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.

JAMES MCCORMICK
Professor of Social Medicine
Medical School Building,
St. James's Hospital,
James's Street, Dublin 8.

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.

E. C. ATKINSON
296 Twentywell Lane,
Dore,
Sheffield S17 4QH.

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

ICD. It must, however, be doctors themselves that make the measures. Secretarial staff cannot be involved in this process because they do not define the problem (or "make the diagnosis"). Both doctors and secretaries will always be unreliable, to a certain extent, when they interpret and transfer information.

G. KEELE

Department of General Practice,
Darbishire House Health Centre,
Upper Brook Street,
Manchester, M13 0FW.

REFERENCE

Bain, D. J. G., Bassett, W. J. & Haines, A. S. (1973). *Journal of the Royal College of General Practitioners*, **23**, 474–9.

REORGANISATION OF THE NATIONAL HEALTH SERVICE

Sir,

Although I am sure that this is a simple slip of the editorial pen in translating D.M.T. as District *Medical* Team rather than District Management Team, I am sure that this is something you will wish to correct at an early opportunity.

D. E. CULLINGTON
County Medical Officer

Berkshire County Council Health Department,
Bernard Sundley Building,
49 Friar Street,
Reading, RG1 1EA.

REFERENCE

Journal of the Royal College of General Practitioners (1973). Editorial, **23**, 385.

RESEARCH UNIT

Sir,

An outline of the functions of the Research Unit of the College was presented in the June *Journal*. The papers dealt with specific aspects and because of this one important function of the Research Unit, perhaps its most important function, might be overlooked and we would like to take this opportunity to draw the attention of your readers to it.

The primary purpose and function of the Research Unit is to act as an advisory service to general practitioners, either as individuals or groups who have research problems of any kind. This advisory function is definitely orientated towards the problems associated with the development of research in its very earliest phases. Both Dr Pinsent and I are convinced that our major contribution is made in personal discussions with practitioners at the earliest stages in the development of their ideas as well as at the more conventionally-accepted later stages of development.

We would encourage anyone who is embarking on a research enquiry of any kind to feel free to make use of us at a very early stage and to feel free to come back and follow up initial contacts and discussions as often as they feel they should. To establish the problem and its structure clearly is much the most important part of any research enquiry or project. This is the level at which the Research Unit encourages maximum use of its services. These include assistance with the design, printing and distribution of relevant documents, help with the analysis at the very simple 'desk top' level, preparation of tabulations and typing of reports and papers.

Although the Research Unit provides a technical service in terms of the design of research projects and the development of analytical programmes for data, we stress that the most important decisions are taken at an earlier stage still.

D. L. CROMBIE
Director, The Research Unit

c/o Birmingham Regional Hospital Board,
Newland House,
139 Hagley Road,
Birmingham, B16 8UA.

PREVENTION OF TAY-SACHS DISEASE

Sir,

Tay-Sachs disease is rare, fatal and in a sense preventable. The gene responsible for it is carried by at least one in 30 Ashkenazi Jews and about one in 300 of the rest of the population, so that the chance of an Ashkenazi couple having an affected child is 100 times as great as in marriages not involving their racial group. They are the obvious target for a preventive campaign, as the chance of hitting a bull's eye is great, but Tay-Sachs disease occurs in the rest of the population and we hope that ultimately everyone at risk will be discovered.

The disease is transmitted as an autosomal recessive character, so the risk occurs only if both husband and wife are carriers. Such couples can be told of the risk and can then decide not to have children (except by adoption) or to have amniocentesis at about the fifteenth week of pregnancy, when diagnosis of the fetus is possible. If it is affected, pregnancy can be terminated. Thus parents who are carriers can be assured of never having a child with Tay-Sachs disease and enduring the two to three years of agony which the slow death of such a baby involves.

The laboratories of the British Tay-Sachs Foundation are equipped to carry out detection of carriers and antenatal diagnosis. We shall be glad to visit groups (e.g. synagogue congregations or student associations) to obtain specimens, or to take them from individuals who telephone (01-405 9200, Ext. 313) for appointments at The Hospital for Sick Children.

Partners in one general practice are about to start a survey to find carriers among their patients, in which we are naturally pleased to co-operate, and we hope that other doctors will be interested in carrying out surveys.

A brochure on this topic is being circulated with this issue of the *Journal*; further copies may be obtained (free) from the Foundation.

P. R. EVANS
Director

British Tay-Sachs Foundation,
The Hospital for Sick Children,
Great Ormond Street,
London, WC1.