

however, is open to error. A considerable educational effort would be required to alter established prescribing habits. To complicate matters further, the title of the products on the datasheet does not reflect the name printed on our stock of the reformulated product. Omnopon Paediatric is actually packaged and labelled as Omnopon 10 with no reference to paediatric on the box.

We believe that the risk of the wrong strength of Omnopon being prescribed and administered is great and does not warrant its continued use.

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1 Committee on Safety of Medicines. Genotoxicity of papaveretum and noscapine. *Current Problems* 1991 June (No 31).

*We sent this letter to the manufacturer, who replied as follows.

EDITOR,—After *Current Problems* warned about the potential genotoxicity of noscapine Roche Products considered that there were two possible options. These were either to discontinue the product or to reformulate it without the noscapine component. The weight of opinion from the medical profession seemed to support a continuing therapeutic requirement for the mixed alkaloid preparation.

Having decided to reformulate Omnopon preparations, we reluctantly changed the prescribing recommendations to include doses expressed as volumes. This was thought to be less confusing than listing the three ingredients separately as the active ingredient could no longer be referred to as papaveretum. This situation is likely to remain until such time as we can negotiate a redefinition of papaveretum or establish a separate term to encompass the three constituent alkaloids in their fixed proportions.

Meanwhile, we are listening to the views of those such as Diane Ketley and T O'Carroll and are looking at the best way of revising the product's labelling to minimise the possibility of dosing errors. A dosing chart for Omnopon is available from our drug information and surveillance department for easy reference.

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Visual problems in the elderly population

EDITOR,—R P L Wormald and colleagues confirm the common and disabling nature of cataract in the elderly population.¹ Unfortunately, the size of their study population produces confidence intervals too wide to be useful in planning and contracting.

To take an example, in the population aged 65 and over Wormald and colleagues quote the prevalence of cataract that reduced vision to less than 6/18 as 5.8% (95% confidence interval 3.0% to 9.9%). It is useful to know the prevalence of cataract that reduces vision to this level as patients are likely to complain of visual difficulties² and may be referred to an ophthalmologist.³ Such information may then be used to adjust activity levels in contracts. If the estimated prevalence and confidence interval are applied to a health district with a population of 45 000 people aged over 65, however, the estimated number of people affected is 2610, but with a confidence interval of 1350 to 4455. When factors such as relative contra-indications to intervention and refusal of treatment are quantified the variation in the number referred

and treated is likely to be even greater. Therein lies the difficulty for both purchasers and providers of health care.

Studies of incidence and prevalence provide an important measure of the burden of a disease in the community; unless these studies are rigorously conducted with a population of suitable size (in this case around 50 000; A K McCallum, unpublished MFPHM thesis) the implications for services are merely intelligent guesstimates.

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- 1 Wormald RPL, Wright LA, Courtney P, Beaumont B, Haines AP. Visual problems in the elderly population and implications for services. *BMJ* 1992;304:1226-9. (9 May.)
- 2 Trevor-Roper PD, Curran PV. *The eye and its disorders*. Oxford: Blackwell Scientific, 1984.
- 3 Featherstone PL, James C, Hall MS, Williams A. General practitioners' confidence in diagnosing and managing eye conditions: a survey in south Devon. *Br J Gen Pract* 1992;42:21-4.

Cataract in developing countries

EDITOR,—Andrew R Potter expresses a point of view with which few people would wish to disagree—namely, that if a technology is cheap and quick by all means use it.¹ We would add safety and efficacy as other important variables. Though intracapsular cataract extraction with correction of aphakia with spectacles is indeed inexpensive, quick, and, in good hands, a safe method of curing blindness due to cataract, questions have been raised about the quality of visual rehabilitation in the longer term. Intracapsular cataract extraction with correction of aphakia has been almost universally replaced by extracapsular extraction with intraocular lens implantation in those countries able to afford the necessary technology.

There are arguments for and against both intracapsular and extracapsular cataract extraction, either with or without intraocular lens implantation, in developing countries. The patients' requirements, the equipment and facilities available, and the training and experience of the eye surgeon dictate that the treatment of cataract will also differ according to local circumstances. Controlled trials addressing these complex questions are being undertaken, and their outcome should be awaited.

Potter refers disparagingly to the World Health Organisation's document on the use of intraocular lenses in developing countries.² Intraocular lenses are already being introduced in many developing countries. The purpose of the WHO report is to provide information to allow states to formulate their own policies in such a way as to avoid the mistakes made in the industrialised countries during the evolution of intraocular lenses while maximising the use of limited health care resources. We believe the report to be a valuable and forward looking document, which reflects the views of experienced ophthalmologists and international non-government organisations working in the developing world to eliminate curable blindness.

WHO's prevention of blindness programme has closely collaborated with a group of 10 non-government organisations, forming the consultative committee. The result has been the development of activities and programmes in 83 of 106 countries in which blindness is a public health problem. In addition, WHO, with non-government organisations, has organised workshops and produced publications on childhood blindness; the local preparation of low cost eye medicines; manpower development for eye care in Africa; low cost spectacle production; the distribution of ivermectin

for the treatment of onchocerciasis; and use of intraocular lenses for cataract surgery in developing countries. Rather than criticising WHO, those concerned with the control of blindness should be encouraging WHO's prevention of blindness programme for its valuable initiatives and its efforts to work together with ministries of health and non-government organisations to reduce blindness globally.

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- 1 Potter R. Developing countries and medical progress. *BMJ* 1992;304:1249. (9 May.)
- 2 World Health Organisation. Use of intraocular lenses in cataract surgery in developing countries. *Bull World Health Organ* 1991;69:657-66.

Adrenaline in allergic emergencies

EDITOR,—We disagree with the advice on the correct route for administering adrenaline in allergic emergencies given in both Thomas Hedner and colleagues' paper¹ and Gregory Y H Lip and Malcolm J Metcalfe's letter in reply.² The advice perpetuates the widespread ignorance among British junior doctors regarding anaphylaxis and misconceptions about the role of adrenaline.³ Intravenous adrenaline (5-8 µg/kg) is the foundation drug in treating grade III or IV anaphylactoid reactions (Ring's classification), and case reports of myocardial reactions with intravenous adrenaline do not stand close scrutiny.⁴

In an unpublished survey in which 30 senior house officers from all accident and emergency departments in the north west were interviewed (by MG) 21 did not name adrenaline as the essential drug for this treatable life threatening emergency and 27 did not know the dose and how to calculate the concentration of adrenaline in mg/ml from ampoules marked 1:1000 and 1:10 000.

Our department has now got a clear protocol for anaphylaxis, which is part of our induction course for new casualty officers.

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- 1 Hedner T, Samuelsson O, Lunde H, Lindholm L, Andrén L, Wiholm B-E. Angio-oedema in relation to treatment with angiotensin converting enzyme inhibitors. *BMJ* 1992;304:741-6. (11 April.)
- 2 Lip GYH, Metcalfe MJ. Adrenaline in allergic emergencies. *BMJ* 1992;304:1443. (30 May.)
- 3 Watkins J. Anaphylactoid reactions in anesthesia. *Int Anesthesiol Clin* 1985;23:17-40.
- 4 Sage DJ. Anaphylactoid reactions in anesthesia. *Int Anesthesiol Clin* 1985;23:175-86.

Altitude induced illness

EDITOR,—A J Pollard's editorial on altitude induced illness provokes me to make several partial refutations and further comments.¹

Firstly, not all rapid ascents to altitudes above 2500 m are characterised by acute mountain sickness. Indeed, in the Mount Everest region of Nepal the incidence of acute mountain sickness has been recorded as 49% among trekkers who flew to 2800 m.²

Secondly, the ascent schedule mentioned is not widely recognised.³ The rule of thumb should be that above 3000 m, each night should be spent on