Regular funduscopy should therefore be undertaken by expedition doctors to detect the presence of haemorrhages in otherwise symptomless people. Direct ophthalmoscopy in a darkened tent should be sufficient. While the presence of a small (diameter less than one half disc) uncomplicated haemorrhage may not necessarily be an indication for descent, certain factors may lead to long term damage to the eye—for instance, rebleeding, involvement of the vitreous, the presence of a detectable scotoma, or symptoms of early retinal detachment—and descent should be advocated when these are present. The desire to climb has to be balanced against the possibility of long term visual impairment.

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Dornase alfa for cystic fibrosis

EDITOR,—The use of dornase alfa has been a topic of recent controversy.[1-3] South and West region's development and evaluation committee of senior clinicians supported by a research review team undertook to determine the drug's cost effectiveness on the basis of the published evidence.[4] The net cost (total costs less savings) to the NHS of prescribing a daily dose of 2·5 mg of dornase alfa to patients with cystic fibrosis in the former Wessex Regional Health Authority, excluding children under 5 and patients with severe disease, would be £1 367 000 (1994 costs), or £5900 per patient per year, for no apparent survival benefit. This is despite savings, including 26% fewer days of treatment with parenteral antibiotics and an 18% reduction in inpatient stay. In the phase III trial lung function was marginally improved and the relative risk of developing a respiratory tract infection defined in the protocol was reduced. Patients in the trial were asked several questions about whether the quality of their lives had improved and the magnitude of the improvement. While the proportion who reported an improvement, and the magnitude of the improvement, was higher among patients receiving dornase alfa than among patients receiving placebo for several (but not all) questions, the changes in mean score were small and the net proportion of patients reporting an improvement was low.[4] When these data on effectiveness are translated into a cost-utility estimate the best possible calculation on present evidence would be an average cost of somewhere around £25 000 per quality adjusted life year. With better (longer term) evidence this would imply a "beneficial but high cost" treatment; that is a poor buy in comparison with other treatments, even for cystic fibrosis. For example, the committee similarly evaluated tertiary referral centres for cystic fibrosis that used treatments used before dornase alfa was marketed and found that the cost per life year gained was £1300.

The proved benefits of using dornase alfa may improve with further data from trials, but the marginal benefits of the drug taken together with its high cost do not warrant a headlong rush to use it before the results of further longer term trials are available. Work is now continuing locally to produce rigorous guidelines to ensure that only those patients sure to gain considerable benefits are treated with dornase alfa (Davis suggests 30% as derived from the results of the phase III trial[5]). It is not yet known which other patients will benefit over the longer term.

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Hospital management commended for first trimester spontaneous abortion

EDITOR,—I expected Kevin Forbes to find room in his editorial on the management of first trimester spontaneous abortions for two important aspects of the condition—the psychological and the paediatric.[1] His concentration on physical maternal factors omits to consider how a previously expectant mother may feel about continuing with a non-viable pregnancy for any longer than is necessary. The prospect of the abortion becoming complete in the home environment and the uncertainty over when or where this will happen are burdens that many women may not wish to contemplate. The best management that I have come across includes a clear discussion of the prospects, with the patient participating in the decision on whether evacuation is desirable. This may have beneficial effects on coping during what would have been the remaining gestation and at a similar stage in future pregnancies and is surely grounds for a controlled study.

From a paediatric prospective, samples vital for diagnosing chromosomal or congenital abnormalities—particularly in cases in which recurrent abortion ensues—may be lost if they are disposed of out of hospital.

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Mildly raised intraocular pressure is a risk factor, not glaucoma itself

EDITOR,—A P Booth and J S Hillman[1] object to Ronald Pitts Crick and Maurice W Tuck's sensible recommendations for referring patients with suspected glaucoma to the hospital eye service.[2] They do so on the basis of regulations covering the activities of ophthalmic opticians.

They state that "intraocular pressure of 22-25 mm Hg is a sign of disease or abnormality in the eye." Most specialists in glaucoma would disagree and consider this level of intraocular pressure to be a risk factor for the development of disease.[3,4] The value of 21 mm Hg as the upper limit of the normal range for intraocular pressure is the mean plus 2 SD. The distribution of intraocular pressure in the population is not gaussian, and so this normal range is invalid statistically. The prevalence of detectable glaucoma in white people with an intraocular pressure in the range 22-25 mm Hg is less than 5%, although some of these people will develop the disease later. Conversely, about 30% of patients with glaucoma have an intraocular pressure below this value.[5]

If all people with intraocular pressure in this range were referred to the hospital eye service our eye clinics would be overloaded with healthy patients. Their risk of developing glaucoma is similar to that of patients who have a first degree relative with glaucoma (this latter group is entitled to an eye test at taxpayers' expense). Both these groups require regular screening until a sign of disease develops. The community would be better served by ensuring that ophthalmic opticians provide a uniform and reliable service targeted at people at high risk.

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Being on first name terms may signify greater respect

EDITOR,—I enjoyed reading A L Wyman's views,[1] apparently also held by Katherine Whitehorn[2] on the formal British preference of being addressed by their surnames. Conventionally trained at a British medical school, I too initially had the same preference to maintain "respect and distance" from my patients. Thus, some years ago as a junior cardiology registrar in New Zealand, I was amazed to find how frequently first names were used between patients and doctors. I clearly remember the shock when first addressed as "Chris" by a respectful farmer, who I then struggled to call "Bob."

With time, however, I appreciated that the use of first names in New Zealand often reflects a patient's increased confidence in the doctor, which is to be earned, and that this term of address often signifies more, and not less, respect. I now think that a closer relationship is possible with this relaxed manner, which is of benefit to patient and doctor alike. Politeness, of course, still dictates an initial formal approach from both parties, which is usually maintained for more elderly patients, such as Dr Wyman's generation.

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Correction

Bone densitometry in clinical practice

An editorial error occurred in this letter by J E Compston (9 September, p 687); John Kanis and Cyrus Cooper were omitted from the authorship.