

head of the population were lowest in the UK and Denmark of the EC countries, and highest in France and Italy. I have elsewhere [1] suggested that one explanation for this difference is that the UK has the highest number of senior academic clinical pharmacology staff per medical school in the EC, while France and Italy are among the lowest. It is tempting to suggest that three decades of clinical pharmacology education in the medical schools of this country have led to a more rational approach to drug prescribing by UK medical graduates, and to an intelligent but cautious interest in the benefit/risk information available on new products.

Reference

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Sir—Your correspondents Walley and Watt (April 1993, pages 198–9) ask if therapeutic conservatism, as described in my earlier paper, has wasted NHS funds or harmed patients.

In the space available I gladly offer some examples where such conservatism is costly to the NHS. A recent study showed that when the more expensive idarubicin was used instead of daunorubicin for the treatment of cancer there was an overall saving of £870.00 per patient treated, taking into account the extra cost of idarubicin at £607.00 per patient against consequent savings in hospital costs of £1,477.00 per patient [1].

Immunisation against hepatitis B was not encouraged by the DoH for its medical staff until 1988, largely on the grounds of cost. However, two patients infected by surgeons carrying hepatitis B cost the NHS more than if it had vaccinated all surgeons in the UK in the first place. Compensating the two surgeons, recalling 2,000 patients and consequent counselling, and compensation for infected patients is likely to be of the order of £5 million.

Patients are frequently disadvantaged by the lack of take-up of new medicines, such as ACE inhibitors in hypertension. Progress in hypertension treatment has not moved forward in the UK at the same pace as in other major European countries. In Italy ACE inhibitors are now the leading therapy. Is this because the British are more ready than Italians to accept drug-induced impotence (and lethargy, dyspnoea, and cold hands and feet) associated with β -adrenergic blockers?

The report of the second working party of the British Hypertension Society has drawn attention to the advantages of both calcium antagonists and ACE inhibitors over older treatments as first line treatment for patients with diabetes, gout, dyslipidaemia, ischaemic heart disease, heart failure and asthma [3].

Erythropoietin is one of the leading products on the German market but many patients who could benefit from it in Britain are denied it because of its perceived expense [4]. In Britain '... the annual cost of treatment with erythropoietin is £2,000–4,000 which can be offset against the cost of transfusions and hospital admissions... The improvement in the quality of life for these patients is such that nephrologists argue strongly for erythropoietin to be made widely available'. (Winearls 1992) [5].

Guidelines issued to consultant oncologists at the Royal Marsden Hospital, London state: 'Ondansetron is undoubtedly an effective antiemetic and has the advantage of being virtually devoid of side-effects. However, because of the significantly higher cost of ondansetron, we felt its use should be restricted'. A consultant oncologist in a London teaching hospital adds: 'Ondansetron is similar to the erythropoietin situation... The problem with ondansetron is worse'.

Dr Mallick of the Royal Infirmary, Manchester, speaking at a conference on 'Rationing health care in medicine', pointed out 'the gross underprovision of services for the treatment of end-stage renal failure in the UK in comparison with Western Europe. Poor planning has been responsible for rationing, with the result that many thousands had died prematurely. Further, if resources are inadequate in the early stages of chronic renal disease, this results in greater morbidity' [6].

Government constantly defends moves to restrict prescribing, such as the Limited List, by arguing that it does not result in damage to patient care. Could anyone, please, produce evidence to support such statements?

References

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Clinical geratology

Sir—Professor Stout (April 1993, page 192) is concerned for the future of the human species now that the University of Oxford has designated our subject as

clinical geratology. I am delighted to discover that Professor Stout has access to the *Shorter Oxford English dictionary* whence he has plucked the archaic implications of decadence and impending extinction that he quotes. I could wish that he also had a copy of *Collins dictionary* from which he would learn that nowadays geratology is 'the branch of medicine concerned with the elderly and the phenomena associated with ageing' [1].

Dr Alex Comfort [2] pointed out that while 'geriatrics' is a serviceable term for medical practice among old people, 'gerontology' is a false coining for the science of ageing since it implies restriction to the study of old men (γέρωντες). The more commodious concept of geratology is derived from γήρας (old age) and is a proper interest for an academic department of a liberal university.

The editors of the *Oxford English dictionary* assured me last year that they will modernise the definition of geratology for their next edition citing Dr Comfort in literary provenance. This will be worthy tribute to an author whose various writings have done so much to inform the professional and enliven the private lives of geratologists.

References

- 1 *Collins English dictionary* (2nd edn) London: Collins, 1986.
- 2 Comfort A. *The biology of senescence*. Edinburgh: Churchill Livingstone, 1956.

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Oxygen desaturation during endoscopy

Sir—Like Solomon *et al* (January 1993, pages 16–8) we have been concerned about oxygen desaturation during oesophago-gastro duodenoscopy (OGD). In their study, Solomon *et al* gave both pharyngeal lignocaine spray and IV diazepam as pre-medication. We asked our patients to choose one or other of these pre-medication methods after a verbal explanation from the endoscopist (JM).

Oxygen saturation fell in both groups (1.9% and 6.9% respectively, $p < 0.001$) and was significantly greater in the diazepam group ($p < 0.001$ Student's *t* test).

None of the 48 patients receiving topical anaesthesia required oxygen, but six of 27 subjects receiving diazepam required oxygen due to a fall in oxygen saturation $>10\%$. None of our patients had any cardiac or respiratory problems during or after the procedure as reported in other studies [1].

Elderly patients receiving IV diazepam are at risk of injury due to drowsiness following endoscopy if close supervision is not available; one of our patients fell through a glass door following OGD when IV diazepam had been given. They will also be unable to drive home and alternative arrangements must be made. These additional disadvantages should be considered before IV sedation is used.

Nevertheless, with either pre-medication, it may be prudent to monitor O_2 saturation and administer oxygen via nasal cannulae, particularly in patients with pre-existing cardiac or respiratory disease.

Reference

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