

the increased mortality. I would find it difficult on the present evidence to ask a fit, asymptomatic, elderly patient to agree to undergo parathyroidectomy.

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- 1 Mundy GR, Cove DH, Fiskin R, Somers S, Heath DA. Primary hyperparathyroidism: changes in the pattern of clinical presentation. *Lancet* 1980;i:1317-20.
- 2 Heath HW, Hodgson SF, Kennedy HA. Primary hyperparathyroidism: incidence, morbidity and potential economic impact on the community. *N Engl J Med* 1980;302:189-93.

Non-mydriatic Polaroid photography in screening for diabetic retinopathy

SIR,—I have been using a non-mydriatic camera in a district general hospital diabetic clinic for the past three years and think that the finding by Dr D Jones and colleagues (9 April, p 1029) that one in five Polaroid photographs are uninterpretable is a remarkably high figure; in our experience failures are fewer than 1 in 10.

The age distribution of patients in their study is not mentioned; problems caused by constricted pupils and lens opacities rise progressively over the age of 65. If both eyes are photographed at the same clinic visit we have found that the second photograph is invariably of poorer quality than the first, and our practice now is to photograph the contralateral eye at the next clinic visit.

We have been screening all patients under 65 attending the diabetic clinic. Those with visual symptoms and those known to have retinopathy who were already under review by an ophthalmologist were excluded. The patients' mean age was 42.8 years (range 16-65) and mean duration of diabetes 9.8 years (range 0.4-7); 63% had type 1 diabetes. A total of 1166 retinas were examined with a Canon CR2-NM camera and Polaroid 779 film. Retinopathy (maculopathy, cotton wool spots, new vessels, and intraretinal microvascular abnormalities) was identified in 54 retinas (4.6%).

In an ideal world diabetic patients would undergo annual fluorescein angiography or be examined through dilated pupils by a consultant ophthalmologist (although many of my patients would be unwilling to submit repeatedly to either of these experiences). This utopian situation is unlikely to occur in most district general hospital diabetic clinics and the non-mydriatic camera should not be dismissed without further evaluation.

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What sort of health checks for older people?

SIR,—The leading article by Dr E G Buckley and Professor J Williamson (23 April, p 1144) commenting on the white paper *Promoting Better Health* raises the problem of the organisation of health services research and the dissemination of its findings.

In the late 1960s and 1970s comprehensive reviews of the value of screening for a variety of conditions and the criteria to be observed before introducing screening were published.^{1,3} Furthermore, the Department of Health funded a major controlled trial of the value of multiphasic screening in middle age.⁴ In suggesting that health checks might be of value the authors of the white paper do not appear to have taken into account the results of these studies (funded by the Department of Health and Social Security).

In view of the correct insistence by the present government on the improvement of efficiency and effectiveness in the National Health Service, it is disappointing to find its own white paper wanting to perpetuate ineffective and inefficient procedures.

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- 1 Wilson JMG, Jungner G. *Principles and practice of screening for disease*. Geneva: World Health Organisation, 1968.
- 2 Nuffield Provincial Hospitals Trust. *Screening in medical care. Reviewing the evidence*. Oxford: Oxford University Press, 1968.
- 3 *Lancet. Screening for disease: a series from the Lancet*. London: *Lancet*, 1975.
- 4 South East London Screening Study Group. A controlled trial of multiphasic screening in middle age. *Int J Epidemiol* 1977;6:357-63.

Frequency of attendance at anticoagulant clinics

SIR,—We would like to add our comments to the findings of Drs M R Howard and D W Milligan (26 March, p 898) that 12 weeks between visits is compatible with good control in patients receiving long term anticoagulant treatment. It is our practice to work up to a 12 week period in all patients receiving anticoagulants. Once they are stable on an oral anticoagulant dose for this period we are very cautious about reducing the interval unless there is a genuine reason why the patient may require closer monitoring.

In the past recall of such patients at an earlier date has proved to be superfluous, and indeed changes in their doses have rendered them outside the recommended international normalised ratio (INR) range. We have come to the conclusion that because oral anticoagulants are influenced by many interactions (drugs, alcohol, compliance, disease state) any one factor or a combination of factors could be a reason why a patient has an abnormal INR value. Long term stable patients presenting with an unusual or an abnormal INR are quizzed very thoroughly for a reason. The patients for whom no reasons for variation are found are brought back to the clinic early with their dosage unaltered. If on return their INR is still abnormal only then is their dose adjusted.

If a reason for variance is clear, however, then their dose is adjusted and they are brought back to the clinic early for restabilisation.

In our hospital we have recently switched over to the narrower guidelines suggested by the British Society of Haematology for anticoagulant control. We have found that, while initially it takes longer to stabilise the patients, consistent control within the narrower limits is possible once patients are established. Finally, we are under pressure to increase the time between visits to limit the number of patients in our clinic, which is having to serve ever greater numbers of patients as more patients undergo cardiac surgery and receive anticoagulants long term.

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SIR,—Drs M R Howard and D W Milligan's study (26 March, p 898) produces some interesting questions but few solutions. In 1984 Wilson and James discussed the use of a computer in anticoagulant clinics.¹ We have used their program, with minor refinements, for over two years. The international normalised ratio can be set for a particular patient, and extremes of anticoagulation of some groups of patients can be avoided.

Control of anticoagulation in our clinic has improved.² There has been a reduction in people underanticoagulated (INR <2.0) from 14% to 6% and the number overanticoagulated (INR >4.5) has remained unchanged.

The importance of clerical help and a readily accessible database is highlighted by the apparent disappearance of 21 patients during the study by Drs Howard and Milligan. A computerised record system would help to prevent this. Increasing numbers of patients are being anticoagulated in the United Kingdom. We must provide a safe means of monitoring control. The use of computers in this regard has not yet been exploited fully.

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- 1 Wilson R, James AH. Computer assisted management of warfarin treatment. *Br Med J* 1984;289:422-4.
- 2 Wyld PJ, Wilson TH, West D. Computer dosing in anticoagulant clinics—the way forward. *J Lab Clin Haematol* (in press).

Healthy cities

SIR,—Glasgow is often cited as an "unhealthy" city and has been included by the World Health Organisation in its healthy cities project, described by Dr Tony Delamothe (16 April, p 1117). It is considerably larger than any other city in Scotland, and the cost it places on the health care system is enormous. When the mortality data in Scotland for 1959-83 were reviewed, however, it became clear that Glasgow did not have the highest mortality.

Although Glasgow had an excess mortality of 15% between 1959 and 1963, nine towns had greater excesses, with the small town of Coldstream heading the list with an excess of 34%. In 1969-73 mortality from all causes in Glasgow did not even fall within the top tenth of the distribution, although it had an excess mortality of 12%. Doune, a small town in central Scotland, had the highest mortality with an excess of 50%. In 1979-83 the mortality from all causes was computed for the 56 districts of Scotland. Glasgow had an excess of 15%, which was second to the district of Cumnock and Doon Valley.

Nine towns were in the top tenth of the distribution during both 1959-63 and 1969-73, indicating persistent health problems. For example, Whithorn (in the south west) was ranked second highest for both periods with excesses of 32% and 46% respectively. During 1969-73 the disease profile for Whithorn showed an excess mortality for all cancers, coronary heart disease, and cerebrovascular disease; but excesses were also found for bronchitis, emphysema and asthma, breast cancer, stillbirths, and perinatal mortality. Similar disease profiles, showing that ill health is not the prerogative of the cities, can be constructed for many of Scotland's small towns.

While ill health in a small town will never pose the cost on the National Health Service that is imposed by a large city, the relatively high numbers of deaths found in some of Scotland's small towns should not be ignored. Health for all by the year 2000 is as relevant to the smaller towns in Scotland as it is to Glasgow.

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Inhaling heroin during pregnancy

SIR,—Dr J E M Gregg and others (12 March, p 754) make the unsupported assertion that "the