possible theoretical benefit from saving a very few women from thromboembolism will have been swept away by the fact that a huge number of women, panicked by the media hype, will have stopped taking their pill immediately. Any scare about oral contraceptives causes a higher morbidity from pregnancy or terminations than it saves. This does not take into account the appreciable extra stress caused to general practitioners, primary care nurses, and receptionists faced with one and a half million extra consultations in one and a half days. There is also no way of measuring how many really urgent consultations were displaced by the clamour of the pill taking population.

The whole exercise was made infinitely worse because we knew nothing about it. My colleagues and I had no chance to discuss a strategy as a practice or to arrange extra counselling clinics. At the end of my "morning" surgery at 110 pm the first women started to telephone in, or came to reception, in tears. They had listened to the news at 1 pm. By the time we had received a fax from the Committee on Safety of Medicines at 340 pm (when we were all out on visits) 60 out of a possible 350 patients had already contacted us. Our patients could not believe that we did not even know which pills had been affected.

We have tried extremely hard over the years to encourage our population to ask for information. With a national decision of this magnitude, it was an error at the highest level that general practitioners were not given the full details of the studies so that our patients could make up their own minds. The concept of evidence based medicine has been accepted for many years in primary care but not, it seems, in government. There seems to be one standard of expectations for the medical profession to have a rational approach to resources, priorities, good quality information, and communication with our patients and a different one for the Department of Health.

A constructive critical response from the whole of the medical profession is needed to stop this happening again.

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Perception of risk is affected by presentation

EDITOR,—T Fahey and colleagues advise that informed clinical and health policy decisions should be made on the basis of full understanding of the limitations of the data presented, and they show how members of health authorities were influenced more by relative risk than by other presentations of the same data.¹ This may apply to the general public too. If that is so, the public relations disaster of the Committee on Safety of Medicines' release of conclusions from unpublished data on the risk of thromboembolism with certain combined oral contraceptives might have been avoided if the data had been presented in a form showing the difference in the percentage of event free women (table).² This would have alarmed women less and allowed a more measured

*Risk of venous thromboembolism with combined oral contraceptives**

	Oral contraceptives containing gestodene or desogestrel	Other combined oral contraceptives
Absolute (excess) risk per 100 000 per year	15	7.5
Relative risk	2.0	1.0
% Of women free of thrombosis	99.985	99.993

*Based on data given by Committee on Safety of Medicines.²

determination of policy when the results of the relevant studies are published.

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Screening for diabetic retinopathy

Adequate programme would save money

EDITOR,—Bob Ryder's editorial on screening for diabetic retinopathy notes the potential cost of litigation if those at risk are not screened adequately but fails to mention the more certain savings that may result from a comprehensive screening service.¹ Even when non-insulin dependent diabetes alone was considered an American computer model that compared the efficacy of treating macular oedema and neovascularisation with the federal costs of blindness calculated savings of \$247.9m (£165.3m) and 53 986 person years of sight.² These figures assumed only a (current) 60% uptake of services.

Perhaps more worrying is not the exact mechanisms of screening but the consequences of failure to screen. In a study of the diabetic patients in the Avon region who were registered as blind only a quarter had been screened once or more and half had not been screened although they were known to be diabetic.³ The other quarter had been diagnosed as diabetic only after presenting to an ophthalmologist with visual symptoms.

The American computer model predicted savings of \$472.1m (£314.7m) and 94 304 person years of sight if all of the population with non-insulin dependent diabetes were to be screened, which translated into savings of \$975 (£650) per person enrolled into the screening programme in the United States. Although allowance must be made for some differences in costs between the United States and Britain, the need for vigorous screening speaks for itself.

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Services are still patchy in Britain

EDITOR,—Bob Ryder emphasises the need for a screening test of adequate sensitivity and specificity in programmes to detect diabetic retinopathy,¹ but this is only part of the problem. For a screening programme to be effective, high population coverage is needed, prompted by an accurate call and recall system. This is far from the case with diabetes. Studies suggest that fewer than half of people known to have diabetes, whether they are cared for by hospitals or in general practice, have an annual examination of their fundi.^{2,3} Several studies have shown that when attendance for screening is prompted (to either a hospital or a screener based in the community) coverage of over 70% can be achieved.^{2,4}

Present services for detecting diabetic eye

disease are patchy, and there is a strong case for a national programme.⁵ We have recently been funded by the Department of Health to examine the current provision and organisation of screening. This will include a national survey and detailed examination of the performance of different systems in delivering high rates of coverage. The study is coordinated by an intercollege group, which includes representatives from the Royal College of Physicians, the Royal College of General Practitioners, and the Faculty of Ophthalmology of the Royal College of Surgeons. We hope that our results will contribute to the development of a policy for the detection of diabetic retinopathy that not only uses appropriate tests but includes the other essential attributes of an effective programme.

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GPs in south London have direct access to screening service

EDITOR,—Bob Ryder encourages those engaged in screening for diabetic retinopathy to use both of the two main methods of retinal examination: direct ophthalmoscopy and retinal photography.¹ Photography has the advantage of providing a permanent record so that progression of retinopathy can readily be monitored, and if Polaroid prints are used they can be shown to the patient to indicate the importance of the eye test. Ophthalmoscopy can detect smaller lesions, can be used to check the peripheral retina, and can be useful when lens opacities blur the photographs.

Current strategy in the provision of health care for diabetic patients has seen a shift to primary care, with general practitioners and practice nurses delivering the care that was formerly the sole province of the hospital diabetic clinic. In response to this shift St Thomas's, Guy's, and King's College Hospitals now provide general practitioners with direct access to an eye screening service for patients who receive the rest of their care from their practice. These diabetic eye complication screening clinics, sited in each hospital, provide a standard set of screening tests for large numbers of people with diabetes in south London.² Polaroid photography of the fundus and direct ophthalmoscopy after mydriasis, as recommended by Ryder, are combined with measurement of the intraocular pressure and visual acuity. The results are reviewed by the consultant ophthalmologist responsible for treating retinopathy, who decides whether an ophthalmic referral is required or whether mild retinopathy can be monitored safely at further visits to the clinic to conserve the resources of the eye department. Linking screening with treatment in this way is invaluable in reducing visual loss due to diabetes; identifying the retinopathy without making a timely referral is not enough.

The advantages of centralising screening are that