long term administration because of its lack of side effects. Clearly a formal trial of DSCG in children with chronic cough whose history suggests cough variant asthma is needed. Naturally, disabling side effects on the parents of these children should not be neglected.

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Focus on Women at 35

Sir,
Several years ago our practice compiled an age sex register, but now that it is complete, what should we do with it?

Late in 1982 we decided to offer all our women patients reaching their 35th birthday a comprehensive health check, which would include a cervical smear and thus make use of the fact that smears taken from that age attract a fee every five years. We considered that most women had completed their family by 35, had a settled lifestyle and might even think of themselves as middle aged and so welcome a check-up. Our aims were to establish a simple positive health care trial and we hoped to catch those patients who might otherwise not be seen in surgery for such checks. We also hoped that husbands might be encouraged to attend for simple health checks as a result of the screening programme offered to their wives.

We drew up a list of 29 questions designed to assess the general health and lifestyle of the patient. From the age sex register we found that 96 women would have their 35th birthday during 1983 and we sent most of these a letter wishing them a happy birthday, explaining the scheme and offering them an appointment. The nurse made the bookings, then each letter was scrutinized by the patient's own general practitioner and signed before being sent out timed to arrive on the patient's birthday.

At her appointment, which was within normal surgery hours, the patient was seen by the nurse who explained the procedure, discussed the questions and checked weight, blood pressure and urine. The doctor then went through the answers to check details before carrying out a full pelvic check and smear and any other examination that appeared to be necessary. Finally, the patient signed the claim form, which allowed her yet more time for informal chat when additional worries often emerged.

The scheme has now completed its first full year and has been generally welcomed by the patients and considered a success by both doctors and nurses. 85 of the 96 eligible women were sent letters and 61 attended. Five of those sent letters could not be traced and nine were new patients who will be followed up at their first attendance, leaving ten who did not respond. Forty thought it was a good idea, but eleven did not appreciate the approach on their birthday and eight confessed that they were worried and suspicious of our motives or findings.

A wide variety of minor ailments was reported and 13 were taking medication at the time of questioning; but 38 felt on top of everything.

We took cervical smears from all but two of the women, of which 26 per cent were reported as showing no endocervical cells. One examination revealed a large ovarian dermoid the size of an orange, which was later removed. No abnormalities were discovered on testing urine samples or blood pressure. Only one husband is known to have taken up the nurse's offer to check his blood pressure, although others could have been spurred to attend their own doctors. Several of the questions were of a social nature which turned up some interesting answers.

It was pleasing to find that most of our 35-year-old women patients were healthy and were not suffering from unsuspected problems. However, it is those who do not turn up for such screening programmes who cause the most concern; perhaps we should mark their notes accordingly and take special interest when they do turn up for ordinary consultations. On the whole, however, it seems to have been a sensible way to use our age sex register; to look positively at the general wellbeing of one small section of our patients. The chance of finding unsuspected pathology appears to be very low, but 59 × £5.70 = £336.30 additional income is welcome. We shall continue to send invitations to our 35-year-old women.

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Cardiac Rehabilitation

Sir,
A symposium on cardiac rehabilitation organized by the Research Panel of the Society of Occupational Medicine[1] laid stress on the beneficial effects of early return to work after myocardial infarction or cardiac surgery. A recent leading article in the *British Medical Journal*[2] drew attention to the fact that many patients can get back to normal activity and return to their previous jobs within a few weeks, and warned of the permanent damage to the well being of the patient that can ensue from inadequate or incorrect medical advice given in the recovery period in limiting physical activity.

Indeed, at the symposium the opening speaker, Dr Celia Oakley questioned whether perhaps the imposition of a rehabilitation programme may in some cases in itself give rise to iatrogenic disease. Following appropriate investigation a decision should be made on whether cardiac surgery or further medical treatment is indicated, and where this is not the case, there can be no justification for keeping a patient away from work. Physiological demands which physical exercise makes upon a patient will be less severe after training, producing according to Professor Fentem a beneficial 'sparing' of the heart. A vigorous exercise programme with running, swimming and circuit training up to 80 per cent of maximum heart rate has been in operation at the Queen Elizabeth Military Hospital, Woolwich, for the last four years, and beneficial effects were found, in particular on indices reflecting anxiety and depression.

The psychological consequences following a 'coronary' were outlined by Dr Elizabeth Cay, and the ensuing loss of confidence was dramatically brought home by a contribution from a patient who had suffered a recent infarction. He considered return to work would have taken longer, if he would have returned at all, without a course of rehabilitation. The post coronary rehabilitation programme at Northwick Park Hospital, aimed at the restoration of maximal physical function and confidence in the performance of daily activities includes both occupational therapy and physiotherapy and this was briefly described.

Two thirds of the patients undergoing cardiac surgery at the Queen Elizabeth Hospital, Birmingham, returned to gainful employment, and were thus able to contribute to the society which underwrites the considerable cost of their treatment.

Return to work after infarction or cardiac surgery was also discussed from the viewpoint of the doctor working in industry. While the value of a formal course of rehabilitation was considered controversial, all were agreed that maximal restoration of function for the patient who has suf-

fered a myocardial infarction would be facilitated by better communication between the general practitioner who has the key role, the hospital and the doctor working in industry.

Following the symposium, a brief questionnaire completed by participants showed that more than half had changed their practice in direct response to what they had heard. The most frequently cited changes were those related to getting people back to work and their normal duties much earlier than before, certainly by six weeks after uncomplicated myocardial infarction or cardiac surgery.

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How Effective is Acupuncture in the Management of Pain?

Sir,

Dr Lewith has earned our gratitude for reviewing the literature on the efficacy or otherwise of acupuncture as an analgesic, (May *Journal,* p.275). The lesson is that this subject is asking for attention.

If, however, he wishes his favourable verdict to be convincing, he must know that it is not enough to give a superficial appearance of open-mindedness; he must learn to think with as much rigour as he would expect to find in a well-designed clinical trial.

Three classical examples of sloppy thinking:

1. *Begging the question,* p.276. 'Therefore, studies using random needling are perhaps best thought of as an evaluation of acupuncture versus a less effective form of needle puncture.' Who said 'less effective'?
2. *Not comparing like with like,* p.276. 'The acupuncture group,' (compared with the placebo group,) 'had needles inserted into their tender trigger points on the back.' Acupuncture points and 'tender trigger points' only occasionally coincide. Acupuncture, unfortunately, is not defined here, but few if any of its practitioners restrict their needling to 'tender trigger points'.
3. *Non sequitur.* Dr Lewith reports his own results in the treatment of postherpetic neuralgia. 'Acupuncture resulted in improvement in 24 per cent of patients and the placebo in a 21 per cent response.' These figures are so bizarre coming from a writer who is happy to accept a 30 per cent placebo response that one wonders if there is not a misprint somewhere. They make a poor introduction to his glib first conclusion, that 'Acupuncture has an analgesic effect in approximately 60 per cent of patients suffering from chronic pain.'

As I have practised acupuncture myself, I would love to think acupuncture as effective as some claim, but faint praise is no more damning than muddled over-praise. The subject yells for unbiased attention.

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Sir,

Dr G. Lewith (May *Journal,* p.275) has pointed out how fashionable acupuncture has once again become in the last few years. He reviews the results from 20 trials that have attempted to evaluate acupuncture as a treatment for painful musculoskeletal conditions. He concludes that these studies show an analgesic effect in 60 per cent of patients suffering from chronic pain; that the effect of acupuncture was greater than that of placebo and that acupuncture was as effective for musculoskeletal pain as were more conventional treatments.

Of the 20 studies that he cites, he acknowledges that 11 of them (including his own study) showed no significant advantage of acupuncture over placebo or conventional therapy. Six studies had serious methodological flaws that cast doubt on the validity of the conclusions, or numbers so small that the likelihood of detecting a significant difference, where in truth none exists, becomes embarrassingly large. Three studies showed significant differences between the effects of acupuncture and placebo or conventional treatment.

In weighing up the conclusion to be drawn from these studies, Dr Lewith has his foot on the scales. Surely the balance doesn't swing in favour of acupuncture. His conclusions are all the more remarkable, when of the same studies, he pointed out in the *British Medical Journal* that 'These trials have not, however, convinced the sceptics. Most were poorly designed, with small numbers of patients, muddled entry criteria, short follow-up and no clear definition of success or failure.'[1] We would have to effectively suspend our critical faculties to become true believers on the evidence so far. P. Skrabanek has reviewed the literature on controlled trials in acupuncture[2] and emerged with his critical faculties intact, concluding that the claims made for acupuncture have no scientific validity.[3]

The current vogue is for fringe medicine, better known as alternative medicine, and now to be known as holistic medicine. We should leave our minds open to the claims of acupuncture, homoeopathy, transcendental meditation, chiropractic and other more exotic techniques. But not so open that our brains fall out.[4] So far, their only tangible benefit has been to make poor men richer.

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Sir,

Readers of Dr Lewith's article (May *Journal,* p.275) on acupuncture in pain management may be left with the impression that acupuncture is a single form of treatment. Acupuncture incorporates a number of widely differing diagnostic and therapeutic approaches. Therefore, in comparing it to other methods, it is vital to include some details of the approach that was used and something of the competence and experience of the practitioner.

The most common ways that acupuncture is practised in this country are:

1. The 'traditional' approach using concepts and terminology which seem archaic, foreign and scientifically unacceptable to western trained doctors.
2. Formula or 'cookbook' techniques which involve a scanty basic knowledge of acupuncture and use relatively fixed combinations of points for treatment.
3. The use of trigger points and the periosteum for needling.
4. Uneasy and irrational combinations of all three.