

in better paediatric care, education, or social environment, which are more likely than in vitro fertilisation to maximise utility. When resources for health care are scarce we need to consider the opportunity costs of any investment. While infertility can cause psychological distress, a better use of resources may be to offer counselling to allow couples to accept their condition, or to attempt to alter the expectations of relatives and friends.

DARREN SHICKLE
Lecturer

PETER DONNELLY
Senior lecturer

Centre for Applied Public Health Medicine,
University of Wales College of Medicine,
Cardiff CF1 3NW

SHARON HOPKINS
Consultant in public health medicine

SU VUILLO
Consultant in public health medicine

South Glamorgan Health Authority,
Cardiff CF1 3NW

1 Hope T, Lockwood G, Lockwood M, Jackson J, Bewley S, Craft I. Should older women be offered in vitro fertilisation? *BMJ* 1995;310:1455-8. (3 June.)

Existing children are treated differently from embryos

EDITOR,—Tony Hope and colleagues rightly point out that the analogy drawn between assisted conception and adoption is false since in the case of adoption the child already exists.¹ They themselves, however, go on to draw a similar analogy when they quote society's reluctance to take children into care except under the most dire circumstances. But again, the child already exists. Does society usually consider that "the level of parenting would have to be very low for it to be preferable not to exist at all rather than exist as a child of those parents"¹ when it comes to the ethics of aborting potential children?

TREVOR G STAMMERS
General practitioner

Church Lane Practice,
London SW19 3NY

1 Hope T, Lockwood G, Lockwood M, Jackson J, Bewley S, Craft I. Should older women be offered in vitro fertilisation? *BMJ* 1995;310:1455-8. (3 June.)

Lowering patients' cholesterol

Excluding patients from trials increases uncertainty

EDITOR,—In their editorial Michael Oliver and colleagues rightly emphasise the important results of the Scandinavian simvastatin survival study,¹ which shows that overall mortality can be reduced by simvastatin in patients with existing coronary artery disease.² They do not, however, mention the problem of patients with heart failure, who were specifically excluded from the study, presumably on the premise that the mortality in such patients was likely to be determined more by their ventricular function than their serum lipid profile.

Coronary artery bypass grafting produces a similar relative reduction in mortality in patients with normal and abnormal ventricular function.³ Since mortality is higher in those with impaired left ventricular function, the absolute benefit of revascularisation is higher in this group. By analogy, lipid lowering treatment may also confer greater absolute benefit on those with heart failure, making the exclusion of this group from the Scandinavian simvastatin survival study particularly unfortunate.

Thus, according to the principles of evidence based medicine, treatment to reduce mortality after myocardial infarction should be selected according to left ventricular function. If the ventricle is normal

we should treat raised cholesterol concentrations with simvastatin. If it is impaired we should use an angiotensin converting enzyme inhibitor, but should we apply the study strictly and ignore the lipids?

ROGER H JAY
Consultant physician

Department of Geriatrics,
South Tyneside District Hospital,
South Shields,
Tyne and Wear NE34 0PL

1 Oliver M, Poole-Wilson M, Shepherd J, Tikkanen M. Lower patients' cholesterol now. *BMJ* 1995;310:1280-1. (20 May.)

2 Scandinavian Simvastatin Survival Study Group. Randomised trial of cholesterol lowering in 4444 patients with coronary disease: the Scandinavian simvastatin survival study (4S). *Lancet* 1994;344:1383-9.

3 Yusuf S, Zucker D, Peduzzi P, Fisher LD, Takaro T, Kennedy JW, et al. Effect of coronary artery bypass graft surgery on survival: overview of 10-year results from randomised trials by the Coronary Artery Bypass Graft Surgery Trialists Collaboration. *Lancet* 1994;344:563-70.

Few eligible patients currently receive treatment

EDITOR,—Michael Oliver and colleagues' editorial states that there is no longer any controversy over the treatment of patients with hypercholesterolaemia and coronary heart disease.¹ Since few published data exist on current practice with regard to treatment of hypercholesterolaemia in patients with coronary heart disease, we wish to report our findings derived from a computerised patient database and from health authorities' records.

After the benefits of lowering cholesterol concentrations had been proved convincingly we started a project to optimise the treatment of hypercholesterolaemia in patients with coronary heart disease at the health centre in Kuusankoski in southeastern Finland. The health centre is responsible for the primary care of 22 000 people. In the first phase of the project we analysed current practice. Our objective was to find out, firstly, how many patients visited a physician at the health centre during 1994 for suspected or diagnosed coronary heart disease; secondly, how many of these patients had their cholesterol concentration measured during 1994; and, thirdly, how many of these patients were receiving cholesterol lowering drugs at the end of 1994. The table shows the preliminary results.

In addition to showing gross undertreatment, the analysis showed insufficient measurement of the patients' cholesterol concentrations. Even though we suspected that the treatment might be inadequate, the true degree of undertreatment was disquietingly high. Unfortunately, we believe that the situation is no better in other municipal primary open care units in Finland.

Interestingly, the statistics of the Social Insurance Institution of Finland indicate that in Kuusankoski there are 621 patients who are entitled to preferential reimbursement for drugs used to treat coronary heart disease (including

Number of patients visiting physician at Kuusankoski Health Centre because of suspected or diagnosed coronary heart disease in 1994 and number (percentage) of these patients who had their cholesterol concentration measured in 1994 and who received cholesterol lowering drugs by end of 1994

	Age (years)			
	Total	<65	65-	≥75
Patients visiting physician	631	132	240	259
Cholesterol measured	147 (23.3)	68 (51.5)	60 (25.0)	19 (7.3)
Cholesterol lowering drugs prescribed	NA	13 (9.8)	NA	NA

NA=Not available as analysis not yet completed.

nitrate, β blockers, and calcium antagonists). The health centre's database on patients thus seems to provide a relatively comprehensive record of coronary heart disease in the municipality.

As the second phase of our project we have started a structured intervention to improve the inadequate treatment. We urge all primary care units and hospitals to do the same because treatment of hypercholesterolaemia in patients with coronary heart disease saves lives and reduces clinical events, revascularisation, and admission to hospital.²

SEPPO TUOMINEN
Director of health services
PAAVO ROMPPANEN
Chief medical officer
ARI ROSENVALL
Medical officer

Kuusankoski Health Centre,
SF-45700 Kuusankoski,
Finland

1 Oliver M, Poole-Wilson M, Shepherd J, Tikkanen M. Lower patients' cholesterol now. *BMJ* 1995;310:1280-1. (20 May.)

2 Scandinavian Simvastatin Survival Study Group. Randomised trial of cholesterol lowering in 4444 patients with coronary disease: the Scandinavian simvastatin survival study (4S). *Lancet* 1994;344:138-9.

Extrapolating results of trial of simvastatin gives room for doubt

EDITOR,—In their editorial Michael Oliver and colleagues clearly state the case for cholesterol lowering treatments in the secondary prevention of coronary heart disease.¹ From the information presented there indeed seems "little justification for inertia" or room for "controversy." Are there some important unanswered questions, not addressed in the editorial, that will inevitably lead to delay in the implementation of the research findings discussed?

Firstly, as a three to six month trial of diet is recommended, most patients requiring cholesterol lowering drugs after infarction will probably have the treatment initiated by their general practitioner. There is limited evidence on how results from randomised controlled trials in highly selected patients in secondary care translate to unselected patients in primary care.

Secondly, how well can the results of the Scandinavian simvastatin survival study be extrapolated to women? Although simvastatin reduced the risk of major coronary events in women, it failed to reduce mortality, the primary outcome measure. There was a 6% mortality in women taking placebo compared with a 7% mortality in those taking active treatment. The only definite conclusion from this has to be that the study lacked sufficient power to detect a significant difference in mortality in women.

Thirdly, about 40% of subjects were ineligible for inclusion in the Scandinavian simvastatin survival study because they had arrhythmias, heart failure, previous strokes, etc—all common accompaniments to established cardiovascular disease. Randomised controlled trials require a reasonably homogeneous population so that hypotheses can be adequately tested. How far can these results then be extrapolated to patients who would not have met the strict criteria for entry to the study? Do we need to validate the results of the controlled trials by studies of a heterogeneous unselected population in primary care or can we assume that it does not matter?

Finally, "number needed to treat" analysis is becoming increasingly popular. Ferner and Neill estimate that 162 patients need to be treated for one year at a cost of £60 500 for one life to be saved.² This analysis does not affect the optimum treatment recommended but is a factor that of necessity will determine the implementation of cholesterol lowering treatments into everyday practice.

The results of the trials discussed in the editorial

are of enormous potential consequence, given the prevalence of ischaemic heart disease and hypercholesterolaemia in Britain alone. Many hundreds of thousands of patients could require cholesterol lowering drugs once dietary advice has failed. Given the magnitude of the problem, do we need more evidence that such results can be generalised before we embark on this colossal task?

J HIPPISSLEY-COX
Trainee general practitioner

Crookes,
Sheffield S10 1LF

1 Oliver M, Poole-Wilson M, Shepherd J, Tikkanen M. Lower patients' cholesterol now. *BMJ* 1995;310:1280-1. (20 May.)

2 Ferner RE, Neill HAW. A suitable case for treatment. *Lancet* 1995;345:1051.

Occupational health: undefined, under reported, and uncompensated

Definitions of disease categories are important

EDITOR,—D Sen and K Osborne highlight the fact that occupational disease is underreported and possibly underdiagnosed by general practitioners.¹ They fail, however, to try to rectify the situation by giving the correct definitions of notifiable, prescribed, and reportable diseases. It would be advantageous if articles criticising doctors for lack of knowledge of important definitions included these definitions. Brief definitions are as follows.²

Notifiable infectious diseases (under the Public Health Act 1984) must be reported by the doctor to the local authority. Examples include acute meningitis, infected jaundice, measles, tetanus, and tuberculosis. A full list is given by Kloss.²

Prescribed diseases are specific diseases related to work that are prescribed for particular occupations by the secretary of state in regulations. Sufferers can claim benefit. An example of a prescribed occupational disease is carcinoma of the lung, with evidence of asbestosis, when the sufferer has worked in a specific occupation with asbestos. Another example is vibration white finger when the person has worked in a specific occupation using handheld power drills or other specified equipment.

Reportable diseases are those diseases related to work that must be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations,³ which are currently being updated.⁴ It is the employer's duty to report these diseases if he or she has received a written diagnosis on an employee from a doctor—for example, a medical certificate. Reporting the disease does not necessarily mean that it was caused by work and does not allow the person to claim any benefit. Two examples of reportable diseases are decompression sickness and leptospirosis.

There are 28 reportable diseases and 39 prescribed diseases. Not all reportable diseases are prescribed, and most, but not all, prescribed diseases are reportable. Consequently the two lists of reportable and prescribed diseases overlap considerably, and for patients to gain any benefit from the state they must prove that they worked in a specific occupation that resulted in their disease.

ELIZABETH M FISHER
Area occupational health physician, Marks and Spencer
Horsham RH12 2PP

1 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

2 Kloss D. *Occupational health law*. Oxford: Blackwell Scientific, 1989.

3 *Reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR)*. London: HMSO, 1985.

4 Health and Safety Commission. *Draft proposals for the reporting of injuries, diseases and dangerous occurrences regulations 1990-*. Sudbury, Suffolk: HSE Books, 1994.

Occupational health pilot study finds unmet need

EDITOR,—We endorse Anthony Seaton's suggestions regarding occupational medicine,¹ but the current staffing and structure of the NHS occupational health departments seem unlikely to be able to meet the demands of their surrounding communities. What is to happen in the interim?

Our pilot occupational health project found that 61 (13%) of 474 patients interviewed in general practice surgeries were visiting their general practitioner because of health problems related to work; this is higher than the national findings (7%) reported by the Health and Safety Executive.^{2,3} Altogether 191 of the patients interviewed reported ill health resulting from their current or previous jobs, and 400 of the patients reported their lack of access to an occupational health service.

Providing only an outpatient referral service for local doctors as a measure to improve the mechanisms for managing ill health related to work will be inadequate. Programmes to increase awareness among general practitioners are needed, as highlighted by D Sen and K Osborne.⁴ Such programmes would not only enable doctors to identify cases that require referral but also prevent possible conflicts that could arise between general practitioners and occupational physicians.⁵

Given the current emphasis on diagnosis and treatment in the community and primary care settings, occupational health services based in primary care should be supported and developed. At present such services exist as occupational health projects and are mostly funded by the local family health services and district health authorities. There are two in London, four in Yorkshire, one in Liverpool, and one planned for Scotland. They raise awareness of occupational health issues among primary care staff and their patients through interviewing patients and eliciting occupational histories, which become part of the patients' medical records. They also provide interactive feedback with case studies at practice meetings, information, seminars, and advice and support issues such as benefits. In view of the promising evaluations of these projects, making advice on occupational health standard practice in primary care settings should be considered seriously.

R ISANEDIGHI
Occupational health project worker
J MANNALL
Public health specialist
J HARVEY

Health promotion strategist
Public Health Directorate,
East London and the City Health Authority,
London E3 2AN

G FEDER
Senior lecturer

Department of General Practice and Primary Care,
St Bartholomew's Hospital,
London EC1A 7BE

1 Seaton A. Diagnosing and managing occupational disease. *BMJ* 1995;310:1282. (20 May.)

2 Isanedi RO. *An occupational health project in the east end—a report*. London: East London and the City Health Authority, 1994.

3 Health and Safety Executive. *Your patients and their work. An introduction to occupational health for family doctors*. Sudbury, Suffolk: HSE Books, 1992.

4 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

5 Gratton JCD. Effective occupational health—difficulties of delivery. *Occup Med* 1995;45:61-2.

Prescribed diseases yield substantial compensation

EDITOR,—S C Stenton and colleagues suggest that medical practitioners underrefer patients with occupational asthma,¹ while D Sen and K Osborne have gathered evidence highlighting general

practitioners' lack of knowledge about prescribed diseases.² Both papers mention briefly that people diagnosed as having a prescribed disease are eligible to claim disability benefit.

The disability benefit awarded to such people can be substantial, especially if they are also awarded a linked benefit, reduced earnings allowance. This is particularly so with diseases such as asthma, byssinosis, and asbestosis, which can often be diagnosed only on the basis of a detailed work history taken several years after the onset of the disease. Three of my own recent cases serve as examples: a client deemed to have had byssinosis for the past 30 years obtained £15 000 in arrears of disablement benefit and a continuing award of nearly £30 a week; a client diagnosed as having had asbestosis for 20 years was awarded £16 000 in arrears of benefits and £60 a week; and a client with dermatitis was awarded £3000 in arrears and £20 a week.

Many people like these retire early on grounds of ill health, are in poor health, and exist on state benefits. Disability benefit can help them to spend their retirement more comfortably. For some, however, the route to being awarded disability benefit is not easy. The three clients referred to above were successful only after taking their cases to a medical appeal tribunal, which overturned the Department of Social Security's initial decision that they did not suffer from any of the prescribed diseases.

Increased awareness of prescribed diseases should increase the uptake of disability benefit. It should also result in more successes at the point of claim so that fewer claimants are faced with what for many is a lengthy and daunting appeal procedure. Once a diagnosis has been made, people then require sound advice on benefits, particularly when large awards are at stake. Some citizens advice bureaux have developed links with their local general practitioners. In Rochdale we hold regular advice sessions at three local practices and I have had several productive referrals from local general practitioners. While closer liaison between the Benefits Agency and other medical services might be one approach,² having and using a high profile advice agency on the doorstep might also be useful.

JULIA WILKINSON
Welfare benefits caseworker

Rochdale Citizens Advice Bureau,
Rochdale OL16 1RS

1 Stenton SC, Sandhu PS, Hendrick DJ. Industrial injury benefit for occupational asthma in north east of England. *BMJ* 1995;310:1299-300. (20 May.)

2 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

Incidence of toxoplasma retinochoroiditis

EDITOR,—R E Gilbert and colleagues offered a new insight into the incidence of toxoplasma retinochoroiditis, but raised some doubts.¹ The fascination is that the results are different from previous reports,² which has implications for the management of toxoplasma infection in pregnancy.

The study methods should be carefully examined. Ophthalmologists were required to notify cases of toxoplasma retinochoroiditis to the researchers. Ophthalmologists are busy people and the help of none was acknowledged, so the study's results depended on the altruism of the participants. Three of the nine units reported no cases, which is a bit surprising, but the distribution of patients does seem to reflect a geographical sphere of influence of the researchers. There can be great inaccuracies with voluntary reporting. In Scotland toxoplasmosis is a notifiable disease through a