spermatocytes. After three years with a gluten-free diet seminal analysis in 1958 showed a sperm count of $45 \times 10^6/\text{ml}$ with 90% active progressive motility and normal morphology, and a second testicular biopsy, apart from slight capsular thickening, was essentially normal. He married in 1960 and his wife gave birth to a normal male child.—I am, etc.,

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1 Foss, G. L., *British Medical Journal*, 1962, 2, 368.

Relative Cost of Drugs

SIR,—As the cost of the N.H.S. soars attention is, rightly, being paid to reduction in expenditure wherever possible. The Department of Health and Social Security's contribution to cost-consciousness in prescribing is the circulation of bar graphs showing, with immediate visual impact, the relative costs of different medicaments in a therapeutic group. While the small print makes disclaimers the result of this visual approach is to suggest that the drugs mentioned are of equal dose and benefit. The absurdity of these comparisons has reached its apogee in the recent handout "Drugs used in Rheumatic Diseases." The cost of 100 tablets of each of six preparations—soluble aspirin B.P., Brufen, Indocid, Fenopron, Orudis, and Naprosyn—was compared. The only logical comparison is of the usual recommended starting dose of each preparation, the dose of aspirin being the minimal anti-inflammatory dose (12 tablets). Such a comparison yields both a difference in order of cost and a narrowing of the gap between different preparations (table I).

TABLE I—Comparison of Costs of Different Medicines in a Therapeutic Group in Relation to their Dose

Preparation	Cost/100 Tablets (£)	Starting Dose/Day	Days/100 Tablets	Cost/Day (p)
Soluble aspirin B.P.	0.24	12	8½	2.9
Brufen	2.06	6	16½	12.4
Indocid	2.54	3	33½	7.6
Fenopron	3.09	3	33½	9.3
Orudis	5.31	3	33½	15.9
Naprosyn	7.70	2	50	15.4

TABLE II—Preference of 200 Patients and 72 General Practitioners for Dose Frequency of Drugs

	Mean Preference Scores (%) for:			
	Once Daily	Twice Daily	Thrice Daily	Four Times Daily
Patients	73	67	56	38
Doctors	74	70	49	31

Publicity of this kind is counter-productive for two reasons. Firstly, those with a knowledge of the comparative doses of these drugs will immediately dismiss this pamphlet, and by association all others from the same source, as misleading nonsense. More tragically, this approach militates against preparations which require reduced tablet intake and less frequent dosage. In a survey which we have recently completed patients and general practitioners were asked to score the various features of anti-rheumatic therapy. Both groups showed a significant preference for reduced dosage frequency (table II). Departmental denigra-

tion of these desirable features might prejudice further attempts to ease the burden of medication in patients with long-standing disease. At best this shows a lack of appreciation of the problems; at worst a heartless contempt for the patients' needs.

Finally, a pharmaceutical company claiming a cost benefit for its product by comparing the price of eight days' treatment with 50 days' of a competitor would be considered unethical. Why should the D.H.S.S. adhere to any lesser ethical standard?—We are, etc.,

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Late Recurrence of Thrombotic Thrombocytopenic Purpura

SIR,—In their report on "Late Recurrence of Thrombotic Thrombocytopenic Purpura after Splenectomy" Dr. D. J. Howard and his colleagues (10 May, p. 317) use the term "unique" in referring to their case and also state that "late recurrence of T.T.P. has not been described."

A case was seen by me in 1956, and subsequently published,¹ of several relapses and recurrences over a period of 18 years before the final fatal episode. Histological proof of the existence of the characteristic lesion was found in a breast biopsy performed three years before death. This publication included a résumé of cases reported in the literature to date in which late recurrences had been described. One of them² was of a patient whose condition recurred two years after splenectomy, as in the case described by Dr. Howard and his colleagues.

This all makes me to reflect a little sadly and shake my not too grey locks and wonder how recent is recent, how old is old. Eheu! fugaces, Posthume, Posthume.—I am, etc.,

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1 Cahalane, S. F., and Horn, R. C., *American Journal of Medicine*, 1958, 27, 333.

2 Meachan, G. C., Orbison, J. L., and Heinle, R. W., *Blood*, 1951, 6, 706.

Teaching of General Anaesthesia in Dental Schools

SIR,—Your leading article "Deaths in the Dental Chair" (8 February, p. 293), in common with subsequent correspondence, fails to recognize a contentious point. There is much which suggests that the dentists concerned believed that they were using "intravenous sedation" and not general anaesthesia. If this is so, then dentists are at complete cross purposes with anaesthetists and others who discuss these fatalities. It is instructive to look at the situation from this view.

In your report of the inquest on one patient who collapsed under methohexitone anaesthesia (10 August 1974, p. 419) the dentist, describing his technique, mentions giving a dose of methohexitone and then waiting "for an eyelash reflex" before proceeding to operate. The evident intention is to ensure that the patient is merely sedated and not unconscious; the reason for failure of realization of this good intention is to be

found chiefly in the dentists' education. Accounts given of this suggest that in anaesthesia and sedation their education has sometimes been superficial and empirical in the extreme and has often been based on an anachronistic undergraduate training in general anaesthetics. Dentists do not need "more anaesthetic training" as undergraduates nor "more postgraduate courses in sedation."

The whole of the dentist's education in general anaesthesia and sedation needs radical revision. By default of anaesthetists, the teaching of sedation is so largely in the hands of dentists and so cut off from the discipline of general anaesthesia that it becomes progressively more empirical and therefore potentially dangerous. Dental school practice of general anaesthesia needs complete rethinking if teaching of dentists is to be sound. The application of modern anaesthetic practice in the dental school is feasible; it has been achieved in the dental school of the University of Melbourne and an account of this will be published shortly¹ along with a review of the practical realities of the use of sedation by dentists.

Little will be achieved by mere condemnation of current practice by people who do not understand the problem.—I am, etc.,

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¹ Bell, J. M., *Clinical Dental Anaesthesia*. Oxford, Blackwell Scientific. In press.

G.M.C. and Indian Doctors

SIR,—May I, as an Indian doctor who came here before the N.H.S. came into being, be permitted through your columns to express an immigrant's view on the recent move by the General Medical Council to halt the reciprocal recognition of medical degrees between the U.K. and India (31 May, p. 512)?

There has recently been a marked increase in the number of articles and letters in medical journals casting aspersions on and in some cases suggesting the inferiority of overseas doctors. The Morrison Report¹ has done much to lend support and credibility to these ideas. On reflection it would seem to me that the authors of the report could have had only limited personal knowledge of overseas medical graduates and that their findings were based largely on second-hand information.

Not so long ago overseas doctors were tolerated and even welcomed here just so long as they remained willing to fill the junior hospital posts in the unpopular areas of the N.H.S. It was when they aspired to higher status in hospital services and general practice that the resentment and bitterness began to creep in.

The interests of the Government and the public on the one hand and those of the British doctors on the other would seem to be contradictory. Because of the emigration of British doctors, creating a shortage of manpower previously filled by Irish graduates who now find medicine here less attractive, the Government gave a qualified approval to overseas graduates in order to fulfil their statutory obligation to run a comprehensive N.H.S. In the view of British doctors and their organizations this has frustrated their