

case series and may not be justified.¹³ Only long term follow up of a population based sample of patients with tuberous sclerosis will establish which lesions are likely to become symptomatic and when, if at all, clinical intervention is best timed.

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Tackling health inequalities in primary care

Recording socioeconomic data in primary care is essential

The adverse health effects of social inequality are enormous. In the United Kingdom death rates at all ages are two to three times higher among people in social class V than among those in social class I.^{1,2} Poor socioeconomic status also erodes social, psychological, and physical health.³ Reducing health inequalities is central to the United Kingdom government's recently outlined health policy,⁴ a commitment confirmed by the positive reception given to the recently published Acheson report on inequalities in health.⁵ However, in spite of their importance both to the overall health care of individuals and in health policy, socioeconomic factors are not routinely assessed in clinical practice.

The power of the socioeconomic determinants of ill health requires that we should adapt the traditional medical model. We now understand that diseases have both biological and societal causes, yet our interventions remain focused on the biological.¹ We need to begin to take histories which routinely include the eliciting and recording of societal risk factors, and we need to begin to use society's resources for both prevention and treatment of illness and disease.

Deciding exactly what to ask and record will require further research. The registrar general's classification of social classes has been used in the United Kingdom for most of this century and is currently being modified. However, it is too cumbersome to use during a consultation, does not always provide a good measure of the socioeconomic factors important to health, and may be inappropriate in countries other than the United Kingdom.⁶ General practitioners will want to concentrate their efforts where evidence for the influence on health is strongest by finding simple, user friendly, and non-stigmatising methods of eliciting and recording data on material poverty, unemployment, poor housing, and social isolation.

Factors reflecting the social environment and an individual's involvement within it—which include levels of perceived hostility, trust in others, or membership of groups within the community—may be important determinants of health inequalities.⁷ In addition, it is increasingly clear that people's cumulative socioeconomic experiences over their whole lifetimes play a greater part in determining health than does their socioeconomic level at a single point in time.⁸

Recording socioeconomic data would be useful for several reasons. Recent guidelines on preventing cardiovascular disease emphasise the need to base management on an individual assessment of absolute risk.⁹ Socioeconomic status should be an important part of any such assessment. The approximate doubling of risk of coronary heart disease seen in people in the poorest socioeconomic groups in comparison to those in the richest groups is similar in size to the increased risk produced by cigarette smoking. No one would seriously suggest that an individual's risk of coronary heart disease could be accurately assessed without knowledge of their smoking habits. Knowledge of socioeconomic factors would also facilitate targeting of preventive healthcare measures such as cervical screening¹⁰ and childhood immunisation,¹¹ which are known to reach those in poor socioeconomic circumstances less well. In addition, specific interventions designed to reduce health inequalities require knowledge of patients' socioeconomic status if they are to be offered to those people most likely to be helped.

The people registered with general practitioners in the United Kingdom represent one of the largest, most comprehensive, and most representative sources of epidemiological data in the world. Routinely collected socioeconomic data would be a valuable resource for research into health inequalities and for assessing progress in the efforts to reduce these. One of the cen-

tral themes of the Acheson report was the need for high quality comprehensive data to improve the capacity to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.⁵

With increasing computerisation of practices, the actual recording of socioeconomic data should be straightforward. Simple questions relevant to the particular patient could be asked when patients first register and opportunistically at subsequent consultations. New computer codes for the different questions and their responses could easily be produced.

What we are suggesting is not a radical change. It is not about asking intrusive questions, and it would take up very little time. It is simply a systematic and formal way of doing what most clinicians in primary care already do, albeit in a largely opportunistic and possibly rather haphazard way. Recent work from Norway has shown that while the level of general practitioners' knowledge of psychosocial factors varied widely, when such factors were known they often influenced management.¹²⁻¹³ In practice, older people are often asked if they live alone and about social contacts, and young single mothers are asked about social isolation, their housing situation, and other socioeconomic factors. Such information may not always be recorded and hence may not be put to the greatest use—for example, in generating a referral to a community organisation or to a health visitor.

The government seems to be sincere in its wish to tackle health inequalities. For general practice to play a full part in translating this commitment into improved health for those most in need we will need to record

accurate and valid socioeconomic information about our patients.

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Reconstruction of dislocated hips in children with cerebral palsy

Is difficult—and in many cases could be prevented by regular monitoring

Children who suffer from cerebral palsy and do not walk before the age of 5 have a 58% incidence of hip dislocation (44% bilateral, 14% unilateral).¹ Other factors involved in the causation of hip dislocation include four limb cerebral palsy² and tightness of the adductor and iliopsoas muscles with concomitant weakness in the abductor muscles at the hip.³ Whatever the cause, reconstructing the hip in these children involves complex surgery, and parents and their doctors need to be aware that management is not straightforward.

Investigations used to detect dislocation include x rays of the pelvis and whole spine; from the former the physician or surgeon can document any progressive tendency of the hip to dislocate by measuring the migration percentage.⁴ Such monitoring is important. Associated radiological features of hip dislocation are femoral neck anteversion, valgus femoral neck shaft angles, and acetabular dysplasia.

If a child over the age of 5 has a migration percentage of the hip greater than 40% the time for soft tissue surgery alone has almost certainly passed.⁵ Hip reconstruction after dislocation is in effect a salvage

procedure. It involves anatomical correction of bony abnormalities in the femur and acetabulum, with shortening of the femur to allow the femoral head to be relocated in the acetabulum. Tethers to the femur, with the inevitably tight pubofemoral ligament and the adductor and psoas muscles, will have to be cut to allow relocation of the femoral head. The acetabulum itself must be cleared of all fibrous, fatty, and ligamentous tissue, and during the operation a decision will need to be made regarding pelvic osteotomy or acetabuloplasty. Chronic damage to the femoral head may be noted during operation and this includes either flattening of the whole head or grooving or pitting of the articular cartilage.

Just as important as the surgery itself is the preoperative and postoperative preparation of the child and parents. A team consisting of an orthopaedic surgeon, a paediatric neurologist, a senior physiotherapist, and a skilled orthotist needs to be involved, and it helps families to meet a member of the ward staff, the play leader, and the clinic coordinator before surgery. The final preoperative assessment, which takes place in a preadmission setting, must ensure that any feeding dif-