and that can establish intensity–duration curves from 0.1 to 30 ms, for a muscle and corresponding nerve. The procedure takes no more than three or four minutes, and can be repeated as required. Such measures of neuromuscular excitability are a valuable tool for the practitioner.

I obtained intensity–duration curves for a muscle and nerve in 1000 consecutive patients consulting one general practitioner for non-acute conditions from 1 October 1989 to 1 April 1990. A retrospective analysis of patient records (627 women and 373 men; mean age 48 years) was carried out, including clinical follow up and repeat testing. Among these a group of 102 ambulatory hypertensive patients were identified. Of these 35% showed hypo-excitability, indicating that prescription of a beta-blocker or diuretic drug was required and 25% showed hyper-excitability and would benefit, in the first instance, from an angiotensin converting enzyme inhibitor or calcium antagonist. The 40% of hypertensive patients whose neuromuscular excitability was not clearly perturbed, would better tolerate one of the older centrally acting antihypertensive drugs.

These results demonstrate that measuring neuromuscular excitability can help general practitioners to monitor the global metabolic repercussions of an illness and its treatment.

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Cholesterol level testing

Sir,
In 1992 we audited a cholesterol testing programme. The practice's records were examined from before and after the introduction of a protocol (in 1988 and second half of 1990) and the results pooled. Of the 198 patients tested the mean age was 49 years and 65% were men. Almost all of the tests were carried out by a practice nurse. The results, according to the categories used by Cooper and Cocksedge,[1] were normal (less than 5.2 mmol l^{-1}) in 34% of cases, borderline (5.3 to 6.4 mmol l^{-1}) in 36%, raised (6.5 to 7.9 mmol l^{-1}) in 24% and very high (8.0 mmol l^{-1} or more) in 5%. Significantly fewer patients had raised cholesterol levels than found by Cooper and Cocksedge.[1]

Forty five per cent of patients tested had no cardiovascular risk factors. Retesting was often misdirected: 26% of patients with cholesterol concentrations below 6.5 mmol l^{-1} were retested, contrary to the practice protocol, while 27% of patients with concentrations between 6.5 and 7.8 mmol l^{-1} and 45% of those with concentrations above 7.8 mmol l^{-1} were not retested, necessary according to the protocol to monitor the effect of dietary change. Elderly patients (65 years and over) and those without established risk factors were often tested — 22% and 29% of those tested, respectively. The mean cholesterol concentrations of all 198 patients was 5.8 mmol l^{-1}, similar to that found in large population surveys in the United Kingdom.[2,3] The value of this retrospective study was reduced by the incompleteness of patients' notes — in 107 cases the notes did not record whether the patient was a volunteer or had been invited, making adherence to the protocol impossible to assess. We detected no impact of the protocol on practice.

It is difficult to know how to test and treat only patients who stand to benefit most from cholesterol level reduction. The Dundee risk-disk[4] with the Coronary Prevention Group guidelines[5] may help general practitioners to use limited resources effectively by indicating which patients need special care and which only need general advice. The risk-disk produces a score based on smoking status, blood pressure measurement and estimated or measured cholesterol concentration.[4] The patient's score is then compared with the general population to indicate his or her risk relative to others. Patients without a personal or family history of coronary heart disease only have a cholesterol test if other risk factors indicate that they are likely to benefit substantially from cholesterol reduction.

The level of cholesterol-attributable risk for which testing and special care are offered can be set according to the resources available. All patients have their cardiovascular risk quantified while only those who require it are tested. The multifactorial assessment of individuals' risk, together with the population-based measures that Cooper and Cocksedge advocate,[1] such as dietary change, is the most effective way to combat cardiovascular disease.

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Recording ethnic origin

Sir,
I recommend recording patients' ethnic origin by asking them for their country of family ethnic origin. This can help identify those at increased risk of carrying or likely to suffer diseases known to be more prevalent in certain racial groups. It can also give an indication of cultural background which may reflect the health needs and expectations of a cultural group.

The classification recommended by the Commission for Racial Equality gives racial groups which range from white to groups which imply nationality, such as Pakistani or Indian.[1] The advantage of recording by country of family ethnic origin is that it gives an immediate clue to current health requirements. For example, recording Somalia at the present time suggests that I am dealing with a refugee, and I can be prepared for the patient's health needs. Recording 'black African' would provide negligible information for the assessment of health needs and no indication of language requirements.

This approach has been implemented in my practice for two years and I have found no resistance from patients. It has not proved difficult for third generation families to give country of family ethnic origin and for mixed families to give two countries. The two countries are recorded with the mother's country first, for example, Jamaica Nigeria. The answers patients give do not imply nationality and this is appreciated by many patients. Practice computers should hold a list of countries and regions to avoid free text entries and the Read codes[2] should include a gazetteer of countries, written as proper nouns for the coding of ethnic origin.

The health service is fortunate in that a birth in the United Kingdom can usually