Government had to act where we had failed. Have the Representative Body and those who agree with Dr. O. Ive (23 August, p. 487) considered fully the implications of a refusal to adopt effective controls over the prescribing of barbiturates? The total amount of barbiturates prescribed has been reduced but, largely because of the thoughtlessness of many doctors, they are still available almost everywhere. Unaffected by inflation the going price of Tuinal remains around 5p a capsule.

Dr. Ronald Maggs (23 August, p. 487) sees the other side of the coin, the deteriorated behaviour of those who become dependent and the distress of their relatives and friends. Mortality is a poor indication of morbidity, but since January 1967 10 patients attending the Brighton drug dependency clinic have died; of these 10 deaths, nine were associated with the misuse of barbiturates.—I am, etc.,

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Prescribing Habits

SIR,—The report of a tape-recorded discussion "Are Our Barbiturates Really Necessary?" (2 August, p. 285) and in particular some of the comments made by Dr. A. Elithorn prompt me to express some of my views as a pharmacist on prescribing in general.

It seems to me that whenever anyone—doctor, pharmacist, or layman—suggests that prescribing habits should be examined cries of "infringement of clinical freedom" are raised. Whatever this is, in 1975 it cannot be used to explain, justify, or cover up the reckless and irrational prescribing that does occur. All those involved in the use of drugs should be concerned with the safety, efficiency, and economy of drug treatment and safe, efficient, and economic prescribing can result only if the following questions are asked after diagnosis: (1) Does the patient need drugs? (2) Which drug or drugs? (3) What is the acceptability, side effect, or possible interaction of the treatment? (4) How much? How often? How long?

How many doctors ask themselves these questions and how many for convenience or because of patient expectation or pressure prescribe often relatively large quantities of potent drugs for which the patient may have no real need? From surveys of unused medicines returned to pharmacies for destruction we can assume that a large proportion of the drugs purchased annually by the N.H.S. are never used by the patients for whom they were prescribed. In many cases after the first few doses have been taken the remainder lie unused in the patient's home just waiting to be misused or to add to the poisoning statistics. At least 25% of patients omit doses, fail to complete a course of treatment, or do not take the medication at all, and yet some of these patients will return month after month to the doctor for repeat prescriptions, and for many of these the patient will not see the doctor but the receptionist, who often even writes the repeat prescription. This gives rise to some interesting prescriptions and is a practice which I hope all doctors would agree should be discouraged.

While I appreciate that the whole concept of the control of prescribing is a sensitive

area which tends to be regarded as an infringement of so-called clinical freedom, it is high time that some prescribing habits were subjected to critical examination and it is heartening to see that some doctors are making a start on this.—I am, etc.,

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Drugs for Addicts

SIR,—Since my last letter (12 April, p. 88) we at this unit decided to use the approach described therein with addicts of opiate type in a neighbouring area. Fourteen of the 28 addicts known in this area were invited to use their drugs under supervision daily at the regional centre. Within four weeks 10 unknown drug users came forward to request notification. It is obvious that the prescribing of drugs through local pharmacists was allowing a large number of other people to become addicted.

I think it is time for the country as a whole to rethink its prescribing policy for addicts and that to treat addiction must surely mean that one must treat the individual and only the individual and not allow him to be a pusher for interested youths.

It is worth pointing out that it has become habitual for some concerned persons to "play down" the drug scene, but while this may be productive in focusing on larger problems (for example, alcoholism) it is counterproductive in tackling the drug problem. Surely one does not have to deny a smaller problem to face a larger problem. There are far more addicts than are officially recognized.—I am, etc.,

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Aetiology of Optic Neuritis

SIR,—Your leading article (2 August, p. 265) does not define optic neuritis. Most ophthalmologists and neurologists recognize the syndrome¹ as usually occurring (1) between the ages of 20 and 50 years, (2) with a sex incidence showing a predilection for the female of three to two, and (3) presenting with unilateral blurred vision, (4) most commonly a central scotoma, (5) accompanied by pain on movement, and (6) resolving, with or without treatment,² within a few weeks, and (7) leaving a residual temporal pallor of the optic disc.

This syndrome is not caused by diabetes; indeed, it is likely that when diabetes causes optic atrophy it does so only secondarily by its effect on blood vessels, save for a rare genetic association.³ Nor is this syndrome caused by pernicious anaemia, which occurs in an older age group, with bilateral visual failure, without pain, and improving only with vitamin B₁₂ therapy. Optic nerve compression may present with a unilateral central scotoma, but this field defect is progressive and often "breaks through" to the peripheral field; remission is exceptionally rare, occurring only in cystic lesions such as aneurysm.

Similar criticisms can be made of the

other putative causes mentioned by you and the confusion probably arises from equating the syndrome of optic neuritis, as delineated above, with other optic nerve lesions. With an experience of several hundred cases of optic neuritis I have not been convinced of any cause other than a plaque of demyelination in the optic nerve.

The follow-up figures of those developing multiple sclerosis are taken only from retrospective studies, where transient symptoms and signs indicative of multiple sclerosis might not be recorded. In a prospective study the incidence of multiple sclerosis increased with the follow-up period.¹

I agree that "multiple sclerosis has an overall prognosis which is relatively milder than was once believed," but the evidence that it is even better in those presenting with optic neuritis may be artefactual in that follow-up studies of patients presenting in other ways—for example, Brown-Séquard syndrome or brain-stem demyelination—have not been so extensive.—I am, etc.,

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¹ Rose, F. C., in *The Optic Nerve*, ed. J. S. Cant, p. 217. London, Henry Kimpton, 1972.

² Bowden, A. N., et al., *Journal of Neurology, Neurosurgery and Psychiatry*, 1974, **37**, 869.

³ Rose, F. C., et al., *Quarterly Journal of Medicine*, 1966, **35**, 385.

* * The features included in Dr. Rose's definition apply only to the majority of cases; patients with undoubted optic neuritis may not have one or more of the criteria outlined. For instance, undoubted cases are seen outside the ages stated, attacks may occasionally be bilateral, pain is not always present, and remission may take several months rather than weeks. We would certainly not accept that patients without all these diagnostic features cannot be accepted as having optic neuritis.

Certainly it is rare for the syndrome of optic neuritis to be caused by conditions such as diabetes mellitus, pernicious anaemia, and optic nerve compression, and often in these cases there are a number of features which are not typical of optic neuritis. Nevertheless, one must consider these very treatable causes, which may present a similar or at times identical clinical picture of optic neuritis.

Finally, several studies have been undertaken where follow-up has been similar in patients presenting with optic neuritis, the Brown-Séquard syndrome, and brain-stem demyelination; all have supported the conclusion that optic neuritis carries the best prognosis with regard to later multiple sclerosis.—ED., B.M.J.

SIR,—Your leading article on this subject (2 August, p. 265) points out that since "only a proportion of patients with optic neuritis later develop indications of multiple sclerosis it would be helpful for prognosis to have some test to distinguish them."

Before our work was interrupted by circumstances beyond our control we had in fact begun a prospective study based on the linoleic acid depression (L.A.D.) test for multiple sclerosis (M.S.).^{1,2} We had studied nine patients who presented with retrobulbar neuritis. Of these, four gave results in the L.A.D. test ranging between 91.9 and 91.3%