

## Viewpoint

### For every ill a pill

I will lift up mine eyes unto the pills whence cometh my help . . . . For every ill a pill. Tranquillisers to overcome angst, pep pills to wake us up, life pills to ensure blissful sterility.

This is an apt parody of the psalmist's song 'I will lift up mine eyes unto the hills . . .' and Malcolm Muggeridge is certainly correct in suggesting that we are living in an age of pills. Last week a doctor looking after rheumatic patients complained that a new 'Drug Prescription and Administration Record' (i.e. prescription sheet) should not be introduced because it contained spaces for only 8 different drugs whereas many patients were receiving 10 or 12. Polypharmacy is rife. We all see the patient who casually brings out a handful of brightly coloured tablets from his pocket or produces several bottles—with little knowledge of the names or objects of the drugs. Rheumatology must be among the top 10 specialties for polypharmacy. Patients with their chronic painful conditions haunt doctors who feel that they have to 'do something', and it is easy to forget to cross off one analgesic when trying a newer one. Also they are bombarded by pharmaceutical firms with their new formulations. These are often me-too drugs, and the monotonous reports of small clinical trials show them to be a little stronger or little weaker, or to have slightly fewer side effects, than aspirin. Furthermore, their esoteric or euphonious names and synonyms confuse and make it difficult for the doctor to keep abreast of worthwhile advances.

Other victims high in the table for multiple drug therapy are the elderly, the hypertensives, and the middle-aged neurotics with their drugs to pep them up or calm them down and their addiction to sleeping pills prescribed to overcome insomnia which is often imagined rather than real.

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No doubt we should all take a more critical attitude. One way is to vote secretly on the value of drugs being given to one's own patients. The prescription sheet of every patient is put out and the staff—consultant, juniors, and students—allot each drug to one of the following groups: (a) drugs

proved and irreplaceable (e.g. vitamin B<sub>12</sub> in pernicious anaemia); (b) drugs proved by controlled trials (e.g., antibiotics, gold, etc.); (c) drugs of doubtful value or proved to be useless but still used—often as harmless placebos (e.g., tonics, appetisers, expectorants, vitamins where no deficiency exists, and so on); (d) Dangerous placebos (e.g., gold, penicillamine, and immunosuppressive drugs continued after 6 months when no improvement has been shown by objective tests such as a fall in the ESR).

So far the sceptic score shows only a slight increase with age, indicating that our students are taught clinical pharmacology well.

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So many drugs are placebos. Indeed there may occupy about one-third of National Health Service prescriptions. One laments the passing of the bottle of medicine. It acted as a tonic to the run-down and soothed the anxious; its placebo effect was probably stronger and its cost trivial compared with most pills. Mist. rhubarb. Co. together with reassurance from the doctor helped countless patients and often lowered the blood pressure of hypertensives. There is no placebo in the *British National Formulary*, so that futile and often expensive drugs are prescribed—as a placebo for the patient or perhaps for the doctor himself—costing the taxpayer probably £20 million or more each year. It is a pity that doctors cannot spend more time speaking to patients instead of writing prescriptions, for talking itself has such a powerful therapeutic effect. Reassurance and relief of the fear of crippling may raise the pain threshold so that less analgesic is needed, and explanation together with advice about posture will obviate the need for collars and neck traction in most patients with cervical spondylosis.

One wonders how the patient copes with the drug regimen when 8 or 10 drugs are prescribed, some twice, thrice, or four times daily, others at night, before or after meals, rectally and so on. An obsessional person could spend all day on this. Fortunately few patients do take their drugs regularly, and I know of one who sold his to others. We have

all seen the new lease of life and restoration to health when all drugs (except those in categories *a* and *b*) are crossed off. Also the fewer the drugs prescribed, the more likely is compliance. How to educate patients about their drugs is becoming even more important. One simple method is for each tablet to be stuck on a card by Selotape with its name and purpose beside it: for example, allopurinol—to prevent attacks of gout.

It was a step forward in educating the patient when the name of the drug and instructions were written on the label of the bottle, instead of the former sterile secrecy. But, no doubt however hard we try, errors in communication will still occur. One amusing and less serious example happened at my outpatients Queen Elizabeth Hospital, Birmingham.

A middle-aged woman had been prescribed phenylbutazone thrice daily by her family doctor. Her conversation went as follows: 'Marvellous in stopping pain but I can't go on with the tablets . . . no side-effects . . . it's just that doctor told me to take them with a drink . . . on the third day I got tired of sherry and changed to gin and tonic but later my husband suggested Scotch'. She was a sensible woman but lived in a circle of society where the invitation 'have a drink' automatically meant alcohol. This is true, whereas the story of the man who, after mistakingly swallowing his suppositories, complained that for all the good they did he might just as well have stuffed them up his arse, is, as far as I know, apocryphal.

CLIFFORD HAWKINS

## Correspondence

### Implications of a sex difference in osteoarthritis

Sir,

We have recently been studying results from examination of the left knee joint at necropsies in Liverpool. Osteoarthritic bone exposure at the patello-femoral articulation was found in 17 of 30 women (57%) aged 70 to 96 years but in only 4 of 27 men (15%) in this age range (chi-square with Yates's modification 8.97;  $P < 0.01$ ). We have also observed that women are twice as numerous as men in patients from North Wales seeking surgical treatment for osteoarthritis of the hip. Our findings are in line with previous evidence for a sex difference in osteoarthritis.<sup>1</sup> This might be attributable to sex differences in gait and skeletal morphology. Also the mean surface area of the patellar articular cartilage is smaller in women than in men,<sup>2</sup> so that in women this tissue may have less 'functional reserve' against the effects of a degenerative process.

However, another possible explanation would be that there is an inherent sex difference in articular cartilage or in some other component of synovial joints. This possibility has implications for cartilage research. It is helpful if data from studies of cartilage and related tissues are presented separately for women and men. Current hypotheses about the pathogenesis of idiopathic osteoarthritis can then be tested for their ability to explain the sex difference in this disease.

Radin has suggested that the progression of cartilage degeneration to osteoarthritis may be influenced by the resilience of the subchondral bone.<sup>3</sup> Following his suggestion, we have recently shown that progressive cartilage degeneration on the patellar surface can be related to topographical variation in patellar subarti-

cular calcified tissue density.<sup>4</sup> However, there is no significant sex difference in the subarticular density values at the two sites we studied.

Freeman and Meachim<sup>5</sup> have reviewed evidence which suggests that degeneration of cartilage may be due to fatigue failure of its collagen fibre network. It is therefore pertinent that there appears to be a sex difference in the fatigue properties of this material.<sup>6</sup> It would be of interest to know if there are any sex differences in the other mechanical properties of articular cartilage, its metabolism, its proteoglycan profile, and its enzymatic degradation, or differences in the wear-protective properties of synovial fluid.

G. MEACHIM, R. BARBARA PEDLEY  
Department of Pathology,  
Duncan Building,  
Royal Liverpool Hospital,  
Liverpool.

#### References

- 1 Kellgren J H. Osteoarthritis in patients and populations. *Br Med J* 1961; 2: 1-6.
- 2 Meachim G, Emery I H. Quantitative aspects of patello-femoral cartilage fibrillation in Liverpool necropsies. *Ann Rheum Dis* 1974; 33: 39-47.
- 3 Townsend P R, Rose R M, Radin E L, Raux P. The Biomechanics of the human patella and its implications for chondromalacia. *J Biomechanics* 1977; 10: 403-7.
- 4 Pedley R Barbara, Meachim G. Topographical variation in patellar subarticular calcified tissue density. *J Anat* 1979; 128: 737-45.
- 5 Freeman M A R, Meachim G. Ageing and degeneration. In: Freeman M A R, ed. *Adult Articular Cartilage*, 2nd ed. London: Pitman, 1979; 487-543.
- 6 Kempson G E. Mechanical properties of articular cartilage. In: Freeman M A R, ed. *Adult Articular Cartilage*, 2nd ed. London: Pitman, 1979; 333-414.