

tion system which, to the user, appears as a coloured screen in 'video arcade' type box. There are about 100 topics of health information and over 900 screens of information. Information has mainly been abstracted from leaflets supplied by the Health Education Board for Scotland and has been edited by health professionals in the Glasgow Institute of Public Health.

Between March and September 1991 six *Healthpoint* units were moved between 14 sites in and around Glasgow. Like the system described by Stanley and Tongue, *Healthpoint* included internal monitoring of the screens viewed. We also observed users, carried out interviews with users and conducted a questionnaire survey of potential users.² The five topics most frequently selected by the public were contraception, alcohol, the acquired immune deficiency syndrome (AIDS), women's health and sexually transmitted diseases. Unlike Stanley and Tongue, there was a similar selection of topics at each site.

Trying to put a value on such a service is difficult; there is no intention to charge for use but the 'willingness to pay' approach provides one estimate. Each unit costs approximately £3000 and assuming a conservative estimate charge of 10 pence per user, the approximate time needed to recoup the value of *Healthpoint* at each site was calculated. This took into account a 'discount' for abuse by children under 12 years and the number of days available during the week on average. Nine of the 13 sites would recoup the cost within the likely five year life of the machine.

In the second phase of evaluation, 10 *Healthpoint* units were moved to Clydebank, a town on the outskirts of Glasgow and placed in a chemist, post office, library, two in a health centre, social security office, public house, technical college, sports centre and housing office. After being in place for six weeks a street survey of an opportunistic sample of 300 people in the shopping mall on weekday mornings were interviewed (100 aged under 30 years, 100 aged 30-49 years, and 100 aged 50 years and over; 50% male). Only people who had been to at least one of the 10 sites were included in the sample. They were asked, for each site, if they had been there, if they had seen *Healthpoint* and if they had used it. Seventy four per cent had seen it and 25% of the 300 respondents had used it.

Both the report by Stanley and Tongue and our own experience show that the use of computers is a good method of making general health information available to the public.

R B JONES

Department of Public Health
University of Glasgow
2 Lilybank Gardens
Glasgow G12 8RZ

References

1. Jones RB, McLachlan K, Bell G. HEALTHPOINT: a public access health information system. In: de Glanville H, Roberts J (eds). *Health computing 90*. Weybridge: British Journal of Healthcare Computing, 1990.
2. Jones RB, Navin LM, Bell B, Ritchie J. Sex on the screen: what HEALTHPOINT can do for us. In: Brown P (ed). *Health computing 92*. Weybridge: British Journal of Healthcare Computing, 1992 (In press).

Detection of colorectal cancer

Sir,

David Mant and colleagues have discussed the importance of screening for colorectal cancer and the difficulties involved (January *Journal*, p.18).

Colorectal cancer is the commonest cancer in non-smoking men and second only to breast cancer in women, survival is related principally to the stage at which the disease is diagnosed and deaths from colorectal cancer outnumber those from cancers of the breast and cervix combined.^{1,2} Since most colorectal cancers probably arise from benign adenomas, the case for population screening to detect these is strong but the methodology remains uncertain and cannot be recommended until randomized controlled trials have demonstrated a decline in mortality rates.³ The best chance of influencing outcome therefore depends on early detection of symptomatic disease. In practice this means responding appropriately to patients with lower bowel symptoms, in particular to rectal bleeding.

In a recent questionnaire study of functional bowel symptoms in 1620 subjects registered with eight general practitioners, 20% had experienced rectal bleeding, 15% in the previous 12 months.⁴ Only about one third of these patients had consulted a general practitioner. Rectal bleeding was found to be commonest in younger patients (30% in men aged 20-29 years, compared with 15% in men aged 50-59 years). Consultation rates rose with age and were generally higher in women. It is of concern, however, that 14% of people aged 40-69 years had experienced rectal bleeding and yet only 34% of these had sought medical advice.

In patients referred to hospital with a diagnosis of rectal bleeding, as high as 10% may have malignancies and 30% a neoplastic condition.⁵ However the prevalence of these disorders in general practice is much lower and the proportion of patients with local ano-rectal conditions correspondingly greater. General practitioners have to tread a narrow and potentially hazardous diagnostic path between overinvestigation and inappropriate reassurance. With increasing age, the

likelihood of malignancy rises and middle-aged and older patients deserve an adequate and well considered explanation for their symptoms.

A serious obstacle to early diagnosis is highlighted by Mant and colleagues: it can only be achieved if people accept the offer of a health check or consult their general practitioner. The major stimulus to consultation is concern about the potential seriousness of symptoms⁶ and there is evidence to suggest that this may also influence the response to an invitation for a general health check.⁷ Until the effectiveness of faecal occult blood screening in reducing mortality from colorectal cancer has been proven, there is a case for a sensitive initiative aimed at raising public awareness of the significance of rectal bleeding.

ROGER JONES

Department of Primary Health Care
Framlington Place
University of Newcastle upon Tyne

SUSAN LYDEARD

Grant Building
Southampton General Hospital
Southampton

References

1. Office of Population Censuses and Surveys. *Mortality statistics 1989*. DH2 (16). London: HMSO, 1989.
2. Stower MJ, Hardcastle JD. The results of 1115 patients with colorectal cancer treated over an 8 year period in a single hospital. *Eur J Surg Oncol* 1985; 11: 119-123.
3. Hardcastle JD, Chamberlain J, Thomas WM, et al. Randomized controlled trial of faecal occult blood screening for colorectal cancer. *Lancet* 1989; 1: 1160-1164.
4. Jones R, Lydeard S. Irritable bowel syndrome in the general population. *BMJ* 1992; 304: 87-90.
5. Anonymous. Investigation of rectal bleeding. *Lancet* 1989; 1: 195-197.
6. Lydeard S, Jones R. Factors affecting the decision to consult with dyspepsia: comparison of consulters and non-consulters. *J R Coll Gen Pract* 1989; 39: 495-498.
7. Pill R, French J, Harding K, Stott N. Invitation to attend a health check in a general practice setting: comparison of attenders and non-attenders. *J R Coll Gen Pract* 1988; 38: 53-56.

The health of the nation from a local perspective

Sir,

Can general practitioners influence the health of the nation? When the Cambridge and Huntingdon Royal College of General Practitioners group discussed *The health of the nation*, the government's green paper,¹ it was concluded that what general practitioners do is not enough in isolation; we can only have some influence as part of an integrated policy for change.

When we considered smoking, one of our members described how his practice