cording becomes more universal and is applied to younger age groups. All population studies that I know of, in all parts of the world, show a higher prevalence of hypertension (on any definition) in young men than in young women, and an excess of female hypertension from about 45-50 years which increases with age. The excess in the aged is almost certainly due to preferential survival for women, probably because of their much lower associated risk of myocardial infarction.

Drs King and Bleaney (February *Journal,* p.95) have made no case at all for anything unusual in the Falkland Islands, except perhaps a culture lag in general practitioner clinical behaviour. As there were under 2,000 people in the study, we are presumably observing the clinical behaviour of only one or two doctors, and since this is essentially a study of doctor behaviour and not of the population distribution of blood pressure, this hardly achieves statistical significance. It's a pity that the title 'Low prevalence of hypertension in Falkland Islands men' has now entered the Cumulative Index Medicus, and will be disgorged every time someone presses a computer button for a literature search in this field.

JULIAN TUDOR HART

The Queens
Glyncorrwg
West Glamorgan SA13 3BL.

Protection against Tetanus

Sir,

Tetanus is rare, with only between 15 and 24 cases being reported each year in England and Wales, although the true figure may be four to five times as high.[1] In spite of its rarity we should not become complacent about it as it is an unpleasant disease with an appreciably mortality and it may complicate any wound including burns and varicose ulcers and also recurs in patients with no history of any wound at all.[2] The causative organism, *clostridium tetanus,* is widely distributed and so will never be eliminated as the smallpox virus has been, but the disease it causes is totally preventable.

The best prevention is active immunization with a course of tetanus toxoid injections. This is cheap, effective and has very few side effects, and a course gives protection for 10 years.[3] This covers the patient not only for serious wounds for which they will seek medical help anyway, but also for *all* the minor wounds which they treat themselves. Unfortunately, much of the population, especially the elderly, is still unprotected.

If a non-immune patient gets a contaminated wound a single injection of tetanus toxoid gives no protection. He should be given human tetanus immunoglobulin (costing £14.30 if the proprietory preparation is used) and at the same time should be started on a course of tetanus toxoid. He may be given an injection of 'Triplopen' for good measure. This will prevent tetanus (though at a much greater cost than active immunization) but unfortunately the system frequently breaks down.

Firstly, the patient may not get the human tetanus immunoglobulin as few general practitioners keep it in the surgery and many casualty officers seem reluctant to prescribe it for reasons that are not altogether clear but may relate to folk memories of anti-tetanus serum and its complications and may relate to cost.

Secondly, the patient should leave the accident and emergency department with a letter to the general practitioner (which may or may not get delivered) and instructions to have a second dose of toxoid after six weeks (which may or may not be given) and a third after six to twelve months (which almost certainly does not get given). So, when the patient attends later with another wound, we start again. Unfortunately, neither hospital nor general practitioner has any means of checking that the patient gets his immunization.

All patients, including the elderly, need adequate active immunization against tetanus. An organized campaign such as exists for child immunization would be costly and probably ineffective and so this is probably best done when the patient attends the surgery for some other purpose. My plea is that questions relating to tetanus immune status should be routine at the geriatric screening clinic, the pre-employment medical, the post-natal clinic, the BUPA style 'check-up' and so on, and that full immunization should be given to those who are not immune.

H. R. GULY

Consultant in Accident and Emergency

The Royal Hospital
Wolverhampton.

References

1. PHLS. Tetanus surveillance and prophylaxis. *Br Med J* 1982; **1:** 1715-1716.
2. Edmonson RS, Flowers MW. Intensive care in tetanus: management, complications and mortality in 100 cases. *Br Med J* 1979; **1:** 1401-1404.
3. Smith JWG, Lawrence DR, Evans DG. Prevention of tetanus in the wounded. *Br Med J* 1975; **3:** 453-455.

Sale of Cigarettes to Children

Sir,

In May 1983 Council held a reception at the House of Commons to try to secure a dialogue with MPs on matters of mutual interest and concern. This was successful and a number of relationships were established centrally, which continue to develop.

In order both to extend this initiative, and I hope to reduce the sale of cigarettes to children, I have suggested that secretaries ask faculty board members to contact their local MPs, either personally or by letter, and ask them to support *and sign* the following Early Day Motion (number 346), which has been put down by Mr Charles Irving, MP for Cheltenham.

> 'That this House notes that almost £60,000,000 is spent annually by children on cigarettes; and calls on the Government to uphold more effectively the law relating to the sale of cigarettes to children, as defined in the Children and Young Persons Act 1933, and to undertake urgently a review of the terms of the Act and the level of penalties for convictions under it.'

My action was prompted by the paper by N. C. A. Bradley relating to the sale of cigarettes to children in Exeter (September *Journal,* p.559) and the results of a recent Government survey.[2]

The response by faculty boards has been good and I hope that this can be reinforced by all College members using this opportunity to initiate contact with their local Parliamentary representatives.

When I wrote to faculty board members the indications were that there had been no prosecutions for offences relating to the sale of cigarettes over the last five years. However, the statistical section of the House of Commons library has finally produced the figure of seven prosecutions in England and Wales in 1982, the same year in which the Government survey indicated that £60 million had been spent by children on cigarettes! A very convincing reason for the profession to be concerned.

I enclose a few other relevant details which doctors might like to pass on to their local MPs.

1. 85 per cent of tobacco retailers profess ignorance of the law on the sale of cigarettes to children.[1]
2. The maximum penalty (£200) is not sufficient deterrent to support effective policing of the law (Gloucestershire Police Authority).
3. The mortality from smoking-related

illness is between two and three times higher amongst people who begin to smoke before the age of 15.[3]

4. 88 per cent of cigarettes bought by children are sold by retailers (the remainder coming from vending machines).[2]
5. 65 per cent of adults favour raising the legal age for purchase of cigarettes from 16 to 18. *(Pers. comm.* Parliamentary Undersecretary of State for Health.)
6. The law was enacted 50 years ago, long before the scale of smoking-related illness was appreciated; a review now is long overdue.

CLIVE FROGGATT

129 St George's Road
Cheltenham
Gloucester GL50 3ER.

References

1. Bradley NCA. Sale of cigarettes to children in Exeter. *J R Coll Gen Pract* 1983; **33:** 559-562.
2. Smoking attitudes and behaviour. Office of Population Censuses and Surveys. London: HMSO 1983.
3. Hammond EC. Smoking in relation to death rate of 1,000,000 men and women. *National Cancer Institute Monograph* 1966; **19:** 127.

**In Scotland, the relevant Act prohibiting the sale of tobacco to persons under 16 years of age is the Children and Young Persons Act (Scotland) 1937, Section 18—editor.*

Computers in Medicine: Patients' Attitudes

Sir,

I was interested to read P. J. Cruickshank's article (February *Journal,* p.77). There has been a very similar article by Dr M. Pringle and colleagues.[1] The authors have followed up an earlier similar study by Dr A. R. Potter.[2] I find it hard to accept that such questionnaires provide any really useful information. The patients are being asked questions to which they are unable to give an informed reply.

I appreciate that the authors are attempting to assess patients' attitudes and views rather than the truth behind them. All that one can obtain in response to such questionnaires is a collection of responses made from a standpoint of total ignorance relating to the subject under discussion.

Presumably the findings from these questionnaires are intended to guide those general practitioners contemplating computerization in the field of likely responses from their patients. I am bound to express concern both at the reasonableness of asking patients questions relating to matters about which they have no real factual information, and also astonishment at the willingness on the part of patients even to attempt to respond to such enquiries. In real life some of us have found that a microcomputer can be placed in the secretary's office to store and access patient data, with adequate safeguards of confidentiality and resulting in enormous benefits in practically all aspects of a general practitioner's field of activities. I see no cause to alarm our patients and every doctor knows that most patients would, in fact, be alarmed if they were truly aware of the difficulties relating to confidentiality using the usual manual records.

F. K. MINWALLA

22 Shenley Green
Birmingham B29 4HH.

References

1. Pringle M, Robins S, Brown G. The patient's view. *Brit Med J* 1984; **288:** 289-291.
2. Potter AR. Computers in general practice: the patient's voice. *J R Coll Gen Pract* 1981; **31:** 683-685.

Prescribing Cervical Collars

Sir,

Contrary to popular belief, general practitioners *can* prescribe cervical collars on FP10: not ready made, but as the raw materials which are then easily made into a soft collar. These are a piece of adhesive latex foam—22.5 cm × 45 cm × 7 mm and some surgical tubular cotton stockinette—7.5 cm × 1 metre.

The collar is made thus: peel off the waxed paper backing and fold the foam in half lengthways, sticky side inwards. Encircle the neck with this double thickness length of foam and mark where the foam should then be cut to the correct length for the individual. Then cut out a semi-circle from the middle of the upper edge of the foam, for the chin. Cover the foam with the stockinette and use the loose ends of the stockinette tied to hold the collar in place.

NICHOLAS BRADLEY

30 Barnfield Road
Exeter EX1 1RX.

Prescribing—a Suitable Case for Treatment

Sir,

This editorial (January *Journal,* p.5) made me feel very guilty about contributing to the £60 million wasted on prescribing. The College would be right to ostracise me from the 'educated practitioners, who prescribed less, prescribed *generically* more and used cheaper equivalent drugs'. It is our duty as general practitioners to ensure that the limited NHS funds are best used to serve the whole community and not frittered away by thoughtless prescribing.

However my Collegiate and professional fervour was somewhat dampened when the full page advertisement on the opposite page suddenly caught my eye.

'Why Have You Changed My Tablets, Doctor? Write *Inderal* by name . . . ensure that the patient always receives the original ICI formulation.'

I realize that advertising revenue is important but surely, for the College and its *Journal* to retain their credibility it must vet these advertisements more carefully.

R. J. GALLOW

The Bungalow
Featherbed Lane
Felden
Hemel Hemstead.

A similar letter has been received from Dr W. H. Foster of 18 Park Brake, Highnam, Gloucester.

Payment for Practice Performance

Sir,

It seems to us that there are converging trends in general practice which could be encouraged by a payment based on performance.

First is a desire to measure and improve the quality of care; secondly, a feeling that there should be more patient feedback; thirdly, with vocational training now compulsory, the vocational training allowance will become effectively an addition to the basic practice allowance, and an easy target for government economy. Lastly it is illogical to think in terms of compulsory retirement on the one hand and make payments based solely on seniority on the other.

We propose that there should be negotiated a new payment awarded on the basis of practice performance. Performance would be assessed primarily on objective measures of practice and clinical activity. There would also be accountability to the consumer, perhaps in the form of a questionnaire sent to a sample of patients and consultant colleagues. The payment would be to the practice rather than to the individual doctor. Any award would only be for, say, five years with the opportunity for renewal before expiry.

We maintain that our proposal