access for a large group of patients to a department which is already overstretched to the extent that most ophthalmic departments in this country are is quite frightening.

The other important point to make, particularly to general practitioners, is that senile disciform macular degeneration, which is the condition under discussion, is a separate subgroup of the range of degenerations which occur at the macula. Most doctors are aware of the atrophic "dry" senile macular degeneration, but not many, in my experience, are aware of this subgroup, which has a separate and distinct clinical appearance and aetiology. This distinction is important to make because no eye department can cope with a sudden influx of urgent referrals of patients with atrophic macular degeneration over the next few months. It is also important for referring doctors to realise that their patients are not receiving an inferior service from their local consultants merely because the laser is not being fired at them with gay abandon.

E DAVID ALLEN

Eye Infirmary,
Sunderland SR2 9HP

[1] Grey RHB, Bird AC, Chisholm IH. Senile disciform macular degeneration; features indicating suitability for photocoagulation. *Br J Ophthalmol* 1979;**63**:85-9.

Screening for fetal malformations

SIR,—The letter from Dr R C M Cook and others on screening for fetal malformations makes sound medical and common sense (2 April, p 1149). Their final paragraph echoes a sentiment with which every doctor would surely agree. Indeed, surgeons already regard the fetus with a correctable congenital defect as a "patient."[1] The authors mention a condition, exomphalos, which can be diagnosed in utero by ultrasound but which must await delivery before surgical treatment can be instituted. There are other fetal conditions which can now be diagnosed and treated in utero. Fetal medicine is one of the most exciting fields in our health care delivery system, and the fetus should now be seen as a small but important patient.[2]

PATRICK W GILL

Neath General Hospital,
Neath,
Glam SA11 2LQ

[1] Harrison MR, Golbus MS, Filly RA. Management of the fetus with a correctable congenital defect. *JAMA* 1981;**246**:774-7.
[2] Johnson ML, Hattan RA, Rees K. The normal fetus. *Semin Roentgenol* 1982;**17**:182-9.

Cimetidine for symptomatic treatment of duodenal ulcers

SIR,—With the number of patients with duodenal ulcer examined by Dr P Lance and Dr B G Gazzard (19 March, p 937) it is possible that a difference in efficacy between treatment protocols as large as 40% was missed.

To detect this difference, where success rate in one of the protocols was 15% and in the other 55%, would require at least 17 (one tailed) or 21 (two tailed) patients in each group. This would give a one in 20 chance (80% power) of missing that difference if it really existed.[1] To detect a 20% difference in efficacy, with the same power, would require 75 (one tailed) or 96 (two tailed) patients in each group.[1]

The suggestion that cimetidine could be taken only until resolution of symptoms is premature and could be dangerous. A much larger study is needed with endoscopy for both groups being performed after the same time interval.

KEVIN A CLEUR

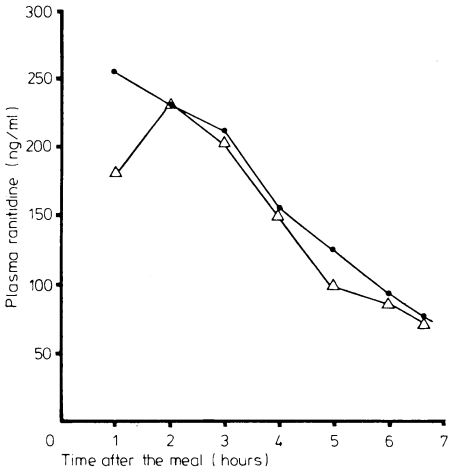
Tewin,
Herts

[1] Cochran WG, Cox GM. *Experimental design*. 2nd ed. Chichester, Sussex: John Wiley and Sons, 1957: 24-5.

High dose of antacid reduces bioavailability of ranitidine

SIR,—Dr G W Mihaly and others (9 October, p 998) showed a reduced bioavailability of ranitidine when this drug was given with high doses of antacids in fasting volunteers. In common prescribing practice, however, the H_2 antagonist is given with a meal and the antacid is given one to three hours after the meal. When this schedule of drug administration is followed there is no reduction of bioavailability of ranitidine,[1] which is consistent with the suggestion that the interaction between antacids and the H_2 receptor antagonists is at the level of gastrointestinal absorption.

On two occasions ranitidine 150 mg was given to 11 volunteers at the beginning of a meal. On one of these occasions the subject also received Link antacid (aluminium hydroxide and magnesium carbonate, neutralising capacity 20 mmol for each tablet) two tablets one and three hours after the meal. Ranitidine concentration in plasma was measured (figure). The areas under the plasma



Ranitidine concentration in plasma after taking ranitidine 150 mg with a meal without (●) and with antacid (△) (Link) tablets one and three hours after the meal. Median values in 11 subjects.

concentration curves showed no difference between treatments. The buffer capacity of the antacids used in our study was low compared with the dose used by Dr Mihaly and others but, nevertheless, this dose proved to be effective in ulcer healing.[2]

Dr Mihaly and others end their article with the statement: "Since the effect of ranitidine on secretion of gastric acid is closely related to the plasma concentration . . ." This is not always correct. Gugler[3] has shown such a relation, but only under constant pentagastrin stimulation. Other studies, including ours,[1] have shown no correlation between plasma concentration of ranitidine and acid inhibitory effect. We think that the concentration of ranitidine at the parietal cell is of importance for the effect, and the blood concentration does not accurately reflect this concentration. Owing to competitive interaction the effect/parietal cell concentration may depend not only on the dose of exogenous histamine[4] but also on the degree of meal stimulation.[1]

KARIN FRISLID
ARNOLD BERSTAD

Medical Department,
Lovisenberg Hospital,
Oslo,
Norway

[1] Berstad A, Frislid K, Rydning A. Relationship between ranitidine plasma levels and reduction of postprandial intragastric acidity in healthy man. *Scand J Gastroenterol* 1982;**17**:109-12.
[2] Berstad A, Rydning A, Aadland E, Kolstad B, Frislid K, Aaseth J. Controlled clinical trial of duodenal ulcer healing with antacid tablets. *Scand J Gastroenterol* 1982;**17**:953-9.
[3] Gugler R, Guntram F, Dieckmann M, Somogyi AA. Cimetidine plasma concentration-response relationship. *Clin Pharmacol Ther* 1981;**29**:744-8.
[4] Konturek SJ, Obtulowicz W, Kwiecień N, Kopp B, Oleksy J. Kinetics and duration of action of ranitidine on gastric secretion and its effect on pancreatic secretion in duodenal ulcer patients. *Scand J Gastroenterol* 1981:**16**;suppl 69:91-9.

Problems of manpower statistics

SIR,—Dr G R Struthers and others (19 March, p 982) have drawn up a table which indicates that there is one current National Health Service senior registrar in rheumatology in the South West Thames region whereas there are in fact three. Their method of obtaining data was "personal contact with individual units."

This illustrates a major problem in all discussions on manpower—namely, how can one obtain accurate and up to date data? In the South West Thames region the medical education information and career system (MEDICS) is available for the purpose, but until similar systems are operating in all regions the problem will remain. In the meantime doctors and politicians who so wish can continue to follow careers as "medical manpower advisers" safe in the knowledge that whatever strategy is adopted to remedy the problem it will, in all probability, only confound it and give them more to talk about.

I sincerely hope that the Körner Steering Committee Working Group E's initiative in this field will be fruitful. Then perhaps a career in medicine will be more secure than one in advising on the hospital career structure.

R S VINER
Information Service Manager,
South West Thames

British Postgraduate Medical Federation,
London NW1 5HD

Correction

Medical effects of nuclear war

We regret that in the letter by Dr A M Carroll (2 April, p 1150) the Medical Campaign Against Nuclear Weapons was wrongly referred to as the Medical Campaign Against Nuclear War.