that organisations such as AHRTAG and its partners in developing countries receive the relatively modest amounts of funding needed to develop new channels of information. Readers who would like further information on AHRTAG and its work should write to me.

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Asymptomatic retinal haemorrhage is common at altitude

EDITOR,—In their article on mountaineering medicine Christine H D A'Court and colleagues neglect to discuss one of the commonest medical disorders at altitude; retinal haemorrhage.¹ This is surprising since macular haemorrhage is listed as having affected one member of their team and was probably detected only after the subject complained of central visual field loss.

Retinal haemorrhage at altitude is usually symptomless and has been studied in detail only relatively recently. Funduscopy performed on expeditions over 6000 m has shown an incidence of 36% in 39 subjects climbing Mount McKinley,² 29% in 14 army recruits climbing in Nepal,³ and 29% in 14 subjects and 20% in 30 subjects climbing Mount Everest.⁴ Retinal haemorrhage at altitude also occurs as a result of severe cerebral oedema,⁵ but little is known of the aetiology of the condition when it develops spontaneously. Links have been made to heavy exercise at altitude^{2,3} and use of non-steroidal anti-inflammatory drugs.⁴

Regular funduscopy should therefore be undertaken by expedition doctors to detect the presence of haemorrhages in otherwise symptomless people. Direct ophthalmoscopy in a darkened tent should be sufficient. While the presence of a small (diameter less than one half disc) uncomplicated haemorrhage may not necessarily be an indication for descent, certain factors may lead to long term damage to the eye—for instance, rebleeding, involvement of the vitreous, the presence of a detectable scotoma, or symptoms of early retinal detachment—and descent should be advocated when these are present. The desire to climb has to be balanced against the possibility of long term visual impairment.

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Dornase alfa for cystic fibrosis

EDITOR,—The use of dornase alfa has been a topic of recent controversy.^{1,3} South and West region's development and evaluation committee of senior clinicians supported by a research review team undertook to determine the drug's cost effectiveness on the basis of the published evidence.⁴ The net cost (total costs less savings) to the NHS of prescribing a daily dose of 2.5 mg of dornase alfa to patients with cystic fibrosis in the former Wessex Regional Health Authority, excluding children under 5 and patients with severe disease, would be £1 367 000 (1994 costs), or £5900 per patient per year, for no apparent survival benefit. This is despite savings, including 26% fewer days of treatment with parenteral antibiotics and an 18% reduction in inpatient stay. In the phase III trial lung function was marginally improved and the relative risk of developing a respiratory tract infection defined in the protocol was reduced. Patients in the trial were asked several questions about whether the quality of their lives had improved and the magnitude of the improvement. While the proportion who reported an improvement, and the magnitude of the improvement, was higher among patients receiving dornase alfa than among patients receiving placebo for several (but not all) questions, the changes in mean score were small and the net proportion of patients reporting an improvement was low.⁴ When these data on effectiveness are translated into a cost-utility estimate the best possible calculation on present evidence would be an average cost of somewhere around £25 000 per quality adjusted life year. With better (longer term) evidence this would imply a "beneficial but high cost" treatment; that is a poor buy in comparison with other treatments, even for cystic fibrosis. For example, the committee similarly evaluated tertiary referral centres for cystic fibrosis that used treatments used before dornase alfa was marketed and found that the cost per life year gained was £1300.

The proved benefits of using dornase alfa may improve with further data from trials, but the marginal benefits of the drug taken together with its high cost do not warrant a headlong rush to use it before the results of further longer term trials are available. Work is now continuing locally to produce rigorous guidelines to ensure that only those patients sure to gain considerable benefits are treated with dornase alfa (Davis suggests 30% as

derived from the results of the phase III trial⁵). It is not yet known which other patients will benefit over the longer term.

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Hospital management commended for first trimester spontaneous abortion

EDITOR,—I expected Kevin Forbes to find room in his editorial on the management of first trimester spontaneous abortions for two important aspects of the condition—the psychological and the paediatric.¹ His concentration on physical maternal factors omits to consider how a previously expectant mother may feel about continuing with a non-viable pregnancy for any longer than is necessary. The prospect of the abortion becoming complete in the home environment and the uncertainty over when or where this will happen are burdens that many women may not wish to contemplate. The best management that I have come across includes a clear discussion of the prospects, with the patient participating in the decision on whether evacuation is desirable. This may have beneficial effects on coping during what would have been the remaining gestation and at a similar stage in future pregnancies and is surely grounds for a controlled study.

From a paediatric prospective, samples vital for diagnosing chromosomal or congenital abnormalities—particularly in cases in which recurrent abortion ensues—may be lost if they are disposed of out of hospital.

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Mildly raised intraocular pressure is a risk factor, not glaucoma itself

EDITOR,—A P Booth and J S Hillman¹ object to Ronald Pitts Crick and Maurice W Tuck's sensible recommendations for referring patients with suspected glaucoma to the hospital eye service.² They do so on the basis of regulations covering the activities of ophthalmic opticians.

They state that "intraocular pressure of 22-25 mm Hg is a sign of disease or abnormality in the eye." Most specialists in glaucoma would disagree and consider this level of intraocular pressure to be a risk factor for the development of disease.^{3,4} The value of 21 mm Hg as the upper

limit of the normal range for intraocular pressure is the mean plus 2 SD. The distribution of intraocular pressure in the population is not gaussian, and so this normal range is invalid statistically. The prevalence of detectable glaucoma in white people with an intraocular pressure in the range 22-25 mm Hg is less than 5%, although some of these people will develop the disease later. Conversely, about 30% of patients with glaucoma have an intraocular pressure below this value.⁵

If all people with intraocular pressure in this range were referred to the hospital eye service our eye clinics would be overloaded with healthy patients. Their risk of developing glaucoma is similar to that of patients who have a first degree relative with glaucoma (this latter group is entitled to an eye test at taxpayers' expense). Both these groups require regular screening until a sign of disease develops. The community would be better served by ensuring that ophthalmic opticians provide a uniform and reliable service targeted at people at high risk.

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Being on first name terms may signify greater respect

EDITOR,—I enjoyed reading A L Wyman's views,¹ apparently also held by Katherine Whitehorn² on the formal British preference of being addressed by their surnames. Conventionally trained at a British medical school, I too initially had the same preference to maintain "respect and distance" from my patients. Thus, some years ago as a junior cardiology registrar in New Zealand, I was amazed to find how frequently first names were used between patients and doctors. I clearly remember the shock when first addressed as "Chris" by a respectful farmer, who I then struggled to call "Bob."

With time, however, I appreciated that the use of first names in New Zealand often reflects a patient's increased confidence in the doctor, which is to be earned, and that this term of address often signifies more, and not less, respect. I now think that a closer relationship is possible with this relaxed manner, which is of benefit to patient and doctor alike. Politeness, of course, still dictates an initial formal approach from both parties, which is usually maintained for more elderly patients, such as Dr Wyman's generation.

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Correction

Bone densitometry in clinical practice

An editorial error occurred in this letter by J E Compston (9 September, p 687); John Kanis and Cyrus Cooper were omitted from the authorship.