his general condition did not improve he was transferred to the ward and given 500 ml of 5 per cent dextrose intravenously. The blood pressure and the pulse rate remained unchanged. He was infused with another 500 ml of 5 per cent dextrose without much benefit. He was conscious throughout this period, and was kept under observation without any further treatment. His blood pressure gradually improved and six hours later was 100/70 mm Hg with a pulse rate of 100 per min. He remained under observation for the next 24 hours and was discharged with a blood pressure of 120/80 mm Hg and a pulse rate of 92 per minute.

As acupuncture point Fengchi (G B 20) is also recommended in the treatment of hypertension,[4] stimulation of this point probably was responsible for the hypotension on this occasion and therefore was avoided in the subsequent treatment. The 10 day course of acupunture was completed successfully without further incident.

Fourteen other patients were treated for chronic sinusitis without the stimulation of acupunture point Fengchi (G B 20) and none of these patients showed evidence of hypotension; further evidence that stimulation of the acupuncture point Fengchi (G B 20) in this patient might have been responsible for his hypotension.

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Fatal but Clinically Undiagnosed Tuberculosis

Sir,

I was interested to read this article by Dr R. M. Whittington (June *Journal,* p. 343). This disconcerting state has been recognized previously with miliary tuberculosis, both in the UK[1] and in Canada.[2]

The Canadian experience showed two groups amongst 48 patients with miliary tuberculosis. In 18 patients the diagnosis was made only at autopsy. In this group there was a particularly high incidence of concomitant disease. In addition, tuberculin testing, bacteriological search for acid-fast bacilli and chest radiography were frequently neglected. Members of this group were considerably older than those in the group in which the diagnosis was made before death. The disease was characteristically insidious in onset, frequently with non-specific symptoms. Fever was a common presenting symptom. Several patients presented with a fulminant illness which, although diagnosed, was not affected by anti-tuberculosis therapy and was rapidly fatal.

Thus, with all forms of tuberculosis, continued vigilance is necessary. This is especially important in the elderly patient who has other chronic illness.

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Prescribing Oral Contraceptives in Oxfordshire

Sir,

This paper (April *Journal,* p.201) provides some interesting insights into doctors' attitudes towards the varieties of oral contraceptive available. When asked to name their three most commonly prescribed brands, 68 per cent of general practitioners and 42 per cent of family planning doctors gave the low dose oestrogen/high dose progestogen Eugynon 30 or Ovran 30, making them second in the league. Although there is no direct evidence, I suspect that this means that a substantial number use them as their first choice for most women.

On the other hand only 14 per cent of general practitioners and no clinic doctors named a brand containing 50 micrograms of oestrogen. This shows that there is still great preoccupation with the oestrogen component and comparative neglect of the progestogen. The Presidents of the two relevant Colleges have stated, 'We are unable to determine from present evidence whether oral contraceptives containing lower doses of oestrogen offer any advantage over those containing 50 micrograms'[1] and I doubt if they have changed their minds. However, 90 per cent of prescriptions for combined pills are for those containing 30 micrograms of oestrogen.

Clifford Kay ably demonstrated in 1980 that it is the progestogen which is responsible for both hypertension and arterial disease.[2] Plowright and Adams' prescribing survey was conducted later that same year. Low oestrogen/high progestogen were in vogue at one time as progestogens were found to reduce blood cholesterol. However, we now know that what they reduce is the protective HOL fraction and this helps to account for the rise in arterial disease. This means that although the low oestrogen/low progestogen pills like Microgynon and Ovranette may continue as first choice, if a second choice is required (for example for breakthrough bleeding) then it should be a high oestrogen/high progestogen pill, such as Eugynon 50 or Ovran as the high oestrogen tends to offset the adverse effects of the progestogen upon blood lipids.

I hope that we can see a diminution in the prescription of low oestrogen/high progestogen pills in coming years.

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Prestel for the General Practitioner

Sir,

Mr Ewan Davis (June *Journal,* p.383) rightly indicates the potential of the Prestel database to family doctors. The service will undoubtedly become increasingly useful as more information comes 'on line', particularly from local health authorities, drug information services and pharmaceutical companies.

One problem not mentioned concerns the cost of telephone calls to the Prestel link. Prestel computers are based in London and Birmingham. Communication from users in other parts of the country is either by calling the computer direct, or more usually by communicating via a local dataplex link which involves calling a more local number at local call rates. Unfortunately practices which are not in