

with congestive heart failure to treatment with angiotensin converting enzyme inhibitors. The mean (SEM) distances walked before treatment by our patients with New York Heart Association class II (five patients) and class III (10 patients) heart failure were 301 (21) m and 190 (29) m, respectively. These are shorter than those reported by Dr Lipkin and colleagues, perhaps because of the greater age of our patients (mean 77, range 69-83 years). Subsequent subjective reduction in symptoms and objective improvement in performance of daily activities and overall functional ability¹ appear to be closely related to increases in walking distance.

Our experience supports the conclusions of Dr D P Lipkin and others. As walking is often seen as the yardstick of health by old people² the six minute walking test would seem particularly appropriate for elderly patients, for whom more sophisticated testing is not at present widely available or practised.

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SIR,—We disagree with the suggestion of Dr D P Lipkin and colleagues (8 March, p 653) that symptoms are an unrealistic guide to the degree of cardiac limitation. Rather, symptoms are a necessary part of the clinical assessment although sometimes misleading. There is no single "gold standard" by which heart failure is judged.

We have recently studied this problem in a group of patients who presented with stable complete heart block accompanied by breathlessness. None were in overt heart failure, and breathlessness improved after pacing. In each patient the ventricular rate was changed at fortnightly intervals in a double blind randomised trial. An overall symptom score (better, same, or worse) was closely linked to other symptom scores,^{1,2} the distance walked in six minutes, and what is perhaps the acid test: weekly walking activity measured using a pedometer (χ^2 test; $p < 0.05$ for all associations).

We have used the six minute walking test in two further studies to assess symptoms of breathlessness in cardiac disease (unpublished findings). Although we have also found the test less useful in patients with mild disease, we believe that the sensitivity can be improved by the use of symptom scoring or possibly strong encouragement during the test.³

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Checks and counterchecks

SIR,—In writing about endotracheal intubation Dr R Sneyd (8 March, p 694) has expressed several opinions which are incorrect and in one instance

at dangerous variation with currently accepted standards of anaesthetic practice.

Firstly, his fear of being led "up the path of check and countercheck" is inappropriate for an anaesthetist. Repeated observations and unceasing vigilance are essential components of safe anaesthesia.^{1,2}

Secondly, it is not accepted practice for doctors to work "independently without checks." Junior hospital doctors treat patients under the supervision of a consultant, to whom some or all of the responsibility of the management of the case may devolve.³ Consultants themselves are not immune from scrutiny, as the current Savage inquiry illustrates.

Thirdly, although I cannot see the relevance of Dr Sneyd's comments on drug administration to endotracheal intubation, the issue is one of recurring topicality.^{4,5} There are many reports of morbidity and mortality arising from errors in drug administration,^{6,7} and the idea of obtaining an independent check, although irksome and time consuming, is actually a possible solution to the problem.

Lastly, the possibility of non-recognition of oesophageal intubation forms part of the central theme of Dr D B Scott's leading article (18 January, p 157) and echoes the findings of the Association of Anaesthetists' confidential inquiry into deaths associated with anaesthesia.⁸ If at any time doubt exists about the position of an endotracheal tube a second opinion, and possibly removal of the tube, might be extremely wise and certainly in the best interests of the patient.

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Restraint of babies in cars

SIR,—We note with great interest the suggestions by Ms Karen Penny-Jones and colleagues (1 March, p 591) that the medical profession and others should accept the challenge to improve the use of safety devices by babies in cars.

We were pleasantly surprised to read that the Southampton surveys found as many as 40% of parents using safety devices for their babies. The national surveys¹ and our own informal inquiries indicated a much lower usage rate than this for babies—somewhere around 25%. The authors may be encouraged to know that the Child Accident Prevention Trust has already accepted the challenge and has reconvened its previous working party on the safety of children in cars. This group is looking at the whole range of children and is expected to come up with recommendations which will include much greater activity by district health authorities and family practitioner committees to improve child car safety.

In 1985 a new British Standard, BS AU202, was published which provided a specification for infant carriers designed to carry young babies in a semireclined position facing rearwards in the car. Its publication has resulted in a few seats becoming available. However, as such seats are useful for only six to nine months and cost at least £30, there

may well be resistance by parents against purchasing them.

In the USA² and Australia³ the first six months is the most vulnerable period, although this is not so in Britain.⁴ There is, nevertheless, a strong case for the use of restraints for babies and an even stronger case for doing this through a hire scheme rather than by outright purchase. Following the examples of New Zealand, Canada, and the USA, the Child Accident Prevention Trust is thus currently preparing guidelines to set up hire schemes for infant carriers. The trust views such schemes as one means of increasing the use of infant restraint systems, complementary to educational and other measures. It is keen to encourage district health authorities and other organisations to establish such schemes based in maternity hospitals and antenatal clinics. Some health authorities—notably so far Fife, south Warwickshire, and indeed Southampton—are already examining their feasibility. We shall watch their developments with interest.

We consider improvements in car safety for children to be long overdue in Britain. The health authority hire scheme has the added advantage of introducing systematic concepts of child safety from the day of birth, not only for car occupants but also for all other aspects of child safety.

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Screening for glaucoma

SIR,—Mr Roger A Hitchings (22 February, p 505) rightly draws attention to the desirability of screening for open angle glaucoma in the elderly. We believe that there is a role for the primary care team in so doing and would support him in this respect. However, he proposes that such screening should be conducted on the basis of identifying risk factors in the personal and family history and on direct ophthalmoscopy to detect abnormal cup to disc ratios. We would question whether this is the appropriate method, both on the basis of published evidence^{1,3} and as a result of work which we have recently performed and prepared for publication.

The advent of "puff tonometry" in many high street opticians has resulted in an increase in referrals via GPs to eye departments for "raised intraocular pressure, ?glaucoma," as mentioned by Mr Hitchings. However, these instruments, as well as being expensive and impractical for GPs to use, give spuriously high readings with resulting false positives. By contrast, the cheaper Perkins applanation tonometer is similar in size to an ophthalmoscope and is highly accurate in trained hands. We felt that if large numbers of patients were likely to be referred by GPs to eye departments as a result of high puff readings alone there was a case for evaluating the results of screening by applanation tonometry alone. We chose the over 65s, a group less likely to see their opticians for the reasons mentioned by Mr Hitchings and among whom the prevalence of undetected glaucoma is estimated at 2.9%.