This month ● AIDS ● stroke prevention ● unemployment ● passive smoking ● blood lipids ● psychosocial knowledge ● UTI ● screening

AIDS again

David Weinberg and Henry Murray have recently reviewed the problem of coping with AIDS in New York City. It makes horrendous reading: 'As of May 1987, approximately 500 000 persons in the metropolitan area were thought to be infected with HIV'. The problem is still largely one of the homosexual and intravenous drug using communities: estimates suggest that 50% of the homosexuals and up to 87% of intravenous drug users may be seropositive.

The implications of such large numbers on the hospital services of the future are frightening. Another guesstimate suggests that between 25 and 50% of New York City's medical-surgical beds will be constantly occupied by such patients in 1991.

In considering what might be done the authors bewail 'the lack of any flexibly designed program for out-of-hospital, less intensive care to help sustain patients with chronic diseases'. Perhaps they need to rediscover general practice.

They also make a strong plea for methadone programmes for addicts and suggest that there should be a large dedicated hospital.

It is easy to dismiss this as New York's problem but were we to go even a small way down the same raod the effects on the NHS would be enormous.

Source: Weinberg DS, Murray HW. Coping with AIDS: the special problems of New York City. *N Engl J Med* 1987; **317:** 1469-1473.

Prevention of stroke

The European stroke prevention study has shown that anti-platelet treatment significantly reduces the likelihood of a first stroke or death after a cerebral event or second stroke or death after an intitial stroke. The authors claim that in previous studies which have not shown any benefit from anti-platelet treatment the numbers were too small or the patients too heterogeneous.

Sixteen centres in six European countries entered a total of 2500 patients in a multicentre, prospectively-randomized, placebo-controlled, double-blind, parallel-group investigation (!) of dipyridamole 75 mg plus acetylsalicylic acid 325 mg three times daily. On intention-to-treat analysis the total number of deaths, including those from stroke, was lower in the treatment group ($P<0.01$). Survival curves for these end-points showed a significant difference between treatment and placebo ($P<0.001$), with a 33% improvement in survival with dipyridamole plus acetylsalicylic acid after two years.

It is a pity, however, that a combined drug was used in the trial. Previous studies did not support the routine use of aspirin or dipyridamole for patients after a stroke, but general practitioners will now have to consider advising patients to take aspirin or dipyridamole or both in addition to the other preventive measures, such as stopping smoking. It would be much better — from the point of view of simplicity and cheapness — if we knew that aspirin alone were as effective as the combined preparation.

Source: The ESPS group. The European stroke prevention study (ESPS). Principal end-points. *Lancet* 1987; **2:** 1351-1354.

Unemployment and health

Recently a whole issue of *Social Science and Medicine* was devoted to the topic of unemployment and health. In the decade since 1974 the number of unemployed in western Europe has increased 10-fold to 20 million and continues to rise. Most of the unemployed are under 25 years old and many have never had a job. The figures for Latin America are roughly 20%, for Asia 26% and in Africa 40%. Throughout the world some 500 million people are un- or underemployed.

The papers in this volume came from Europe, starting with theoretical analyses which discuss solutions to unemployment in terms of increasing production or reducing working time. On the whole people seem to prefer the latter, which has implications for the availability of more informal health care. Subsequent papers present empirical data from a number of sources, notably Harvey Brenner's analysis of economic change and heart disease mortality in nine industrial countries. Economic growth is inversely related to heart disease mortality rates in eight of the nine countries, and the unemployment rate is positively related to heart disease mortality in all the nine countries within a two- to four-year lag period. There were further papers on youth unemployment and on how people cope with the problems of having no job. There was a salutary comment from Germany pointing out that therapeutic programmes which increase the hope of finding a job without increasing the chances are likely to be dysfunctional. Finally, there were two papers which point out that it is not unemployment *per se* which causes unhealth but rather our reactions to it, and indeed the aim of full employment can be seen as an example of the growing power of the state over the freedom of individual citizens.

On a less prosaic note a paper from Sheffield showed how men who had been employed on average for over two years adapted to their circumstances, and perhaps we need to look again at what we consider to be 'healthy' or 'unhealthy'.

Sources: Levi L (ed). Unemployment and health. *Soc Sci Med* 1987; **25:** no. 2. Warr P, Jackson P. Adapting to the unemployment role: a longitudinal investigation. *Soc Sci Med* 1987; **25:** 1219-1224.

Passive smoking — nuisance or risk?

The nineteenth century health movement considered that anything which was offensive to the senses was therefore prejudicial to health and should be dealt with by public health action. In this century legislators have become more cautious, and have distinguished between a nuisance which can cause annoyance and not disease, and health risks which are factors causally related to the prevalence of disease.

A recent conference at Green College, Oxford, reviewed the evidence about passive smoking and clearly concluded that this constituted both a nuisance and a risk to health. The short-term effects are of nuisance value but have clear health implications in terms of ventilatory function for those who already have respiratory disease. The long-term risks of passive smoking are now becoming more widely recognized and there is evidence of a close relationship between the amount of smoke absorbed and the risk of dying from carcinoma of the lung, arterial disease and chronic obstructive respiratory disease. Among people who say they have never smoked, those living with smokers are more likely to develop lung cancer, and the difference is too large to be accounted for by chance. It is estimated that there are several hundred deaths per year in the United Kingdom attributable to passive smoking, including about 200 cases of lung cancer.

Passive smoking is not just a domestic problem because it has been estimated that exposure of individuals to other people's smoke in the workplace can be three

to four times the exposure at home. The few firms who have got data on the results of introducing a non-smoking policy in the workplace report improvements in productivity ranging from 5% to 25%, with employees benefiting from improved health and morale. Recognizing the rights of non-smokers as well as smokers in public places and the working environment is therefore not just a question of ameliorating a nuisance but of reducing substantial health risks. General practitioners may have more success in encouraging patients to give up smoking if they make them aware of the dangers to which they are exposing not only themselves but also their families.

Source: Green College Consensus Conference. Passive smoking in the workplace — nuisance or risk? *Community Med* 1987; **9:** 209-215.

Lowering blood lipids

The DHSS is taking up the banner of prevention as the standard by which we are all to be judged in the future and general practitioners are likely to become more interested in diet and testing patients for blood lipid levels. Here is another large, well conducted, double-blind randomized trial of a lipid lowering agent; 18 966 men aged 40–55 years with, at the outset, no symptoms of ischaemic heart disease, were screened to provide a study group of 4081 with high levels of non-high density lipoprotein cholesterol. Gemfibrozil was given to half, and the group was followed up for five years. There was a 34% reduction in cardiac events over the whole period, although the reduction only began to appear after two years. The cumulative rates of cardiac events were 27.3 per 1000 in the study group, compared with 41.4 per 1000 in the placebo group. The number of deaths was the same in both groups, with an excess in the study group of deaths from accidents, violence and intracranial haemorrhage.

These impressive results mirror those of trials done with other lipid-lowering drugs (including the curious excess of deaths from violence in the treated group) and will add further weight to the drive to identify and treat those with high blood lipid levels. This would create a strategy analogous to the one doctors have been pursuing for many years in hypertension treatment. However, we are now familiar with Geoffrey Rose's argument that the benefits of such a strategy are real but not as great as might be achieved by a small reduction in the blood pressure of everyone, including those in the 'normal' range. What this trial might point to is a need to tackle the problem of the nation's diet, a much longer and more difficult task than paying general practitioners to measure patients' blood lipid levels.

Source: Frick MH, Elo O, Haapa K, *et al.* Helsinki heart study: primary-prevention trial with gemfibrozil in middle-aged men with dyslipidemia. *N Engl J Med* 1987; **317:** 1237-1245.

Psychosocial knowledge of family doctors

Vocational training costs a lot of money, and there are still some rigorous souls in the world who are concerned with the absence of evidence about its results. Apparently the worry is shared in the USA, as evidenced by an attempt to test the psychosocial knowledge of family medicine physicians, compared with that of other primary care physicians who had not been vocationally trained. No difference was found in the levels of knowledge shown by the two groups. The author then advances possible explanations for this disappointing result: the top priority for physicians remains keeping up with biomedical knowledge, interest in behavioural aspects of patients may damage their prestige, time constraints in consultations, the absence of financial incentives for retaining psychosocial knowledge, and the natural process of forgetting knowledge that is rarely used.

These are important, if disturbing conclusions, but are they justified by the results? They are based on a 29% response rate to a multiple choice questionnaire testing psychosocial knowledge, surely an inappropriate method. (Examples cited include 'Which characteristic of the ageing process does not occur typically with advancing age — (1) physical and mental deterioration; (2) loss of income, social roles, and status; (3) interpersonal losses; (4) having to leave home to go to live in an old age institution?') The impartial reader must conclude that the case is unproven and wonder, despite its interest, how this paper got published at all.

Source: Gropper M. Family medicine and psychosocial knowledge: how many hats can the family doctor wear? *Soc Sci Med* 1987; **25:** 1249-1255.

Risk factors for UTI

A study in the USA of risk factors for urinary tract infection compared young women attending a student health service with acute urinary tract infection with women presenting with other acute illnesses.

Any recent sexual activity — masturbation, oral, anal or vaginal sex or vibrator use — increased the risk of infection, and this was particularly marked for vaginal intercourse. Use of a diaphragm was associated with a considerably increased risk of urinary tract infection that increased with frequency of use but oral contraceptive use was associated with a minimal increased risk.

Urination before intercourse did not affect risk of infection but urination after intercourse was protective. The direction of wiping after bowel movements did not affect risk, nor did use of vaginal deodorants, bubble baths, douches or tampons, method of washing the genital area or washing the genitals less than once a day.

Source: Strom BL, Collins M, West SL, *et al.* Sexual activity, contraceptive use, and other risk factors for symptomatic and asymptomatic bacteriuria: a case control study. *Ann Intern Med* 1987; **107:** 816-823.

Risk factor screening

In a study of the psychosocial impact of being screened for cardiovascular risk factors the participants and non-participants in a mass screening programme of men aged 30–33 years in a small town in the Netherlands were asked to complete a questionnaire. The non-participants gave a variety of reasons for not attending but only 7% admitted that fear of finding an abnormality had played a part. Half the participants were found to have one or more of the seven risk factors checked; 23% of them said they intended to change their lifestyle; 19% said they had anticipated the problem (for example 'I knew that I often ate too much fatty food') and 19% said they were not bothered by the result ('high blood pressure, too much fat in my blood, too heavy — that's perfectly normal — it applies to nearly everyone'). A further 19% reported being astonished by the result because of their healthy way of life and the authors caution about the anxiety and confusion which may result when abnormalities are found in random screening of healthy people leading healthy lifestyles. The other worry is the possible 'certificate of health effect' on the young men with no risk factors detected — this group were not leading significantly 'healthier' lifestyles than the rest of the men in terms of exercise, smoking, diet and so on, yet the results of the screening may give them a false reassurance that they do not need to be concerned about their lifestyle.

Source: Tymstra T, Bieleman B. The psychosocial impact of mass screening for cardiovascular risk factors. *Fam Pract* 1987; **4:** 287-290.