a patient with newly acquired right bundle-branch block? Though its appearance suggests the possibility of heart disease it is not specifically related to any condition. A simple history and examination should show up any apparent underlying cardiovascular disease needing treatment. Regular follow-up is justified; but in the absence of any other clinically evident cardiovascular abnormality patients should not have their activities restricted, nor should they need invasive investigation.

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Drug information for patients: keep it simple

What should patients be told about the drugs they take? How should they be told and who should tell them? Should they even be given any written information at all? And, if so, who should produce it and how should it be designed? These were some of the questions tackled by a recent meeting of the Medico-Pharmaceutical Forum.

The conference agreed that oral instructions from the doctor are not enough: doctors sometimes fail to give them, and patients often either do not understand or forget them. Many studies have shown the frightening results of incomprehension and forgetfulness; and instructions on the bottle, which seem simple and uncomplicated to the doctor and pharmacist, are often either wrong or misunderstood as well. These failings seem to make a case for clear written instructions to be given with the drug, but problems remain.

Carefully designed written information can improve compliance with drug taking, the conference was told, but studies of some leaflets have failed to show any improvement. The design of the leaflet is all important, and too many are overlong, overcomplex, and incomprehensible to many patients. The size of the leaflet, the language used, the typeface, layout, illustrations, and the explicitness and specificity of the content are all vitally important, and a deficiency in one aspect may render the leaflet useless. Yet the Medicines (Leaflets) Regulations of 1977 require pharmaceutical companies to include with their drugs either no information at all or a layman's version of everything that is given in the data sheets the doctor receives. This is patently absurd, and the conference thought that a good case could be made for repealing these regulations, although one drug company claimed that the Department of Health and Social Security would allow simpler instructions to be provided in addition to the layman's data sheet.

The problem of who is to produce such leaflets is difficult. Nobody seemed enthusiastic that it should be the drug companies alone, and anyway in Britain only about 20% of medicines are given to the patient as they come from the manufacturer: most are repackaged. The conference heard a proposal that some kind of national body should be established to produce these leaflets. This would mean uniformity and standardisation of the leaflets, and efficient use of resources; doctors, pharmacists, psychologists, consumers, and others could all be represented on such a national body—which could start by designing leaflets for six common drugs, and then do pilot studies to estimate their effectiveness. But will the Government tolerate another quango, who will pay, and who will distribute the leaflets? These issues were not much discussed. Nor was another phantom hanging over the conference: the proposed changes in product liability law—the laws governing compensation for drug injury. The chairman asked that this issue—a complicated and controversial one—should be avoided, but new laws might require that extensive information should be given to patients on the drugs they take. Germany and Holland already require such information.

Undoubtedly we need well-designed leaflets giving clear information on drugs. We know something about designing such leaflets, but we have much to learn, and many doctors will be surprised by the simplicity and directness of the best leaflets. One well-known piece of equipment when it is bought new contains not only the usual complicated instructions but also a card saying: "We know nobody reads the instructions, but this is the one thing you must do, and these are the two things you must never do." This is perhaps the kind of leaflet we will need for drugs.

Outcome of pregnancy after cone biopsy

An inevitable consequence of cervical cytology screening is the problem of persistently positive smears in women who have not completed their families. Although a comprehensive screening programme does not change the rate of positive smears, it increases the number of young women who present for further investigation and treatment.[1] The traditional investigation, cone biopsy, has the advantage that it provides adequate tissue on which the pathologist can base his diagnosis, and at the same time the biopsy will be sufficient treatment to deal with the lesion in many cases.[2] On the other hand, cone biopsy is a mutilating procedure that may undermine the functional competence of the cervix during subsequent pregnancies.

Two studies[3 4] of the outcome of pregnancy after cone biopsy of the cervix found spontaneous abortion rates of 12% and 22% and premature labour rates of 7·5% and 9·5%. Although these premature labour rates seemed high, firm conclusions could not be drawn because women who have had cone biopsies tend to be of higher maternal age and parity and of lower social class than the general population. In a recent study Jones *et al*[5] compared the outcome of pregnancy in 66 mothers after cone biopsy with that in a carefully selected group of matched controls. They found that cone biopsy increased the premature delivery rate significantly from 5% to 18% and the incidence of low-birthweight babies from 8% to 21%. Although the difference fell short of formal significance, the caesarean section rate was also higher after cone