This week in BMJ

All communications to:
The Editor, *BMJ*
BMA House,
Tavistock Square
London WC1H 9JR
Fax: 071 383 6418
Phone: 071 387 4499

Oxytocin-ergometrine has little advantage over oxytocin alone

Postpartum haemorrhage is important, being a major cause of maternal death worldwide. In an attempt to optimise how the third stage is managed McDonald *et al* (p 1167) have examined one component of the package of routine "active management" of the third stage of labour—that is, the choice of oxytocic. Oxytocin-ergometrine (Syntometrine) is currently the routine oxytocic used in this context, but the results of their randomised controlled trial reveal that one ampoule of this drug (ergometrine 0·5 mg and oxytocin 5 IU) has few advantages and several disadvantages when compared with 10 IU oxytocin.

If pertussis vaccine increases the risk of neurological illness then that risk is very small

Early alarmist reports of the effects of pertussis vaccine were shown to have greatly exaggerated the risk, if any, and the benefits of immunisation clearly outweighed any possible harm. Confidence in the vaccine was gradually restored and immunisation rates are now at a record high. 1992 was the first year when no deaths from pertussis were recorded in the United Kingdom. On p 1171 Miller *et al* report on a 10 year follow up study of nearly 1200 children in the national childhood encephalopathy study who had severe acute neurological illnesses in early childhood, and of their controls, to evaluate their current educational, behavioural, and neurological status. Case children were much more likely to have some form of dysfunction than controls, and those whose original illness was associated with recent pertussis vaccine were no different in this respect from others. However, the number of cases associated with vaccine was extremely small and the authors do not consider that the results affect their original conclusions nor that they should influence current advice on the use of pertussis vaccine.

Preregistration year leaves much to be desired, though training has improved in Thames regions

In 1988 Gillard and colleagues surveyed the quality of training for house officers in the Thames regions. In 1992 they repeated their survey, including new questions on workload, among house officers in the Thames regions and four other English regions. In their first paper (p 1176) they compare the 1988 and 1992 data for the Thames regions, to assess the impact of the GMC's new guidelines and the University of London's proscription of non-educational activities in the preregistration year. They found that house officers are now better prepared for their posts, with more training in pain control and communications skills and more induction courses, and their hours of duty are less. However, they have fewer patients under their care, are less satisfied with their clinical experience, and are less likely to recommend their post.

In the second paper they report the education and workload of 1146 house officers in eight regions (p 1180). They found appreciable differences between regions. Most house officers had attended induction courses, but over half had not been trained how to break bad news or control pain. Respondents complained about inappropriate tasks and long hours. Fifty seven per cent would encourage a friend to apply for their post, but only 24% would encourage a family friend to pursue a medical career. The authors conclude that heavy workloads and inappropriate tasks still dog the preregistration year.

Fundholders control drug costs better than non-fundholders

Although several evaluations of general practice fundholding have now appeared, little work has been done on the prescribing element of the funds. In this week's *BMJ* two groups have compared prescribing costs between fundholders and non-fundholders. Maxwell and colleagues, studying practices in two Scottish regions, converted prescriptions for drugs from 11 sections of the *British National Formulary* into standard volumes using the World Health Organisation's defined daily doses. They found that both fundholders and non-fundholders reduced their volume of prescribing from November 1990 to October 1992, though overall costs per patient rose (p 1190). Cost per volume, however, increased less among fundholders. Bradlow and Coulter, who compared prescribing costs among non-fundholders and dispensing and non-dispensing fundholders in Oxford region, found that both the number of items prescribed and their cost rose between 1990-1 and 1991-2, but they rose less in fundholding practices than in non-fundholding practices (p 1186). Both dispensing and non-dispensing fundholders showed the same pattern, with both increasing the proportion of generic drugs prescribed. Both groups of authors conclude that fundholding seems to have curbed increases in prescribing costs.

Early screening and early treatment will prevent diabetic retinopathy

The St Vincent Declaration from the World Health Organisation and the International Diabetes Federation includes the aim of reducing the incidence of blindness due to diabetes by a third. In this week's fortnightly review Eva Kohner claims that effective screening programmes are essential to achieve this (p 1195). Screening will work, she argues, because early retinopathy has no symptoms and because early treatment with photocoagulation to prevent the formation of new vessels can prevent visual loss. Good control over blood glucose concentrations should also reduce both the incidence and the progression of retinopathy in insulin dependent diabetes, though there is little evidence of an effect in non-insulin dependent diabetes.