Ativan
lorazepam
ahead in anxiety
the response that you expect
and your patient needs
with minimal sedation
and rapid elimination
Ativan—the short acting anxiolytic
Logical step in the treatment of hypertension

Step One Tenormin
Highly cardioselective
Cardioprotective
Only ONE tablet daily

Step Two Tenoretic
Combines Tenormin with chlorthalidone
Better control in more patients
Still only ONE tablet daily

Prescribing Notes for 'Tenormin' and 'Tenoretic'

Dosage:
One tablet daily.

Contraindications:
Heart block. Co-administration with verapamil.

Precautions:
Untreated cardiac failure, bradycardia, renal failure, anaesthesia and pregnancy. 'Tenoretic' only. Out.
Changes in serum potassium are minor and probably clinically unimportant. Care should be taken in patients receiving digoxin and those liable to hypokalaemia from other causes.
In diabetes chlorthalidone may decrease glucose tolerance.

Side Effects:
Coldness of extremities and muscular fatigue.
Sleep disturbance rarely seen. Rashes and dry eyes have been reported with beta-blockers - consider discontinuance if they occur. Cessation of therapy with beta-blocker or beta-blocker/diuretic combination should be gradual. 'Tenoretic' only.
With chlorthalidone occasional nausea and dizziness and rarely idiosyncratic drug reactions such as thrombocytopenia and leucopenia.

Pack sizes and Basic NHS cost:
'Tenormin' 28's £7.27.
'Tenoretic' 28's £5.17.

Product Licence Numbers:
'Tenormin' 0029/0122.
'Tenoretic' 0029/0139.

'Tenormin' and 'Tenoretic' are trademarks.
Full prescribing information is available on request to the Company.

Stuart Pharmaceuticals Limited
Carr House, Carrs Road,
Cheadle, Cheshire SK8 2EG.
SPASTICITY FOLLOWING STROKE

LIORESAL®

Brings back a feeling of achievement

Prescribing notes: Indications Relief of spasticity of voluntary muscle arising from cerebrovascular accidents, cerebral palsy, meningitis, traumatic head injury, multiple sclerosis and other spinal lesions. Dosage Adults: Initially 15mg daily in three divided doses, increasing slowly at intervals of at least three days, until the optimum effect is achieved. Satisfactory control is usually obtained with doses up to 60mg daily, but careful adjustment is often necessary to meet the requirements of individual patients. A maximum daily dose of more than 100mg is not advised unless the patient is in hospital and under careful supervision. Children: Initially 5-10mg daily in divided doses, and a maximum dose of 60mg daily. There have been no reports of tolerance. Side-effects Nausea; vomiting; daytime sedation and confusion; muscle hypotonia and fatigue; visual hallucinations. Precautions Concurrent administration of antihypertensives; psychotic states; epilepsy; first three months of pregnancy. Packs Lioresal 10mg tablets in Securitainer packs of 100. Basic NHS price £11.66. PL0008/0053. * denotes registered trademark.

Full prescribing information is available on request from CIBA Laboratories, Horsham, West Sussex.
The antihypertensive

TRANDATE'S BALANCED MODE OF ACTION

Trandate has a mode of action that is different from that of any other currently available antihypertensive agent. It provides the benefits of both beta-blockade and peripheral vasodilatation. And in just one drug.

Trandate lowers blood pressure by reducing peripheral resistance. However, where Trandate differs from simple peripheral vasodilators is that it concurrently blocks beta-adrenoceptors, notably in the heart.

PRODUCES A MORE NORMAL CIRCULATION WITH GOOD EXERCISE TOLERANCE

This beta-blockade protects the heart from the reflex sympathetic drive which is normally induced by peripheral vasodilatation thus blood pressure is lowered, but without cardiac stimulation. And because this beta-blockade is competitive, cardiac output is not significantly reduced at rest or after moderate exercise.2,3

Thus Trandate is able to restore a more normal circulation.

SMOOTHING PEAKS IN BLOOD PRESSURE THROUGHOUT THE DAY AND NIGHT

The normal changes in blood pressure as a result of stress, exercise and circadian variation can be harmful to the hypertensive patient placing additional stress on an already strained cardiovascular system.

Trandate smoothes...
potentially harmful peaks throughout the whole 24 hour period and controls blood pressure effectively during the early morning surge.

complications of raised plasma lipid levels in hypertensive patients treated with beta-blockers it would appear more appropriate to use antihypertensive drugs which do not cause such changes. (Trandate) appears to be such a drug."

USEFUL IN PATIENTS WITH IMPAIRED RENAL FUNCTION

Trandate is particularly useful in the hypertensive patient with impaired renal function.4

"The drug did not seem to cause any significant deterioration in the GFR of those patients whose renal function was monitored closely, and in the majority of those whose renal functional impairment was due to hypertension alone a considerable improvement in GFR was observed."5

EMPLOYING A SIMPLE DOSAGE REGIMEN

Initial dosage is simple. 100 or 200mg of Trandate twice daily with food is adequate to control hypertension in many patients. Trandate therapy can be tailored to meet patient requirements by adjustment of dosage rather than by changing to, or adding in, other drugs. The majority of patients will be controlled at daily doses of up to 600mg. Higher doses may be required in more resistant cases.

WITHOUT ELEVATING PLASMA LIPIDS

It is also reassuring to know that Trandate does not cause a rise in plasma lipid levels. "Until we know the long-term

WITHOUT RESTRICTING LIFESTYLE

What Trandate offers your patients is effective control of their blood pressure without burdening them with additional problems that may restrict their everyday life.
Which antihypertensives also work at 48,000ft?

It is often assumed that aircrew who develop hypertension are grounded and cannot return to flying duties.

But they can.

A recent study in hypertension assessed the efficacy and safety of spironolactone/thiazide combination and the results were encouraging: 94% of patients were adequately controlled after six weeks of treatment. And more importantly, 84% were able to return to normal flying duties.

Thiazides, used alone, have been shown to control less than 50% of all treated patients. This research now indicates a more acceptable group of antihypertensive agents.

In everyday treatment, of mild to moderate hypertension, Aldactide 50 represents a very effective spironolactone/thiazide combination.

At a once daily dosage, Aldactide 50 ensures a gradual reduction of both systolic and diastolic blood pressures. Its antihypertensive effect is maintained during long term administration. And because it has little effect on serum uric acid and conserves potassium, Aldactide 50 can avoid the potential drawbacks of life-long thiazide only therapy.

Therefore when a patient first presents with mild or moderate hypertension, choose an antihypertensive that maintains a high level of performance. Choose Aldactide 50.

Once daily

Aldactide 50
hydroflumethiazide + spironolactone
To start with — to stay with

Reference

Precautions
Aldactide 50 tablets contain 12.5mg of hydroflumethiazide, 250mg spironolactone, and 12.5mg of hydrochlorothiazide. Use with caution in patients with a history of uric acid nephropathy, or gout, or in patients with a history of renal disease or cirrhosis.

Drug Interactions
Hydralazine, methyldopa, guanethidine, or other alpha-blocking agents may potentiate the antihypertensive effect of Aldactide 50. Use with caution in patients with a history of renal failure.

Overdosage
Symptoms of overdosage include hypotension, hypokalemia, and electrolyte imbalance. Treatment includes prompt withdrawal of the drug and supportive measures.

Searle Pharmaceuticals
Division of G.D. Searle & Co. Ltd., P.O. Box 53, Lakewood, 21704

Full prescribing information available on request.

Ciba-Geigy Corporation
Division of Searle Limited
London, U.K.
YOU CAN STILL INSIST ON INDERAL.

INDERAL

Inderal, the world's first and most widely prescribed beta-blocker, is the original propranolol and is backed by the full technical resources and quality control standards of ICI. Its efficacy and reliability have been proven in fifteen years of worldwide clinical practice and in countless trials. Developed wholly in Britain, Inderal now contributes millions of pounds annually to the balance of payments and helps to fund ICI's £45 million a year investment in medical research. Make certain your patient receives Inderal by prescribing it by name.

Write Inderal by name
First Effective Vaccine for Insect Sting Sensitive Patients

Pharmalgen

Prescribing information: PRESENTATION: Packs containing 4 x 5 ml white freeze-dried material (venom) from either honey bees or wasps, together with 4 x 4.5 ml of NSA diluent (normal serum albumin). Each vial of venom contains 100 μg of venom per ml when reconstituted with 1 ml of NSA diluent. Also packs of 10 x 4.5 ml NSA diluent. USES: Diagnosel and treatment of allergy to insect stings. DOSAGE & ADMINISTRATION: To establish starting dose for desensitisation, treatment by "modified aileron" is used. Injections for desensitisation are given subcutaneously. "Modified Rush" schedule is recommended. For full details see the package insert, which must be read before use. CONTRA-INDICATIONS: Other severe immunological illness, infections, and pregnancy. Pregnancy is not an absolute contra-indication, but the risk to a fetus of a possible anaphylactic reaction must be considered. PRECAUTIONS: To be used on the advice or guidance of a specialist. Full sterile procedure to be followed for injections. A 1 ml graduated syringe is recommended. Avoid intravascular injection - check by aspiration of syringe. With insect sting allergies, there is a slight possibility of anaphylactic or generalized reaction following an injection - the patient must be kept under observation for at least one hour after each injection, and full facilities for treating such reactions (e.g. adrenaline injection) should be immediately available. SIDE EFFECTS: Local allergic reactions or, more rarely, generalized allergic reactions. If a reaction occurs the course should be modified according to the dosage schedule given in the package insert. PHARMACEUTICAL PRECAUTIONS: Store at 2-8°C. Shelf life is 2 years for both freeze-dried venom and NSA diluent. After reconstitution solutions for vaccination have a shelf life of 4 weeks at 2-8°C. Venom in solution and NSA diluent must not be frozen. LEGAL CATEGORY: POM. PRODUCT LICENCE NUMBERS: PL 0009/0024 (Bee Venom, with diluent); PL 0009/0025 (Wasp Venom, with diluent).
Every month a different clinical question will be set by a team of consultants. Please send your entries to the May & Baker Diagnostic Quiz, 33-34 Alfred Place, London WC1E 7DP.

The prize will be a £100 British Airways travel voucher, given to the first correct entry opened each month.

This month’s competition has been prepared by D. G. Julian, Professor of Cardiology, Freeman Hospital, Newcastle-upon-Tyne.

Results and the winner’s name will be published in the journal in September. We regret no correspondence can be entered into. No employees or relatives of May & Baker or the publishers can enter the competition.

"In January 1981, an old age pensioner aged 72 was found by his home-help unconscious in his flat, where he lived alone. Over the preceding months he had been visited by his doctor on several occasions because he had complained of breathlessness and chest pain when going upstairs and was being treated with diuretics and nitrates. Bottles of aspirin and diazepam were found at the bedside.

On examination, the patient was unrousable but no focal neurological findings were observed. The pulse was regular at 54/min. and the blood pressure was 110/60. He was breathing slowly and regularly. There were no abnormal heart sounds nor were there any abnormal features in the lungs. The general practitioner could find no cause for the comatose state and admitted the patient to hospital. Again no cause was demonstrated but the electrocardiogram illustrated was recorded."

1. What does this show?
2. How is the diagnosis made?
3. What is the appropriate treatment?
Articular

Prescribing Information
Dosage: orally with food, 50-100 mg early morning and late at night. Contra-indications: recurring history of/or active peptic ulceration; chronic dyspepsia; use in children; in patients sensitive to aspirin or other non-steroidal anti-inflammatory drugs.

Known to inhibit prostaglandin synthetase or with bronchial asthma or allergic disease. Precautions: pregnancy; lactation. Dosage of concomitant protein-binding drugs may need modification. Side effects: occasional gastro-intestinal intolerance. Very rare: gastrointestinal haemorrhage/skin rash.
bronchodilator therapy
need be without
asthmatic

Ventolin
(salbutamol BP)
Becotide
(beclomethasone dipropionate BP)

Controls the inflammatory processes in more severe asthma

Avoids the side effects associated with systemic steroids

Can eliminate or greatly reduce the need for systemic steroids

Restores the response to bronchodilators

Obviates cns side effects and standing or growth in children

Available as a metered-dose aerosol
and a powder with spacer

Prescribing in asthma
THE MSD FOUNDATION

Audiovisual Programmes for General Practitioner Training

The MSD Foundation is an independent charity which produces audiovisual material for use in general practitioner training. Each programme is designed for use with small groups of doctors and paperwork is provided to help the group leader use the programme.

Our 1981 catalogue includes new videocassette and tape/slide programmes on the following topics:

- The patient dying at home — videocassette: The Case of Dorothy Parsons
- The child as a presenting symptom of family stress — videocassette: The Case of Darren Cooper
- Upper Respiratory Tract Infections in Children — a tape/slide programme
- Safer Prescribing — a tape/slide programme in two parts
- The Management of the Arthritic Patient — a videocassette in two parts
- Doctor at Work — Dr Paul Freeling: videocassette analysing one of Dr Freeling’s consultations
- Child Health Care in General Practice — a videocassette comparing two practices (see below)

PROGRAMME OF THE MONTH

CHILD HEALTH SURVEILLANCE

A videocassette lasting half an hour

General practitioners vary greatly in the emphasis they place on well child care. This programme looks at two doctors, both with a special interest in child health but whose practices are very different indeed.

The programme is divided into three sections: the first looks at the objectives of a child health surveillance system with brief illustrations from actual consultations. The second part contains two minimally edited consultations with children: one is the routine examination, including developmental assessment, of a two and a half year old; the other, a less formal family discussion about a sleepless child.

Both doctors detail their differing philosophies and, in the final part, the administration of a practice surveillance system is described. In contrast, a nurse employed in the practice which does not run such a system explains the advantages of informality. Trainees are left to discuss the pros and cons of possible approaches to child care in general practice. Paperwork for trainees includes a quiz based on the financial incentives involved as well as a copy of a comprehensive paediatric medical record.

Audiovisual programmes are offered for sale to vocational training course organizers and other teachers. Some programmes are restricted in use to doctors only, but others are available for use with medical students. Videocassettes are available on U-matic, VHS, Philips or Betamax formats, and the average cost is about £20–£25. Tape/slide programmes cost about £30 per session.

Further information, and catalogue, can be obtained by writing to:

The MSD Foundation
Tavistock House
Tavistock Square
London WC1
Tel: 01-387 6881

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CLASSIFIED ADVERTISEMENTS AND NOTICES

Classified advertisements are welcomed and should be sent to: Production Department, The Journal of the Royal College of General Practitioners, Update Publications Ltd., 33/34 Alfred Place, London WC1E 7DP. Copy must be received by the first of the month preceding the month of issue to ensure inclusion. Every effort will be made to include advertisements received after this date but publication cannot be guaranteed and the advertisement may have to be held over to the following issue.

The charge for space in this section is £5.75 per single column centimetre, plus 25p if a box number is required. Fellows, members and associates of the Royal College of General Practitioners may claim a 10 per cent reduction. Replies to box numbers should be sent to the Production Department, Update Publications Ltd., with the box number on the envelope.

The inclusion of an advertisement in this Journal does not imply any recommendation and the Editor reserves the right to refuse any advertisement. All recruitment advertisements in this section are open to both men and women.

Opinions expressed in The Journal of the Royal College of General Practitioners and the supplements should not be taken to represent the policy of the Royal College of General Practitioners unless this is specifically stated.

RUDOLPH FRIEDLAENDER MEMORIAL FUND FOR RESEARCH IN GENERAL PRACTICE
The Rudolf Friedlaender Memorial Fund invites applications from general practitioners for this award of up to £1,000.
The award is designed to assist in financing the following aims:
1. The preparation, completion and publication of a particular item of research or observations made in general practice.
2. The preparation and presentation of already completed work or findings in general practice.
3. Travelling expenses incurred in presenting the above findings at a local or international conference.
Application forms are available from: Dr F. H. Kroch, Rudolf Friedlaender Memorial Fund, 8 Regent Street, Eccles, Manchester M30 0AP.

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS
TRANSACTIONAL ANALYSIS IN GENERAL PRACTICE
14 PRINCES GATE, LONDON SW7 1PU
6, 13, 20 and 27 OCTOBER 1981
Four weekly sessions of three hours of interest to general practitioners who want to increase their understanding of personality and the communications between people.
This course will cover the theory of Transactional Analysis as expressed by Dr Eric Berne, author of Games People Play. The material will be related to the relationships between the doctor and the people who are his patients.
Apply to: Miss Elizabeth Monk, Courses Secretary, The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.
Approval under section 63 has been applied for.

BALINT SOCIETY
Applications are invited from general practitioners with or without previous similar experience to attend a Balint training seminar. The seminar will meet weekly in London starting later this year.
Section 63 approval will be available. Applicants should write to Dr A. H. Elder, Lisson Grove Health Centre, Gateforth Street, London NW8.

PARTNERSHIP
A fifth partner sought for a progressive group practice in St. John's Wood. We have our own nurse, attached HVs, GVs, etc. Appointments system. Excellent consulting facilities. ECG, vitalograph and access to pathology and x-ray services.
Please write with C.V. to: Drs Newman, Antoniou & Partners, Abbey Medical Centre, 87/89 Abbey Road, St. John's Wood, London NW8 0AG.
REPLACEMENT 6th PARTNER REQUIRED

Initial salaried partnership for mutual assessment, then two or three years to parity. LHA health centre (no capital required) off M18 motorway. Two practice SRNs; practice manager; secretary; receptionists; attached community health visitors; midwives and nurses; dieticians and chiropodists. Equipment includes ECG, microscope, peak flow meters, sonicaid, etc. for enthusiasts. Equal duty rota. Splendid hospital services and postgraduate programmes.

Send applications to: Drs Oakshott, Dobson, Owen, Nicholson and Stafford, The Health Centre, Thorne, Doncaster DN8 5QH.

WHAT IS HAPPENING IN AUSTRALIA?

The Royal Australian College of General Practitioners publishes a monthly journal — The Australian Family Physician.

This high quality journal contains articles of interest to all general practitioners written by leading Australian doctors and presented in a concise, readable format.

Australian Family Physician has a monthly circulation of 19,000 and is the only Australian journal of family practice to be indexed in Index Medicus.

Subscription rate for 12 issues: A$60.00 (surface mail). Enquiries to: Managing Editor, The Royal Australian College of General Practitioners, 4th Floor, 70 Jolimont Street, Jolimont 3002, Australia.

Medical Officers (Social Security)

£13045-£17950 (under review)

Vacancies for full-time Medical Officers exist at the DHSS Central Office, Norcross, near Blackpool, where successful applicants will join a team of full- and part-time doctors. The office is situated near the coast in a pleasant part of the countryside with excellent housing and education facilities.

These intellectually challenging posts require wide medical knowledge. They are concerned with casework on DHSS cash benefits; these include War Pensions, Attendance Allowance, Mobility allowance, Housewives Non-Contributory Invalidity Pension and Vaccine Damage Payments, and casework for both NHS and DES Superannuation schemes. Although the work is mainly administrative, there is some opportunity for domiciliary medical examinations.

Further information can be obtained from Dr D. A. Prosser, Principal Medical Officer, North Fylde Central

Department of Health and Social Security
THE MEASUREMENT OF THE QUALITY OF GENERAL PRACTITIONER CARE
Occasional Paper 15

The race to measure the quality of care in general practice is on, and the promotion of quality is one of the main objectives of the Royal College of General Practitioners. Nevertheless, for many years the identification of criteria of quality has proved elusive.

Occasional Paper 15 is a detailed review of the literature by one of the senior lecturers in general practice at St Thomas’ Hospital Medical School, Dr C. J. Wilkins, and forms part of the work for which he was subsequently awarded a Ph.D. It is therefore essential reading for those who are studying this fascinating subject.

The Measurement of the Quality of General Practitioner Care, Occasional Paper 15, is available now from the Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU, price £3.00 including postage. Payment should be made with order.

A SURVEY OF PRIMARY CARE IN LONDON
Occasional Paper 16

General practice in inner cities has emerged as a topic of immense concern to patients, the profession and government but, although there are many anecdotes, prejudices and rumours, hitherto there has been a great shortage of facts.

A Survey of Primary Care in London, Occasional Paper 16, is the report of a working party led by Dr Brian Jarman, which gives more facts than have ever been assembled before about the medical problems in London and the characteristics of the doctors who work there. A particularly valuable feature is the number of comparisons with Outer London and England and Wales.

This is likely to become a classic reference for all those interested in the problems of primary care in big cities.

A Survey of Primary Care in London, Occasional Paper 16, is available now, price £4.00 including postage, from the Publications Sales Department of the Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Payment should be made with order.

Answers to the May & Baker Diagnostic Quiz, April 1981

There were no entries giving an entirely correct diagnosis which was Wolff-Parkinson-White syndrome with atrial fibrillation. The prize has been awarded to Dr. D. E. Pelta of Southend-on-Sea who diagnosed paroxysmal atrial fibrillation with phasic aberrant ventricular conduction and described the abnormality in the following terms:

"This is a supraventricular tachycardia with a ventricular rate of over 200 per minute. The rhythm is irregularly irregular and the P waves cannot be clearly identified suggesting the rhythm is atrial fibrillation. The bizarre QRS complex is with bundle branch block pattern suggesting that the atrial impulses are conducted through only one bundle branch. The 'rabbit ears' QRS complex shows the second ear being dominant suggesting phasic ventricular aberration as the most likely diagnosis."

Dr. Pelta suggested treatment with digitalis to increase the conduction delay from multiple atrial ectopic foci and thus reduce the ventricular rate.

Our consultant cardiologist writes:

"Dr. Pelta is correct in diagnosing this as atrial fibrillation with aberrant ventricular conduction and his reasons for doing so are sound. The tracing shows an irregularly irregular rhythm without identifiable P waves. The rate, however, is extremely fast (about 300 per minute) and the normal AV node cannot transmit impulses at this rate. This pattern is characteristic of atrial fibrillation complicating Wolff-Parkinson-White syndrome; the AV node is bypassed by an abnormal pathway which has a short refractory period so that an unusual number of impulses from the atrium can activate the ventricle.

This is the most serious complication of W.P.W. syndrome, though only a minority of patients with the syndrome suffer this complication, it can be life-threatening because the ventricles may not be able to sustain an adequate output when beating so rapidly.

Dr. Pelta was incorrect on two counts. Firstly, the aberration does not represent conduction through one bundle branch—the abnormal pattern of depolarisation occurs because the bypass around the AV node enters the ventricle remote from the main conducting pathways and intraventricular conduction is also distorted because of the high rate. Secondly the condition should not be treated by digitalis because this has a variable effect on the refractory period of the abnormal bypass bundle; it may even reduce it and thereby increase heart rate making ventricular fibrillation more likely to supervene. The emergency treatment is D.C. shock to restore sinus rhythm.

The most effective drug for prophylaxis is amiodarone which has recently been made generally available in the U.K. for treating arrhythmias which occur with the Wolff-Parkinson-White syndrome. Though practically always successful in preventing atrial fibrillation of this type some patients cannot tolerate amiodarone. Surgery provides an alternative method of management. Facilities are available in a few centres for localising the abnormal tract and dividing it; when successful this eliminates the W.P.W. syndrome and the associated tendency to serious arrhythmias.
Behind the gentleness of Burinex K
bumetanide and slow release potassium chloride
lies the power of Burinex

Burinex K

gently effective
for maintenance

Burinex tablets
combine strength with gentleness for more refractory oedema

Burinex injection
fast powerful action for emergencies