panels.[6,13,14] Perhaps it is not surprising, therefore, that in a recent survey carried out among the doctors in this practice (Fooks T, unpublished results), very few areas of consensus emerged, despite the introduction of a hospital derived protocol. There is an overriding feeling of disquiet at the ethical and financial implications of starting large numbers of patients on treatments for which the evidence of their efficacy and safety is far from certain.

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## Screening for diabetes — an alternative view

Sir,

Although the discussion paper by Julian Tudor Hart on the implications of increasing diagnosis and reducing drop out for future workload and prescribing costs in primary care (March *Journal*, p.116) was stimulating, well researched and well written, I think we should be cautious about accepting all his suggestions uncritically. Recent work undertaken in the Newfoundland Chapter of the College of Family Physicians of Canada suggests that the rule of halves may no longer apply in the case of non-insulin dependent diabetes, at least in this part of Canada.[1]

Two years ago, family doctors in 17 clinics in rural Newfoundland tested a random one in five sample of their patients aged 40 years and over for diabetes mellitus. The national diabetes data group's criterion of a fasting blood sugar equal to or greater than 7.8 mmol $l^{-1}$ on two separate occasions was used. Of a sample of 2381 patients, 294 were known to have diabetes. Of the remaining 2087 patients, it was possible to test 1767 (84.7%). A total of 48 patients had a raised fasting blood sugar level on the first test; 41 consented to a second test, and 19 of them had a persistently high fasting blood sugar level. Before the testing, the prevalence of diabetes in the 40 years and over age group was 12.3%; the testing raised the prevalence to 13.1%. In this study there were 15 previously known diabetic patients for each new diabetic patient discovered. Perhaps the high prevalence of diabetes in Newfoundland has resulted in more testing, so that additional screening for non-insulin dependent diabetes is not needed here.

A critical application of Frame and Carlsons' criteria for screening[2] to non-insulin dependent diabetes in elderly people has been carried out by Trilling.[3] He concluded that there are three major obstacles to screening the elderly for non-insulin dependent diabetes: there is conflicting evidence as to whether early detection and treatment reduce complications; the attainment of euglycaemia in the elderly is difficult, compliance is poor and side effects are common; and the adverse effects of labelling people who feel well are uncertain.

Trilling considered that treatment of hypertension and obesity is warranted, whether or not non-insulin dependent diabetes is present. His views are supported by Froom,[4] who considered that hyperglycaemia is only one of several metabolic disturbances that are present in diabetes mellitus; hyperlipidaemia, obesity and hypertension may make more important contributions to cardiovascular complications than do persistently high blood sugar levels. He considered that pharmacologic therapy to control hyperglycaemia may be required to control symptoms, but its use in asymptomatic diabetic people is, for the most part, unwarranted.

While I am a great admirer of Julian Tudor Hart's work, and a disciple of his efforts in the detection and treatment of asymptomatic hypertension, I think more caution is required before his comments about chronic disease can be expanded to other conditions, such as diabetes, at least in the North American setting.

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## Patient alarm bell

Sir,

Carers of elderly, sick or disabled people in the community are often afraid to leave their patient in case a call for help is not heard. Recently two carers in my practice brought to my attention a cordless door chime which they have found to be useful as an alarm.

The device is designed to replace the standard house front door bell, enabling the occupant to be, for example, in the garden yet able to respond to callers at the front door. It consists of a small push button transmitter unit which could be used by the patient, and a small lightweight chimer receiver unit, which could easily fit into the carer's pocket. Both are battery operated. The device has a range of 15–30 metres, and costs less than £15.

The device would enable carers to sleep in a different room, or to do some gardening, knowing their patient could alert them if assistance were required. These alarm bells are often advertised in Sunday supplement magazines. Perhaps others might find this idea useful.

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