Points

Frequency of attendance at anticoagulant clinics

Drs A KUBIE, R P BRITT, and A H JAMES (Hillingdon Hospital, Uxbridge, Middlesex UB8 3NN) write: The article by Drs M R Howard and D W Milligan (26 March, p 898) and subsequent letter by Drs P J Wyld and T Wilson (14 May, p 1399) describe their favourable experiences with an adaption of our original computer program. We have rewritten our system to take advantage of the facilities offered by a later generation of microcomputers and to make it possible for others to make choices to conform with their own judgment and local use. The new system has been running at our clinic since October 1987 and is proving satisfactory. A paper describing it is in preparation.

Health checks for older people

Dr M G BROOK (Department of Infectious Diseases, Royal Free Hospital, London N10 1JN) writes: Dr E G Buckley and Professor J Williamson (23 April, p 1144) suggest that random medical screening of the elderly is not effective in reducing morbidity and mortality. They quote only two papers in support of this argument, and one of those studied middle aged subjects.[1] There is, however, published work that supports the use of routine medical screening in the elderly in identifying a high proportion of apparently fit people with early, but potentially serious, disease.[2,3] We run a service for routine screening of ex-prisoners of war in the Far East to identify the 15-20% who are chronically infected with the gut nematode *Strongyloides stercoralis*.[4] These apparently fit people in their seventh and eighth decades travel from all over the United Kingdom for our specialised diagnostic service. We have diagnosed new diseases other than strongyloidiasis in 25 (22%) of the 113 patients seen. These include malignancies, open pulmonary tuberculosis, diabetes mellitus, and many other treatable conditions. There is a case for routine health checks in the elderly.

1 South East London Screening Study Group. A controlled trial of multiphasic screening in middle age. *Int J Epidemiol* 1977;6:357-63.
2 Williams EI, Bennett FM, Nixon JV, Nicholson MR, Gabert J. Sociomedical study of patients over 75 in general practice. *Br Med J* 1972;ii:445-8.
3 Thomas P. Experiences of two preventive clinics for the elderly. *Br Med J* 1968;ii:357-60.
4 Gill GV, Bell DR. Strongyloides stercoralis infection in former Far Eastern prisoners of war. *Br Med J* 1979;ii:572-4.

Prevalence of urinary incontinence

Mr P BRITTON and Dr A C DOWELL (Departments of Urology and General Practice, St James's Hospital, Leeds LS9 7TF) write: Dr Jacqueline V Jolleys (7 May, p 1300) emphasises how often symptoms can be underestimated since few patients complain spontaneously of their problems. The study used a self administered questionnaire, but the report does not state how this was validated. Our current work on urinary symptoms in men has made us aware of difficulties in questionnaire validation on this topic. The patient's responses to the questions must be compared with those obtained at interview by a doctor who has no knowledge of the questionnaire results. Validation should be performed on a sample of the total study population and not, as in this case, on a sample of patients who have symptoms. Unless this is done the study may still underestimate the prevalence of female urinary incontinence in the community.

Trends in mortality statistics

Dr NICK SAWYER (The London Hospital, London E1 1BB) writes: Dr Anna McCormick (7 May, p 1289) should not be surprised that AIDS is understated as a cause of death in view of the stigma associated with such a diagnosis. The key to improving the accuracy of epidemiological assessment of mortality trends in this condition and in the much older problems of alcohol and drug related deaths is contained in her introduction. Data provided following initialling of box B on the certificate is treated confidentially by the OPCS, and the original copy of the entry available to the public is not altered. This fact is not widely appreciated by the medical profession and particularly by the (often junior) hospital doctors who issue the death certificates for these patients. Drawing attention to this should increase the number of certificates on which box B is initialled, and the information obtained will improve the accuracy of our epidemiological assessment of diseases such as this.

Medical research

Dr L M FRANKS (Imperial Cancer Research Fund Laboratories, London WC2A 3PX) writes: Dr Roger A Fisken (7 May, p 1330) doubts the accuracy of Dr Richard Smith's story about the surgical registrar (16 April, p 1079). As the source of the story I must confirm it. The sad fact is that even in many academic departments research has been regarded as fashionable window dressing and not real work at all. The indubitable fact that today's basic research gives us tomorrow's health care is not accepted widely in the country. Perhaps we ought to accept that this is a widely held attitude and concentrate our medical research in those few areas where the environment is friendly—an unfortunate comment on current medical practice and education.

Delays in diagnosing and treating bladder cancer

Mr B J JENKINS, Dr M A S CHAPMAN, and Ms W HOSEMAN (The London Hospital, London E1 1BB) write: Mr M J Stower (30 April, p 1228) highlighted the delays that may occur in the diagnosis of bladder cancer. Experience at the London Hospital using small calibre fibreoptic endoscopes has shown that a cystoscopy may be performed safely under topical lignocaine anaesthesia with minimal discomfort to the patient. It is now common practice to perform a flexible cystoscopy during the outpatient consultation in patients with haematuria and a normal urogram, and in most cases no serious lesion will be discovered. This can reduce one of the major sources of delay in the investigation of patients with haematuria, and the trend found by Mr Stower of an increasing delay in diagnosing bladder cancer can, hopefully, be reversed.

Cough and angiotensin converting enzyme inhibition

Drs R C BROWN and C W G TURTON (Bevenden Hospital, Brighton BN2 4DS) write: Dr K E Berkin and Professor S G Ball (7 May, p 1279) suggested that treatment with angiotensin converting enzyme inhibitors may need to be discontinued for intolerable cough; we report on a patient in whom this was avoided by the inhalation of nebulised bupivacaine. A man of 73 had an anterior myocardial infarction complicated by left ventricular failure, which could be controlled only with captopril. He developed troublesome persistent unproductive cough, which resolved when captopril was stopped, but then his refractory pulmonary oedema recurred. The cough associated with captopril did not respond to inhalation of nebulised salbutamol or ipratropium bromide but did to nebulised bupivacaine 0·5% (3 ml). It recurred after five weeks, when a further inhalation of bupivacaine was again effective. This treatment was repeated with benefit on nine occasions in 16 months, when the patient had another myocardial infarction and died. Inhaled local anaesthetic agents are effective in preventing cough during fibreoptic bronchoscopy, and they can relieve chronic cough. Both mechanically and chemically induced coughs are inhibited by nebulised local anaesthetics in a dose dependent fashion. Such agents are believed to block some of the sensory receptors that initiate the cough and other airway reflexes. Nebulised local anaesthetics should be given only under controlled circumstances as bronchospasm may occasionally be induced. After treatment the patient should be starved for four hours because of the loss of the swallowing reflex.

Travellers and preventive health care

Dr M S B VAILE (Maidstone Health Authority, Maidstone, Kent ME20 7NJ) writes: Dr Ruth M Hussey's finding of little progress in delivery of health care to gypsies and other travellers is depressing but not surprising (16 April, p 1098). Survey after survey has shown squalid living conditions, poor personal health, and inadequate access to health care.[1,2] Some fairly simple recommendations have been offered[1] and, when these have been implemented, modest improvements have been seen.[3] The fundamental duty of health authorities is to know who and where the travellers are and then to designate a named willing health visitor to take responsibility for understanding their needs. Perhaps even more important than the duty of health authorities is that of local authorities. In Kent 23% of travellers are still without sites at all and camp illegally. Many of the official (local authority provided) sites are admitted by the county council or local authority managing the sites to be substandard. To understand what that can mean demands a visit. Seeing is believing and no amount of tinkering with health services can really succeed when environmental conditions are persistently "substandard." Health authorities therefore must work with all other relevant agencies to persuade local authorities to persist in their, admittedly difficult, task of providing adequate numbers of decently constructed and resourced sites.

1 Pahl J, Vaile M. *Health and health care among travellers.* Canterbury: Health Services Research Unit, University of Kent, 1986.
2 Linthwiate P. *The health of traveller mothers and children in East Anglia.* London: Save the Children Fund, 1983.
3 Streetly A. Health care of travellers: one year's experience. *Br Med J* 1987;**294**:492-4.

Induced ovulation in underweight women

Dr S GOWERS (Royal Manchester Children's Hospital, Pendlebury M27 1HA) writes: Drs Vicky Osgood and Jean Ginsburg (21 May, p 1470) criticised the paper by Mr Z M Van Der Spuy and others (2 April, p 962) but did not mention the probable psychological disorder underlying infertility at low weight. Anorexia nervosa was not mentioned, although the social class distribution of the infertile patients in the original study matches that for anorexia. The deliberate maintenance of a low weight suggests an ambivalence about motherhood and indicates that dietary advice alone is unlikely to be effective. My experience of treating mothers with anorexia nervosa is that they give birth to low weight babies and that the difficulties do not end at birth. Obsessional rituals and difficulties of bonding and mothering are common. Such mothers occasionally restrict their children's diet—I have seen a 7 year old with a bone age of 4. A diagnosis of anorexia nervosa should always be considered in infertile women presenting with low weight. Psychiatric assessment may be indicated, and the potential for damage to the child may be as great after birth as before it. My experience does not confirm the belief that pregnancy dispels fears of maintenance of normal weight.

Informed consent

Mr P J MAHAFFEY (Withington Hospital, West Didsbury, Manchester M20 8LR) writes: Dr D J Byrne and others (9 March, p 839) raise the issues of informed consent. If the surgeon has a duty to inform does not the patient also have a duty to ask? In discussions on consent why is it always implied that the onus is on the doctor to proffer the explanation? If I wish to purchase goods or a service I ask about them. If I think there may be further unforeseen difficulties I will ask if there is anything else I should know. For the doctor not to respond fully to such questions from his or her patient truly would be negligent, but spare us from the mentality that the patient must always be spoonfed from the start.