In the words of his daughter—" He was such a gentle, understanding person ".

For those of us who had the privilege of working with him, the memory of Montie will always be an inspiration and a challenge. He saw the vision splendid. So must we.

C. JUNGFER

CORRESPONDENCE

LOOKING AFTER PATIENTS WITH HIGH BLOOD PRESSURE

Sir,

In your recent editorial, *Looking after patients with high blood pressure* (April *Journal*), you refer to a history of headaches (type unspecified).

Pickering (1968) in his classic text points out that " headaches are more conspicuous in those who are anxious, as are patients who have just been told that their arterial pressure is high ". He then goes on to describe the features of one type of headache which is commonly associated with gross hypertension. Happily the great majority of hypertensive patients in day-to-day practice do not suffer from gross hypertension.

Similar observations have been made by other workers, e.g. Stewart (1973) and the *British Medical Journal* (1973) editorial.

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Sir,

The importance of the clinical examination of the hypertensive patient is given too little weight in your editorial (April *Journal*). Baseline information about the state of the peripheral pulses is invaluable, particularly as these patients have a high prevalence of peripheral vascular disease.

Attention to the femoral pulses is necessary to pick up the rare case of coarctation of the aorta. Careful palpation of the cardiac apex is an extremely important, but all too often neglected part of the physical examination, and may provide evidence of left ventricular overload before the electrocardiogram or chest x-ray become abnormal. The apex is palpated first in the recumbent position to determine its site and then in the left lateral position to determine its character. The normal apex presents a brisk outward movement at the onset of systole, quickly receding in mid to late systole; the hypertrophied left ventricle shows a more sustained thrust which increases throughout systole before fading at the onset of diastole (Conn and Cole, 1971). Left heart disease may be picked up at an even earlier stage by the finding of an atrial gallop. (Bethell and Nixon, 1974.)

The presystolic atrial impulse is often easier to feel with the finger tips than to hear through the stethoscope; the atrial sound may best be heard with the bell of the stethoscope placed very lightly on the apex. The disappearance of the atrial gallop following control of the blood pressure is a good indication of successful treatment (Kincaid-Smith and Barlow, 1959).

The long term management of a chronic condition like hypertension requires more than a single observation of the various clinical features, laboratory findings and electrocardiographic and x-ray changes. Regular checks of some parameters are necessary to ensure that control is not only cosmetically satisfying, but also physiologically effective. An efficient recording system is essential to this task, and the flow sheet, an integral part of the problem-oriented medical record, is ideal for the purpose (Bjorn and Cross, 1970). Columns for blood pressure, weight and drug dosage are filled in at each attendance, while columns for apex character, fundal appearance, peripheral pulses, blood potassium and urea, chest x-ray and electrocardiogram can be completed less often. A glance at the flow sheet shows not only the efficiency of blood pressure control, but also sequential changes in other important observations and when they should be repeated.

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