Social climate and ward atmosphere by D. Hall and R. Pill

General practitioners' estimates of patient expectations and other aspects of their work by G. V. Stimson

Prescribing accountability in National Health general practice by R. E. A. Mapes

Health careers and competence: aspects of behaviour in a children's ward by R. Pill

Enquiries should be addressed to the Medical Sociology Research Centre, Park Buildings, Park Street, Swansea SA1 3DJ.

PRIVATE MEDICAL INSURANCE

The British United Provident Association (BUPA) reports new records for growth in 1974 with a subscription income £7,500,000 higher than the previous year.

About two million people have now taken out private insurance cover with this organisation.

SALARIES FOR PHARMACISTS

The proprietor's notional salary for England and Wales has been raised to £4,725 a year with effect from 1 January 1975.

REFERENCE

The Pharmaceutical Journal (1975). **215**, 5.

FAMILY PLANNING ASSOCIATION

The Family Planning Association estimates that it trained about 300 general practitioners in 1974.

MORGANNWG HOSPITAL, BRIDGEND, MID GLAMORGAN

A course of lectures, tutorials and clinical demonstrations in psychological medicine and allied subjects will be held from 26 September to 12 December 1975. Application should be made to Dr M. W. Annear, Morgannwg Hospital, Bridgend, Mid Glamorgan CF31 4LN.

CORRESPONDENCE

PHYSICAL SIGNS IN ASTHMA

Sir,

Most general practitioners called to see a patient with an acute asthmatic attack will agree that it is often difficult to assess the true degree of airflow obstruction in many cases. Physical signs have been shown to be misleading; noisy wheezes are often present with little obstruction, whereas patients in severe danger can present the listener with relatively normal breath sounds.

Estimation of the peak expiratory flow-rate (PEFR) with a Wright's peak-flow meter is a relatively easy procedure and gives a good guide to the degree of disability; generally speaking a PEFR of less than 100 litres/minute signifies severe and dangerous airflow obstruction in the acute attack.

However, there is another simple observation which can be made on clinical examination which gives an excellent objective measurement of the degree of obstruction; that is the measurement of pulsus paradoxus. This can be elicited with the sphygmomanometer by noting the difference in the systolic pressure between inspiration and expiration at the brachial artery. Important pulsus paradoxus is present when the difference between these two pressures is at least 10 mm Hg in each respiratory cycle.

Knowles and Clark (1973) reviewed the efficacy of this sign and confirmed that the degree of pulsus paradoxus correlated well with the PEFR and FEV_1/FVC ratio in patients with severe asthmatic attacks; the lower the PEFR and FEV_1/FVC ratio the greater the degree of pulsus paradoxus.

In view of the simplicity in performing the measurement of pulsus paradoxus and its apparent accuracy in assessing the degree of airflow obstruction, it should prove a useful additional tool for every general practitioner confronted with the common problem of the acute asthmatic patient.

J. C. DAVIES
Vocational trainee in general practice

REFERENCES

Rebuck, A. S. & Read, J. (1971). *American Journal of Medicine*, **51**, 788.

Knowles, G. K. & Clark, T. J. H. (1973). *Lancet*, **11**, 1356–1359.

USE OF VITAMIN B1 IN CHICKENPOX

Sir,

For many years I have been using Vitamin B1 to control the 'cropping' of chickenpox.

If Vitamin B1 is started *as soon as* the diagnosis is made:

(1) Further crops of vesicles cease,
(2) Inflammation of the original vesicle appears to decrease,
(3) Hence irritation also decreases, and whatever irritation persists is eased by 'Caladryl' lotion diluted one in four,
(4) Scabbing is more rapid.

The dosage of Vitamin B1 I have used is:

Age up to five years:	3mg t.d.s.
Age five to ten years:	5mg t.d.s.
Age 10–14 years:	10mg b.d.–t.d.s.
Adults:	20mg t.d.s.

For the few very severe infections (confluent) in adults: I use 50mg t.d.s.

In addition a few adults with intense irritation

benefited from ' Piriton ', one tablet three times a day.

G. A. DINGEMANS

Tanyard Lane,
Steyning, Sussex BN4 3SB.

RESPIRATORY MORBIDITY AND THE WEATHER

Sir,

I was interested in the article on the effect of weather on reported morbidity (April *Journal*) and in particular the comments that " for practical reasons measures of reported morbidity may be the best available estimate of true morbidity " (p. 248) and " there is a negative association between temperature and the number of respiratory episodes . . . rainfall was not significantly correlated . . ." (p. 250).

Some further information on this matter is available from a survey of 56 families who recorded all symptoms daily over a 14-month period in 1967–68 (Bridges-Webb, 1971), thus providing information about biological (" true ") morbidity rather than behavioural (reported to a doctor) morbidity.

The onset of respiratory illnesses was correlated with details relating to the weather conditions on the day of onset of illness. The lower the maximum and minimum temperature of the day the greater the incidence of onset of respiratory illness (table 1); however, only the association with maximum temperature reaches the 95 per cent level of significance. A decrease in maximum temperature of over five degrees Fahrenheit compared with the day before onset, or a decrease of over ten degrees compared with the average maximum temperature for the week did not significantly increase the incidence of respiratory illness having onset on that day.

TABLE 1

	Number of days	*Number of respiratory illnesses*	*Respiratory illness per day*
Maximum temperature			
under 54 degrees	15	85	5·7
55–64 „	153	739	4·8
65–74 „	113	437	3·9
75–84 „	73	271	3·7
Over 85 „	51	179	3·5
Minimum temperature			
under 34 degrees	20	99	5·0
35–44 „	119	590	5·0
45–54 „	162	670	4·1
55–64 „	85	285	3·4
Over 65 „	19	67	3·5
Change in maximum temperature from day prior to onset			
Decrease over 5 degrees	69	299	4·3
No change	253	1100	4·3
Increase over 5 degrees	83	312	3·8
Maximum temperature of day of onset compared with average for week			
Lower by 10 degrees or more	22	98	4·4
Within 10 degrees	356	1514	4·3
Higher by 10 degrees or more	27	99	3·7

However, an increase in the maximum temperature of over five degrees on the day of onset compared with the day before onset resulted in a significant decrease in the incidence of onset of respiratory illness on that day. There were no differences related to similar changes in the minimum daily temperature. The amount of rainfall on the day prior to onset had no influence on the incidence of respiratory illness.

This information reinforces the conclusions drawn by the authors of the article quoted.

CHARLES BRIDGES-WEBB

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Traralgon 3844,
Australia.

REFERENCE

Bridges-Webb, C. (1971). ' A Study of Morbidity in Traralgon, Victoria ', M.D. Thesis, Monash University.

HYPERTENSION IN GENERAL PRACTICE

Sir,

In response to Dr Juel-Jensen's comment (August *Journal*) on my review of Sir George Pickering's book on hypertension may I state at once that Dr Juel-Jensen has not read my review with any real understanding.

I did not ask Sir George for more information or more epidemiological surveys of the frequency and distribution of hypertension. Many of us have had more than enough of these, but too little, much too little, of the application of these and other surveys to the better management of hypertension in general practice.

It was on this lack of discussion and information, by Sir George, of the nature and management of hypertension in general practice that I commented.

As for studies and surveys from general practice on high blood pressure, the College bibliography lists more than a dozen, and I know of more, that have sought to examine and study not only the frequency of hypertension, but also the ways in which it should be managed in the special field of general practice.

JOHN FRY

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Beckenham, Kent.