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 arteriosclerosis.[2] It is important therefore to assess all the signs and symptoms of high blood pressure and its effects on cardiorenal 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 hypertension 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 hypertension and therefore any influence of treatment 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

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2. Pickering GW. Fundus oculi in hypertension. In: *High blood pressure.* Edinburgh: Churchill Livingstone, 1968.
3. Kannel WB. Role of BP in cardiovascular morbidity and mortality. *Prog Cardiovasc Dis* 1974; **17**: 5-24.

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 practitioner 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 practitioner 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 contraception 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 practice with three male partners and a practice nurse (female). Patients are seen by the doctor and the nurse for family planning advice and examinations by appointment 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 Jessopp 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 1 provides a synopsis of the answers received over a two-week period.

Table 1. Number of responses to questions.

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

These are only small numbers, but they illustrate the point that different patients use different services and are likely to express a preference for what they have chosen. Were Jessop and colleagues to conduct 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 planning care from general practitioners and groups who prefer to attend family planning clinics. In other words, there is room for both of us and we each have an important contribution to make.[1]

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1. Robert Snowden. *Consumer choices in family planning.* London: Family Planning Association, 1985.