Malignant hypertension in
general practice

Sir,
The 19 cases of malignant hypertension
out of 377 cases of hypertension found in
the national morbidity study indicates
that the condition is uncommon (October
Journal, pp. 471-475). There seems
nothing to commend a community study
of malignant hypertension (as opposed to
one for mild hypertension) as the
diagnosis is an indication for hospital
admission. As Dr Bulpitt suggests in his
article these patients should then be kept
under the closest supervision because their
blood pressure is often not well controlled.
Fortunately the incidence of malignant
hypertension appears to be declining at
least in the developed world, perhaps due
to the widespread treatment of
hypertension.1

The recognition of the accelerated
phase of hypertension from retinal
haemorrhages or cotton wool spots is not
at all straightforward. For example, age
and anaemia influence the interpretation
of these lesions and the retinal appearance
of benign hypertension is particularly
difficult to distinguish from arteriosclero-
sis.2 It is important therefore to assess
all the signs and symptoms of high blood
pressure and its effects on cardioenal or
cerebral function as well as to recognize
papilloedema.

The cases studied by Dr Bulpitt seem
to have had a worse prognosis than those
originally diagnosed with benign
hypertension. This appears to be due to
the inclusion of 34 patients with the
original diagnosis of malignant hyperten-
sion and the exclusion of 99 others in
whom the fundal appearances were not
recorded. However, the 10-year mortality
rate for these patients in an uncertain
category seems to have been similar to
those with confirmed benign
hypertension.

The prognosis of untreated hyperten-
sion and therefore any influence of treat-
ment can only be properly assessed by
taking into account the actual level of
blood pressure and multiple risk factor
analysis. Tables from the Framingham
Study help to do this.3 The designation
of benign hypertension is no longer good
enough.

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References
1. Kincaird-Smith P. Malignant hyperten-
sion: mechanisms and management.
2. Pickering GW. Fundus oculi in
hypertension. In: High blood pressure.
3. Kannel WB. Role of BP in car-
diovascular morbidity and mortality.

Well woman care: whose
responsibility?

Sir,
The study of reasons given by women for
attending family planning clinics rather than
their general practitioner (October
Journal, pp. 490-491) is of interest but of
limited value in trying to assess the true
demand for well woman care supplied
from centres other than primary care
teams. The Gloucester Community
Health Council interviewed 96 women at
family planning clinics and found that the
comments made about general practi-
tioner care were similar to the comments
made in the Hackney study. However, of
the 96 women interviewed only 28 had
ever seen their general practitioner for
family planning services: the majority of
women only had an impression of what
family planning care their general practi-
tioner provided without having had first-
hand experience. It would be interesting
to know how many women in the
Hackney survey had actually consulted
their general practitioner about contra-
ception before attending the family planning
clinic.

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Sir,
Following the article on well woman care
(October Journal, pp. 490-491) may I offer
the general practitioner's viewpoint. My
partners and I believe that contraceptive
and well woman care are as important a
part of general practice as obstetric care
and we take it for granted that our
patients would wish to come to us for
family planning care. Ours is a rural prac-
tice with three male partners and a prac-
tice nurse (female). Patients are seen by
the doctor and the nurse for family plan-
ning advice and examinations by appoint-
ment during normal surgery hours. In
addition, the practice nurse runs a
separate cervical screening service with
follow-up by letter. There is also a local
authority family planning clinic in the
local town where many of our patients
work.

I felt that I should test the hypothesis
that patients expect to come to their
general practitioner for family planning
care, and give balance to the paper by
Jessop and colleagues in which they
admit they do not include women who
currently attend their general practitioner
for family planning. I decided to ask
women attending the surgery for family
planning two questions: 'What is your
main reason for coming to the surgery for
family planning?' and 'Are you worried
that the doctor who examines you is
male?' To minimize the effects of
politeness and deference to the doctors,
these questions were asked by the practice
nurse when she was alone with the patient.
Table I provides a synopsis of the answers
received over a two-week period.

Table 1. Number of responses to questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your main reason for coming to the surgery for family planning?</td>
<td>24</td>
</tr>
<tr>
<td>Prefer service</td>
<td>6</td>
</tr>
<tr>
<td>Know/like the doctor/staff</td>
<td>5</td>
</tr>
<tr>
<td>Nearest/obvious place</td>
<td>4</td>
</tr>
<tr>
<td>Convenient</td>
<td>4</td>
</tr>
<tr>
<td>History known</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
<tr>
<td>Are you worried that the doctor who examines you is male?</td>
<td></td>
</tr>
<tr>
<td>Don't mind a male</td>
<td>14</td>
</tr>
<tr>
<td>Do not mind but would see a female if available</td>
<td>2</td>
</tr>
<tr>
<td>Prefer a male</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

These are only small numbers, but they
illustrate the point that different patients
use different services and are likely to ex-
press a preference for what they have
chosen. Were Jessop and colleagues to con-
duct a study in urban general practice
which provides a family planning service,
they would probably obtain similar
answers to ours. The conclusion,
therefore, seems that there are groups of
patients who prefer to obtain family plan-
ning care from general practitioners and
groups who prefer to attend family plan-
ning clinics. In other words, there is room
for both of us and we each have an im-
portant contribution to make.1

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Reference
1. Robert Snowden. Consumer choices in
family planning. London: Family Plan-