potential danger of such medicines and have taken steps to restrict their availability to the public except when required for genuine medical purposes. The council of the Pharmaceutical Society of Great Britain first warned the profession of the dangers of these drugs in March 1950¹ and issued a reminder in 1957.²

A second point worthy of mention is that there is no evidence to support the concept that the misuse of medicines is minimised by making them available only on prescription. Perhaps the most widely misused drugs are barbiturates, which have been responsible for more than 42 000 deaths in England and Wales since their introduction in 1906. All but 640 of these deaths occurred after 1936, when barbiturates were made a prescription only medicine. Moreover, although amphetamine was voluntarily treated as a prescription only medicine by most pharmacists in 1937, it was not made legally so until 1956. The misuse of amphetamines by teenagers increased greatly in the mid-1960s, many teenagers obtaining the drug from supplies prescribed as slimming pills or "pep pills" for their mothers, many of whom were also dependent on amphetamines.³ The current epidemic use of benzodiazepines cannot be due to irresponsible sales by pharmacists because they were made a prescription only medicine soon after they were launched on to the market in the early 1960s.

The current epidemic of amphetamine misuse in parts of the United Kingdom has, I suggest, nothing to do with doctors, pharmacists, pharmaceutical manufacturers, or wholesalers. Most of today's amphetamine misusers inject the drug intravenously, though some take it intranasally. Most of this material has been made illicitly and provides substantial profits for the "bathtub chemists" responsible for its manufacture. It is unlikely to be supplanted by the less satisfying and more expensive P classified proprietary products available from pharmacies, even if pharmacists were prepared to sell them.

Members of the public occasionally have a medical need for drugs such as the sympathomimetics. It seems heavy handed to insist that they see a doctor to obtain a prescription for the drug merely to prevent a few misusers from obtaining access to it.

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1 Council of the Pharmaceutical Society of Great Britain. Slimming preparations and "cold cures." *Pharmaceutical Journal* 1950;1:182.

2 Council of the Pharmaceutical Society of Great Britain. Slimming drugs. *Pharmaceutical Journal* 1957;2:125.

3 Advisory Committee on Drug Dependence. *The amphetamines and isyergic acid diethylamide (LSD)*. London: HMSO, 1970: 7-9.

Cough associated with captopril and enalapril

SIR,—Drs D M Coulter and I R Edwards provide further support for our suggestion that the cough associated with the use of converting enzyme inhibitors is found more commonly in women.^{1,2} Like Drs Coulter and Edwards, we noted that the onset of cough may be delayed for weeks, or occasionally several months, after treatment is started. Unlike them, however, we find that the period of recovery is of similar duration, and we believe that the lack of a close relation between the symptoms and the period of treatment may, at least partly, explain the long delay between the introduction of this class of drug and the recognition of cough as an adverse effect of treatment.

Our experience suggests that the incidence of this side effect may be closer to the 10% reported

elsewhere,³ though the cough is not always severe enough to merit withdrawal of treatment and, indeed, in patients with resistant hypertension may be preferred to the adverse effects of other drugs. We have also found in some cases that reducing the dose alleviates the symptoms. This does not necessarily conflict with the finding of Drs Coulter and Edwards that patients with cough were receiving similar doses of converting enzyme inhibitors to those not suffering from this side effect.

With regard to the cause of the cough, Drs Coulter and Edwards suggest that bradykinin or prostaglandin E₂ may play a part. The recent report by Nicholls and Gilchrist, describing six patients in whom treatment with the prostaglandin inhibitor sulindac improved or cleared the cough,⁴ would tend to support this hypothesis.

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1 Webb D, Benjamin N, Collier J, Robinson B. Enalapril induced cough. *Lancet* 1986;ii:1094.

2 Inman WHW. Enalapril induced cough. *Lancet* 1986;ii:1218.

3 Town GI, Hallwright GP, Maling T, O'Donnell TV. Angiotensin converting enzyme inhibitors and cough. *NZ Med J* 1987;100:161-3.

4 Nicholls MG, Gilchrist NL. Sulindac and cough induced by converting enzyme inhibitors. *Lancet* 1987;ii:872.

Nuclear magnetic resonance imaging

SIR,—Few radiologists have the experience usefully to add to Professor R E Steiner's admirable review of nuclear magnetic resonance imaging (20 June, p 1570). For those interested in musculoskeletal disease magnetic resonance imaging seems to be an essential tool in the study of the soft tissues, joints, spine, etc. Preliminary assessments of the economic implications of this are interesting and potentially cost saving.

As an example, Tyrrell has compared magnetic resonance imaging of the knee with diagnostic arthroscopy. The intra-articular findings were very similar, with imaging also showing extra-articular anatomy (findings presented at European congress on radiology, Lisbon, 1987). The magnetic resonance examination, using a fast sequence and three dimensional volume imaging, may be completed in 20 minutes. Thus the throughput, even including more complex examinations, could be 12-20 daily, so that the cost per patient would be of the order of £60-100. These figures are estimates based on the real costs of staffing and depreciation of a 1.0 tesla system.

The costs of diagnostic arthroscopy are thought to be much higher, the time taken overall much greater, and the possible morbidity not unimportant. As a result, in some centres in the United States magnetic resonance imaging is the procedure of choice for first assessment of problem knees. Furthermore, this particular example of efficient use of resources is not unique.

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Cervical smears: new terminology and new demands

SIR,—Professor P P Anthony and Dr R M Kelly (27 June, p 1687) claim that they have halved the expected number of cases of invasive carcinoma of the cervix in Exeter and North Devon by screening only half of the population at risk. This would

be a remarkable achievement if it were true. The data that they present, however, bear other interpretations.

Professor Anthony and Dr Kelly detected 518 potentially lethal lesions by cytological screening and estimate that 207 of these would have progressed to invasive cancer. Of these cases, 145 would have occurred in Exeter. In the same period in Exeter 152 cases of cervical cancer were diagnosed. Only 44% of these cases, however, were from the unscreened or inadequately screened population, the rest occurring in the screened group. Thus the unscreened population generated around 67 cases, while the screened population produced 85 and, according to the authors, would have produced 230 cases in the absence of the screening programme. Obviously, there is a flaw in this argument, as it is well known that cytology screening programmes select the low risk rather than the high risk half of the population.

There are two possible explanations for these findings. The first is that most of the cases of intraepithelial neoplasia will not progress to invasive cancer. If this is true it carries important consequences for immune surveillance in carcinogenesis. The second possibility is that most cases of intraepithelial neoplasia would progress over a longer period and that we can thus expect a large increase in the incidence of invasive carcinoma, particularly in the unscreened population, in coming years. If the second explanation is correct then the views expressed by Professor Anthony and Dr Kelly are unfortunately complacent.

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The art of debate?

SIR,—On the last day of the recent annual representative meeting in Bristol, when the section on the acquired immune deficiency syndrome was being debated, one of the priority motions was so altered by amendments that the gist of the original motion was reversed. I refer to motion 364. The final amendment was suggested after a short adjournment and approved after further debate.

There was less time for formal debate on the much amended motion than was spent on the somewhat chaotic, and at times heated, debate on the amendments. The use of amendments in debate may serve as a spoiling tactic and may stifle the more open style of those representatives less familiar with the procedures. It was all very democratic, but the final form of the amended motion was so different from the original that if anyone had intended to vote for the motion as it stood on the agenda paper they would have had to vote against the amended motion merely to express disapproval, as the meaning of the motion was so completely changed that it lost the sense of the original. Even the television crews were baffled and gave up on this one.

Perhaps standing orders should be revised again to place certain restraints on amendments to prevent motions being turned inside out and also strictly to limit the time allowed for debating amendments, with extra time being reserved for amendments so that they do not count against other motions in the same section. Then there might be time to debate some of the other motions on the agenda that at present are lost through lack of time.

Perhaps I am carping; perhaps I am mistaken in my understanding; but I think that I am not alone in thinking as I do.

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