fails, we have not found epidurals effective.[3] The small studies quoted by Bush did not have root compression confirmed radiologically. Lumbar epidurals may help, but the indications remain unclear.

Pickin was correct in spotting the illusory angle of the chair seat. Many do find a small wedge helpful. The easel illustrated had a variety of angles, including one of only a few degrees for writing. The block Pickin described would not inhibit cervical flexion effectively.

The importance of the potential for stopping smoking in prevention was emphasised in table I of the review and subsequently in correspondence. Secondary prevention is the philosophy underlying the education provided by general practitioners and back schools.

Indications for radiology do need definition. I emphasised that (*a*) radiology has a therapeutic role, distinct from its diagnostic role—a point ignored by the Royal College of Radiologists' guidelines[4]; (*b*) specificity in films requested saves radiation and expense; (*c*) large central disc protrusions may have no lateralising symptoms or signs, can be diagnosed on scans, and have implications for activities likely to aggravate back pain (box H in the review); and (*d*) ankylosing spondylitis (prevalence 1%; diagnosis often delayed) requires specific investigation.

In vivo research is needed on the relation between the vascular supply to the spine, smoking, aortic atheroma, ischaemia, and back pain. I have seen one patient with claudicant back pain related to abdominal aortic stenosis.

The emotional aspects of the subject were not neglected (figure 1, therapeutic options, and boxes B, E, I, J in the review). The back pain epidemic is not due to psychogenic causes, although emotional factors may predispose to a poor outcome.[5] Criteria for the diagnosis of emotional distress have been refined for low back pain.[6]

Musculoskeletal disorders are often taught and managed poorly. At Northwick Park we have developed a clinical directorate of rehabilitationists, rheumatologists, and orthopaedic surgeons striving to give a comprehensive service for those suffering from musculoskeletal complaints. I would prefer better training for existing specialists and more adequately trained specialist therapists rather than an additional specialty of musculoskeletal medicine.

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Visual function in thallium toxicity

EDITOR,—David Moore and colleagues highlight the systemic features of two cases of sublethal thallium poisoning.[1] Both patients had the classic signs of thallium toxicity, including alopecia and peripheral neuropathy, which had prompted the diagnosis. The ophthalmological features included reduced visual acuity as measured with a Snellen chart and abnormality of colour vision (type not specified), which caused "odd" colour adjustment on the first patient's television set. The question of ocular insult by thallium as the underlying cause of this colour defect was raised.

Recently we investigated, in the ophthalmology department, a patient with proved sublethal thallium poisoning with classic systemic features. The corrected visual acuity measured with a Snellen chart was 6/6 in the right eye and 6/12 in left. The anterior segments, pupillary responses, and optic discs were normal. Contrast sensitivity, however, was diminished across all spatial frequencies, and colour vision was defective in both eyes. Further assessment established tritanomaly (blue colour defect) as the principle defect of colour vision. Automated perimetric tests showed a relative caecocentral scotoma. Optic atrophy ensued in the following two months.

Previously reported ophthalmological features of thallium poisoning include loss of the lateral half of the eyebrows, skin lesions on the lids, ptosis, seventh nerve palsy, internal and external ophthalmoplegia, and nystagmus. Non-inflammatory keratitis and lens opacities have also been described.[2] Optic atrophy as a sequel to toxic optic neuropathy induced by thallium is well reported.[3] The changes in visual function are essentially those related to the damage to the optic nerve. Electrophysiological studies often show abnormalities of the electroretinogram and a delayed visual evoked response. Animal studies showed that the retina, particularly the photoreceptor layer, is susceptible to the effect of thallium and that the degree of impairment depends on the time of exposure and the dose.[4]

This case shows that the defect of colour vision encountered in thallium intoxication is primarily a tritanomaly. Furthermore, the contrast sensitivity is abnormal before other clinical signs of toxic optic neuropathy develop. We believe that tests of contrast sensitivity and colour vision are useful in the early detection of optic neuropathy in thallium intoxication.

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Who should pay for in vitro fertilisation?

EDITOR,—It is clear from Sharon Redmayne and Rudolf Klein's comparison of three purchasing authorities who paid for in vitro fertilisation treatment with three who did not[1] that some women from the latter purchasing authorities are going to have to pay for their own treatment. If they couldn't afford to do this, where could they turn for financial help? Why not a pro-life organisation? I contacted the three main pro-life organisations: Life, the Society for the Protection of the Unborn Child, and the Roman Catholic church.

Peter Garrett said that Life did not support unnatural methods of fertility or methods that weren't in a mother's best interests, so "no" to a woman wanting financial support for in vitro fertilisation. However, Life was providing about £16 000 towards the development of a procedure called natural embryo sonographic transfer, which would enable women to enhance their own fertility naturally—or rather, using ultrasound.

Paul Tulley of the Society for the Protection of the Unborn Child had a largely similar view, but was less scathing about gamete intrafallopian transfer. He felt that the society might consider financially helping a woman having this treatment. However, like Life, it had—up until now—never been asked. He also pointed out that the society financially assists active fertility research, although not in England.

Jean Judge from the Catholic Marriage Advisory Council was delightfully direct: "The Pope has outlawed IVF." But what if the husband is a Catholic and the wife is not? "Oh, that sounds like those lovely adolescent Catholic questions about condoms—is it okay if the partner who isn't a Catholic uses birth control methods. Of course not. It is a question of intention." So the Catholic view of infertility is that it is a natural handicap and you have to put up with it. But, for instance, phenylketonuria is a natural handicap; surely one shouldn't withdraw screening or a dietary treatment? And so on. However, the Catholic church has an extensive counselling service for infertile women, and supports research indirectly through the Linaker Society and Guild of Catholic Doctors.

It seemed clear that if a woman wanted financial support for in vitro fertilisation she would be best advised either to approach her local clinic (some offer free treatment but charge for drugs) or her own health authority on the grounds of inequality of access to treatment or, most usefully, a women's reproductive rights organisation such as the Women's Health and Reproductive Rights Information Centre in London.

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Nestlé supports international code

EDITOR,—I am amazed at the attention given by the *BMJ* to the antics of Ms Patti Rundall and fellow activists in Lausanne.[1] As Luisa Dillner's article might give undeserved credibility to allegations disseminated by groups such as the International Baby Food Action Network I wish to put the record straight.

Nestlé in Brazil has been supporting postgraduate courses organised by the Brazilian Paediatric Society for the past 37 years; this year saw the fiftieth such course. The scientific programme is entirely the responsibility of the society. Participants pay their own expenses. This year, because of the special nature of the event, the society asked Nestlé to offer free places for young doctors to participate in the course. Nestlé had no part in selecting the beneficiaries.

With regard to the alleged violation in Manila of the World Health Organisation's code on the marketing of baby milk formulas, it is true that employees of Nestlé gave samples of milk products and cereal foods (not infant formula) to mothers in health care facilities. When this matter was drawn to the company's attention the Nestlé subsidiary in Manila was immediately instructed to cease such distribution. Any genuine breach of the spirit or letter of the international code would be treated equally firmly and expeditiously once the facts had been ascertained. This is important in view of Ms Rundall's claim that the Nestlé infant formula audit commission replied to only five of 114 complaints against Nestlé before it was disbanded in June 1991.

In fact, the chairman of the Nestlé infant formula audit commission, Senator Edmund Muskie, returned over 20 complaints to Ms