unending therapy and refused to pay as it was discovered it was wholly uneconomic.

Alas, without the direct cost implications to concentrate the mind, experiments in the UK are likely to be disappointing as far as outcome and cost benefit are concerned unless the issues are addressed by doctors and therapists alike.

Another equally pressing problem is that of certification and accreditation of counsellors and therapists. Can one compare the work of a counsellor with 40 hours of instruction and no supervision with that of a trained psychotherapist with perhaps 2000 hours of training, 1000 hours of supervised work and 3000 hours of professional consulting?

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Unilateral headache

Sir,

I was interested to read the letter by Dr Melville (October *Journal,* p.472) on unilateral headache. The tinnitus experienced by three out of the four patients with cluster headache may be explained on two accounts.

1. Altered cochlear blood flow related to the vascular upset associated with cluster headache may contribute to tinnitus.[1]

2. It has been shown that females are more likely to report the symptom of tinnitus in addition to the symptoms of headache.[2]

Dr Melville suggests that herpes simplex infection of the vestibular nerve occurs. However, since none of his patients reported hearing loss or vertiginous episodes, and there was no reported evidence of nystagmus, it is unlikely that there was any infection of the vestibular ganglion. It would be interesting to know, however, if the tinnitus which was present in his patients coincided in onset and cessation with the onset and cessation of the cluster headache.

Herpes labialis is common and recurrent. It is difficult, therefore, to postulate a cause and effect relationship with development of cluster headache.[3] It would be interesting to follow up Dr Melville's cohort to correlate future episodes of herpes labialis infections and the occurrence of cluster headaches and also to carry out further investigations at the time of headache into hearing and vestibular function.

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Coronary heart disease prevention

Sir,

Dr Jewell (Book reviews, September *Journal,* p.429) berates the report of the National Forum for Coronary Heart Disease Prevention[1] which, he says, with its 'austere message may be a late if very fine example of a dying genre'. I am sorry if this was how it came over to him. It is not easy to present a factual report on our biggest preventable health problem in a 'health is fun' style, but this does not mean that health promotion itself need be austere.

He suggests that coronary heart disease is starting to fall in younger cohorts for inexplicable reasons; that the pandemic may blow over without our 'being able to claim the victory for medical science'. In one sense he hits the nail on the head. It is a disease whose rise and fall, like tuberculosis, rheumatic fever and peptic ulcer are related in large part to environmental and social conditions[2] over which individuals and their doctors have limited control. That is why, as he notes, the report concentrates so much on the additional steps the government could take to speed up the slow sea change towards a healthier lifestyle which is already taking place: for example, by encouraging a further decrease in cigarette smoking (the recent drop being the most likely explanation for the slight decrease in mortality from coronary heart disease); building in incentives towards appropriate dietary changes, and increasing sports facilities.

The problems with leaving existing trends to do the job is that social classes C, D and E get left behind, as is already happening, and the whole process is much slower than it need be.

Doctors, however, do have a part to play, especially general practitioners, and I was sorry that Dr Jewell did not draw attention to the chapter on primary care which points out — in a very non-austere way — how much more we could be doing, both in screening for those at high risk[3] and as 'opinion leaders' encouraging lifestyle changes.

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Inappropriate use of casualty departments

Sir,

It is poignant that further correspondence concerning the inappropriate use of casualty departments (November *Journal,* p.519) appears in the same issue as a robust defence of the referral system by Dr Marinker (November *Journal,* p.487).

The recent observation that many patients attend casualty departments when the surgery is open adds credence to the idea that patients' perceptions are important factors in determining the use of services.[1]

Accident and emergency departments necessarily see patients without referral, but these facilities must not be abused. The modification of future health seeking behaviour is an aim of each consultation in general practice[2] — this can only be done if general practitioners have information regarding those abusing the service. Good communication at this troublesome interface between primary and secondary services could provide feedback and thus help in the development of new ideas to combat growing numbers of inappropriate casualty attenders.

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