

allergic rhinitis.^{4 9 10} Indeed, sinusitis with abnormal paranasal sinus radiographs has a high predictive value for Churg-Strauss syndrome.¹¹

Other useful pointers to a multisystem disease include joint pains, myalgias, malaise, neuropathy, palpable purpura, weight loss, or fevers.⁹ The development of such features before the introduction of oral corticosteroids, or on steroid tapering, should lead to further investigation. A persistent peripheral blood eosinophilia (especially if $>1.5 \times 10^9/l$), transient pulmonary infiltrates or cardiomegaly on chest radiographs, microscopic haematuria, and raised erythrocyte sedimentation rates or C reactive protein values in the absence of infection should raise the suspicion of a vasculitis. Some patients with Churg-Strauss vasculitis have perinuclear staining antineutrophil cytoplasmic antibodies (p-ANCA) with specificity for myeloperoxidase, though a negative result does not exclude the diagnosis.⁶

Thus in any patient with asthma (especially late onset asthma that is difficult to control) with features of a multisystem disease it is worth considering an underlying vasculitis that may be partially treated by oral corticosteroid therapy. When patients are already taking oral corticosteroids care should be taken in

introducing other effective antiasthma agents, particularly leukotriene antagonists. These agents may improve asthma to the extent that oral corticosteroids can be withdrawn, unmasking a systemic vasculitis or possibly accelerating the disease to its life threatening vasculitic phase. As the oral corticosteroid dose is reduced such patients should be monitored carefully for the clinical appearance of a multisystem disease, with measurements of erythrocyte sedimentation rate, C reactive protein, and eosinophil counts.

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- 1 Sampson A, Holgate S. Leukotriene modifiers in the treatment of asthma. *BMJ* 1998;316:1257-8.
- 2 Committee on Safety of Medicines. Leukotriene antagonists: a new class of asthma treatment. *Current Problems in Pharmacovigilance* 1998;24:14.
- 3 Wechsler ME, Garpestad E, Flier SR, Kocher O, Weiland DA, Polito AJ, et al. Pulmonary infiltrates, eosinophilia and cardiomyopathy following corticosteroid withdrawal in patients with asthma receiving zafirlukast. *JAMA* 1998;279:455-7.
- 4 Lanham JG, Elkon KB, Pusey CD, Hughes GRV. Systemic vasculitis with asthma and eosinophilia: A clinical approach to the Churg-Strauss syndrome. *Medicine* (Baltimore) 1984;63:65-81.
- 5 Churg A, Brallas M, Cronin SR, Churg J. Formes frustes of Churg-Strauss syndrome. *Chest* 1995;108:320-3.
- 6 Lhote F, Guillevin L. Polyarteritis nodosa, microscopic polyangiitis and Churg-Strauss syndrome. *Semin Resp Critical Care Med* 1998;19:27-45.
- 7 Dubost J-J, Souteyrand P, Sauvezie B. Drug-induced vasculitides. *Bailliere's Clin Rheumatol* 1991;5:119-38.
- 8 Cuadrado MJ, D'Cruz D, Lloyd M, Mujic F, Khamashta MA, Hughes GRV. Allergic disorders in systemic vasculitis: A case controlled study. *Br J Rheumatol* 1994;33:749-53.
- 9 Hughes GRV, D'Cruz D. Joint pains, sinusitis, wheezing and mild vasculitis—a distinct syndrome? *J Rheumatol* 1991;18:495-6.
- 10 Olsen KD, Neel HB, DeRemee RA, Weiland LH. Nasal manifestations of allergic granulomatosis and angiitis (Churg-Strauss syndrome). *Otolaryngol Head Neck Surg* 1980;88:85-9.
- 11 Masi AT, Hunder GG, Lie JT, Michel BA, Bloch DA, Arend WP, et al. The American College of Rheumatology 1990 criteria for the classification of Churg-Strauss syndrome (allergic granulomatosis and angiitis). *Arthritis Rheum* 1990;33:1094-1100.

Patients with learning disability in the community

Have special medical needs that should be planned for

Over the past 20 years we have witnessed the closure of large residential hospitals for adults with mental handicap and an exodus from these institutions into community care. This move was motivated by a desire to give people with handicaps the opportunity to live as normal a life as possible.¹ However, concerns have been expressed by the Department of Health,² some psychiatrists,³ and patients themselves⁴ about the change.

Adults with learning disability are more prone than the rest of the population to chronic health problems, including epilepsy, dementia, hepatitis, peptic ulcer, dysphagia, and problems related to sensory impairment.⁵ Age related diseases such as stroke, cardiovascular disease, and malignancy will also be of growing concern as life expectancy increases. Many may be surprised to learn that in the Netherlands mental retardation is the greatest single source of healthcare costs (8.1% of total).⁶

In the past hospital psychiatrists specialising in learning disability catered for the health needs of

adults living in institutions. These doctors developed skills in managing many of their health problems, including epilepsy, depression, and behavioural disorder. More recently, general practitioners, employed as hospital practitioners and clinical assistants, have worked in residential hospitals, providing general medical care and developing skills in dealing with the particular problems of adults with learning disability. Indeed, many units established their own acute medical treatment facilities, and general hospital admission was rarely needed. Local district general hospitals often offered continuity of specialist input, including dental, orthopaedic, and gynaecology clinics on site.

This system was far from perfect. However, the care of these individuals has now moved to the community, and there is a danger that specialist knowledge and related skills will be lost. People with learning disability must now register with local general practitioners, who are unlikely to have any special interest in learning disability and are ill prepared to deal with some of the complex mixtures

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of physical, psychiatric, and developmental problems of these patients. Specialist psychiatrists now work largely in outpatient services, where the support that they can offer may be restricted.⁷

Difficulties in providing medical care have been highlighted in the *BMJ* recently, with further examples in this week's correspondence (p 536).⁸ Poor uptake of screening for cancer has been reported in women with learning disability.⁹ Cognitive difficulties may prevent some of these patients appreciating the benefits of screening, and even those with more independence may be unaware of available medical services.¹¹ There are also practical obstacles to providing screening tests.⁸ However, doctors may also fail to recognise and treat medical problems in these patients. We have recently reported that osteoporosis is common in adults with learning disability¹² but that underlying causes of bone loss may not be treated.¹³

How might the problems of adults with learning disability in the community best be addressed? Much research in learning disabilities has been on service delivery, particularly in the community, but it now needs to address broader issues and it needs to be published in journals where it can be read by all those offering care, including general practitioners, gynaecologists, dentists, and geriatricians, and not just psychiatrists. One suggestion has been to devolve responsibility for providing services to primary health care, with advocacy¹⁰ and the appointment of case managers¹⁴ helping within this model. In England the new primary care groups, responsible for medical care in the local community, should be in a good position to tailor services for these patients. However, liaison will be required with mental handicap services and agencies representing patients and families, such as MENCAP. Finally, the training of doctors in medical and social issues related to learning disability should be a priority.⁴ The inclusion of these subjects in undergraduate teaching should be the responsibility of the medical schools, and the royal colleges of psychiatrists, general practitioners, and physicians should collaborate on higher professional training.

Care in the community should promote greater autonomy and improve patients' quality of life. In achieving these grand objectives we must include patients' priorities in the delivery of primary health care. Unless the medical and emotional needs of those with learning disability are addressed we risk replacing institutional care with community chaos.

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- 1 Nirje B. The normalisation principle and its human management implications. In: Kugel RB, Wolfensberger W, eds. *Changing patterns in residential services for the mentally retarded*. Washington, DC: President's Committee on Mental Retardation, 1969:181-94.
- 2 Lindsey M. *Signposts for success in commissioning and providing health services for people with learning disabilities*. Leeds: NHS Executive, 1998.
- 3 Community care for the mentally handicapped: a consultant psychiatrist's point of view. *British Society for the Study of Mental Subnormality Newsletter* 1986.
- 4 Singh P. *Prescription for change*. London: Royal Society for Mentally Handicapped Children and Adults (MENCAP), 1997.
- 5 Tyler CV, Bourguet C. Primary care of adults with mental retardation. *J Family Pract* 1997;44:487-94.
- 6 Meerding WJ, Bonneux L, Polder JJ, Koopmanschap MA, Van der Maas PJ. Demographic and epidemiological determinants of health care costs in the Netherlands: cost of illness study. *BMJ* 1998;317:111-5.
- 7 NHS Management Executive. *Health services for people with learning disability (mental handicap)*. London: Department of Health, 1992.
- 8 Hall P, Ward E, Djuretic T et al; Whitmore J. Cervical screening for women with learning disability. *BMJ* 1999;318:536-7.
- 9 Pearson V, Davis C, Ruoff C, Dyer J. Only one quarter of women with learning disability in Exeter have cervical screening. *BMJ* 1998;316:1979.
- 10 Piachaud J, Rohde J. Screening for breast cancer is necessary in patients with learning disability. *BMJ* 1998;316:1979-80.
- 11 Edgerton RB, Gaston MA, Kelly H, Ward TW. Health care for aging people with mental retardation. *Mental Retardation* 1994;32:146-50.
- 12 Aspray TJ, Francis RM, Thompson A, Quilliam SJ, Rawlings DJ, Tyrer SP. Comparison of ultrasound measurements at the heel between adults with mental retardation and control subjects. *Bone* 1998;22:665-8.
- 13 Aspray TJ, Francis RM, Rutter M, Walker M. Consequences of withholding testosterone treatment. *Lancet* 1996;348:609.
- 14 Ardito M, Botuck S, Freeman SE, Levy JM. Delivering home-based case management to families with children with mental retardation and developmental disabilities. *Journal of Case Management* 1997;6:56-61.

Managing osteoporosis in older people with fractures

Needs to be taken as seriously as coronary artery disease

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The World Health Organisation has compared osteoporosis to hypercholesterolaemia and hypertension, which are both asymptomatic conditions until an important tissue damaging event such as myocardial infarction or cerebrovascular accident occurs. Bone fracture, especially fracture with minimal trauma, is the feared endpoint of osteoporosis. Fractures of the wrist, hip, and vertebrae are well recognised consequences of the loss of mechanical strength that occurs as bone thins. These fractures are common in many countries, particularly among elderly people, and the burden they produce is expected to rise enormously in the next few decades. Pal's article in

this issue (p 500) underscores the hesitancy with which doctors currently approach this silent epidemic of osteoporosis.¹

The cost of osteoporosis is huge in both human and economic terms. Data on patients with hip fractures are the most complete, since nearly all such patients require hospital admission for treatment, whereas those with vertebral and wrist fractures do not, making data collection difficult. Although not all of Pal's patients necessarily had an osteoporotic fracture, those with hip fracture might consider themselves lucky to be able to participate in his questionnaire study since a third of patients with osteoporotic hip fracture die as a direct result of their

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