CORRESPONDENCE

TRIAL OF ASPIRIN

Sir,

The time has come when it would be both reasonable and valuable to undertake a prospective controlled trial of aspirin in the prophylaxis of ischaemic heart disease. Because of the risk of gastrointestinal haemorrhage those taking part should be volunteers who understand both the risks and the theoretical benefits.

I am writing to ask for volunteers from the medical profession in Great Britain and Ireland. I should be glad to hear from any doctor aged 35 or over who is not known to have ischaemic heart disease and who would be prepared to participate. The suggested dose of aspirin is 300 mgm twice a day. Allocation to control or treatment groups would be random.

The trial would last five years unless significant results appear earlier. At the beginning and at the end all participants would be requested to complete a simple questionnaire regarding smoking, exercise, medical and family history. They would also be asked to undergo a simple examination which would include height, weight, blood pressure, ECG, fasting blood lipids and blood sugar. The examinations would be carried out locally.

Participation in the trial would end with the diagnosis of ischaemic heart disease or the development of significant side-effects from taking aspirin.

I would be very grateful if anyone prepared to take part would write to me. If the response shows that a trial is feasible details will be sent to volunteers later.

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SYRINGING EARS

Sir,

The method of syringing ears with the modified garden syringe described by your contributor looks, to me, potentially very dangerous.

Surely, the cardinal principle, when syringing ears is to avoid damage to the tympanic membrane as may occur by the sudden unexpected movement of the head towards the nozzle of the syringe. With this in mind, it is essential that any method of ear-syringing must allow the middle, ring, and little fingers of the hand holding the nozzle to the patient's ear, to rest on the pinna and the adjacent temporal bone, or both, so that the nozzle stays in exactly the same place if the patient moves his head unexpectedly. This is particularly important in children and the elderly deaf patient. If this precaution is taken, the patient can never move unexpectedly on to the nozzle, as the nozzle will always move with him.

I do not think there is any easier or safer method than to connect a Higginson syringe to a douche can, by means of an extension rubber tube, to *secure* the nozzle to the Higginson. If the douche can is hung on the wall, both hands are free to control the pressure bulb and the safe position of the nozzle.

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REFERENCE
Blay, E. R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 525–526.

CLASSIFYING DISEASE IN GENERAL PRACTICE

Sir,

It was instructive to learn of the difficulties that both doctors and ancillary staff have encountered when trying to use the *International Classification of Diseases*. As the Livingstone doctors point out "symptom orientation" or "problem orientation" is one way of avoiding the difficulties involved in the use of the *ICD*. The big difficulty in using the *ICD* is to check the validity of the diagnosis made by the doctor. It is a difficulty which even National Morbidity Surveys have failed to face.

When the doctors in Livingstone use the term validity, however, do they mean validity? It appears that they are confusing validity with reliability. They measured the number of mistakes that were made during coding by both secretaries and doctors. This, surely, is a measure of the reliability of their method. Validity is a measure of the extent to which an instrument (or method) succeeds in measuring what it sets out to measure. The reliability of an instrument (or method) may be one of the criteria by which validity is judged.

It is important to make this point in this instance because the issue facing general practice is one of selecting a valid instrument for measuring morbidity. The methods described in the paper in no way test the validity of the *ICD*. This can only be done by testing whether the diagnoses expressed by the doctor in *ICD* terms are accurate in terms of the disease process that the patient has at the time of diagnosis.

This may seem a small point but it reveals the basic deficiency of the *ICD* in general practice. Much illness in general practice is transient in nature and is impossible to validate in terms of the *ICD* because by its very nature it is based on a classification of disease. If the general practitioner were to change his ground and classify morbidity in terms of symptomatology or of problems presented by the patient it becomes easier to validate the classification.

The issue then becomes clearer. Do doctors, for example, agree about the content of the problems that they are defining? This is something that doctors could test in practice and measures of their agreement (or disagreement) could be used to validate measures of morbidity other than the