had cholecystitis, diverticulitis and gallstone ileus. Fourteen patients had a score of 5-6, of whom three (21.4%) had appendicitis. Two patients with appendicitis had a score below 5, one of whom perforated. All three patients with perforation did not have a leucocytosis.

The factors that make up the Alvarado score are specific for inflammation and any gastrointestinal disturbance, this makes it virtually useless in the elderly. It has not been shown to reduce negative appendicectomy rate in all age groups like other recent scoring systems[6]. Finally, eliciting rebound tenderness should be discouraged. Its diagnostic weight is the least[3], it is misleading and causes fruitless discomfort[7]. Percussion tenderness which is gentler and gives the same information, is more useful.

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History of research into hypertension

Dr P M Esunge had, apparently, only a page of the Journal to write a history of research into hypertension from 2600 BC to the present (October 1991 *JRSM*, p 621). Thus, perhaps it was inevitable that some accuracy was sacrificed for brevity. Nevertheless, for the sake of historical verity and the true record of British pharmacological effort, I should like to gently correct two errors. The ganglion blocking agent hexamethonium was introduced by Paton and Zaimis[1], not Zianis as erroneously stated both in the text and in the bibliography. Furthermore, bretylium was not studied by Freis, as stated, 10 years before it was synthesized by Dr F C Copp and 12 years before my colleagues and I described its pharmacological properties and results of its first clinical trial[2,3].

Your readers interested in those exciting times in development of antihypertensive therapy should consult Chapter 2 of *Discoveries in Pharmacology* as an authoritative source[4] describing part of the effort.

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Measurement of HDL cholesterol

I read with interest the paper of Dr Feher *et al.* (January 1992 *JRSM*, p 8) about the importance of measurement of HDL-cholesterol. I agree with their opinion that the measurement of cholesterol is not enough in practice.

We investigated the lipoid metabolism of 249 patients with acute cerebrovascular disease (TIA, RIND and cerebral infarct) within 18 months. In each case we measured the level of cholesterol, the HDL-cholesterol, the triglyceride and calculated the LDL-cholesterol and atherosclerotic index.

In three cholesterol groups (cholesterol under 5.2 mmol/l, between 5.2-6.5 mmol/l, over 6.5 mmol/l) the rates of pathologic HDL-cholesterol were 28.7%, 13.1% and 24.5%, the rates of elevated LDL-cholesterol were 2%, 63.6% and 98%. The mean values are seen in Table 1.

Table 1.

Total-cholesterol (mmol/l)	*HDL-cholesterol (mmol/l)*	*LDL-cholesterol (mmol/l)*	*Triglyceride (mmol/l)*	*Athero-sclerotic index*
<5,2	1.11 *	2.68 **	1.40	4.3 *
5,2-6,5	1.30 *	3.77 *	1.72 *	4.9 *
>6,5	1.22	5.25 *	2.89	7.4

*$P>0.001$; **$P>0.01$

In the group of patients with increased triglyceride there were significantly elevated total-cholesterol, LDL-cholesterol and atherosclerotic indexes and significantly lower HDL-cholesterol levels comparing with values of the patients with normal triglyceride.

Our data suggest that we have to routinely measure the HDL-cholesterol and triglyceride too. The LDL-cholesterol levels and the atherosclerotic index are more sensitive to indicate the disturbances of lipoid metabolism. The hyperlipoproteinaemias as risk factors of cardiovascular diseases occur often with other risk factors. We found significantly higher cholesterol, LDL-cholesterol, triglyceride and atherosclerotic indexes in patients with hypertension and even higher in patients with hypertension and diabetes mellitus compared with data of patients without hypertension and diabetes mellitus.

The treatment of cerebrovascular diseases must involve the control of lipoid disturbances considering all lipoid fractions. Treating hypertension we emphasize the importance of the choice of antihypertonic drugs; we do not give drugs with an HDL-cholesterol lowering effect. In our opinion the hypertriglyceridaemia has also a significant role in the pathogenesis of athero- and arteriosclerosis and must be treated too, mainly with dietary prescriptions or triglyceride decreasing drugs.

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