week of the packet the patient should start a new packet after completing the old, that is without having a gap, and will be unprotected for seven days.

However, the advice given in the *Data sheet compendium* is sometimes more cautious but, more worryingly, at times less cautious than the above. As an example, 13 out of 25 data sheets for the combined pill state that a woman is unprotected if a pill is missed for 12 hours (the remainder imply that two pills have to be missed before she is at risk). Only 11 advise that women should take their missed pill in addition to the next due pill (the remainder advise omitting pills missed for greater than 12 hours or are vague on this advice). Twenty-three of the advice sheets state that the woman is not safe until the withdrawal bleed. This is overcautious for pills missed in the first two weeks of a packet and less stringent than the Family Planning Association advice for pills missed in the last week of the packet. Only two data sheets are totally safe in recommending other forms of contraceptive for two weeks or until a withdrawal bleed, whichever is the longer, but again this is over-cautious.

The advice for progesterone-only pills is similarly confusing. Only three out of six data sheets point out that three hours is the time limit for safety, two state that being late with pill taking can reduce protection but do not state a time limit and one implies that at least two pills have to be omitted before protection is reduced and does not mention the need for punctuality in pill taking. Lastly, five of the six data sheets state that a woman is unprotected for 14 days and the other states until the next period, while the family planning leaflet states that protection is only reduced for two days.

When prescribing oral contraceptives we should perhaps tell our patients to ignore the information they receive with their pills.

D. METSON

29 Lochinver
Birch Hill
Bracknell
Berks RG12 4LD

Local oestrogen for recurrent epistaxis caused by familial telangiectasia

Sir,

Familial haemorrhagic telangiectasia (Rendu–Osler–Weber disease) is a distressing complaint typified by frequent severe nose bleeds. No remedy exists although systemic oestrogens have been considered effective in uncontrolled studies.[1] I wish to report a case where topical oestrogens have effected a remarkable improvement.

The patient, a widow aged 69 years, had suffered from daily nose bleeds of increasing severity for 20 years and found application of 1 in 10 000 adrenalin to be the only effective solution. Because of embarrassment she had begun to avoid social contact and had become depressed and withdrawn. She was recommended to take systemic oestrogens by an ear, nose and throat specialist, but in view of a unilateral retinal artery occlusion which had occurred two years earlier I was unwilling to prescribe this. The patient and I discussed the matter and she agreed to try the daily application of small quantities of dienoestrol 0.01% vaginal cream to Little's area. Following this treatment she reported a dramatic cessation of her epistaxis for the first time in many years, remaining virtually symptom-free over a six month period. She used less than 5 g of the preparation over this period and her general demeanor and mood lifted considerably.

Dienoestrol cream (Ortho Dienoestrol) has been used for atrophic vaginitis for many years, but the medical officer to the manufacturer, Ortho-Cilag Pharmaceuticals Ltd, reports that no satisfactory measurements of serum levels after vaginal administration have been possible. Withdrawal vaginal bleeding is well documented but is probably a rare occurrence compared with the number of prescriptions issued. The medical officer considers that the tiny amounts of cream administered nasally would be unlikely to give significant serum levels, and is not aware of its use in this area before.

I would be most interested to know if this form of treatment for such a distressing complaint has ever been evaluated.

P.M.J. TOMBLESON

Crossways Surgery
Ditchling
Sussex BN6 8UQ

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Evaluation of a waiting list leaflet issued to general practitioners

Sir,

Since 1983 Brighton health authority has had a system of notifying general practitioners of the waiting list numbers and average waiting times in hospitals. A leaflet listing the main inpatient and outpatient services in the district by individual consultant, specialty and hospital is produced quarterly by the information department and mailed to general practitioners by the local family practitioner courier system. The specialties are given in alphabetical order showing outpatient waiting times and numbers on inpatient waiting lists.

A new waiting list leaflet has now been designed incorporating some of the Korner inpatient waiting list statistics, for example the length of time patients have been on the list. In order to evaluate the usefulness of the leaflet and to establish whether other changes in format were required by the local doctors a specially designed questionnaire was mailed out with the June 1987 leaflet to all 170 general practitioners in the Brighton health district. After one reminder the overall response rate was 88%.

The majority of 149 doctors who replied (97%) stated that they found the leaflet useful and 97% wished to continue receiving it. Ninety per cent consulted the leaflet when a patient was referred to a hospital consultant, though only 15% did so every time. Less than a third of the doctors (31%) routinely told the patient about the differences in waiting times between consultants while 53% did so occasionally. The majority of general practitioners (71%) offered the patient a choice in whom they were referred to, based on the information in the leaflet and 7% occasionally did this.

The current quarterly leaflet appears to be useful to most general practitioners in Brighton and there was no overwhelming request to change the format, timing or content of the leaflet. However, although the majority of doctors offer the patient a choice based on the information contained in the leaflet, at least one third do not.

Other initiatives have also been taken in Brighton. Following a seminar entitled 'Teaching hospital doctors how to communicate with GPs', organized at the local postgraduate centre in May 1985 four evening meetings were held in four general practice surgeries and all the orthopaedic consultants in the district attended each meeting. They were able to meet local doctors on their home ground and to discuss referral practices and problems with waiting lists. Sixty-five per cent of the practices in the district were represented at these meetings. In July 1987 a series of sessions on the 'perfect referral' were arranged at the local postgraduate centre. Consultants from different specialties outlined what they would expect from the general practitioner in the patient referral letter, taking a common diagnostic

problem within their specialty as an example. Other initiatives include monitoring referrals and the issue of a standard letter requesting additional information if it is missing from the referral letter.

Until general practitioners find out exactly what consultants do with their referral letters, how much notice they take of the word 'urgent', and whether they should address their letters generally or to a named consultant, they will be no wiser about which consultant can see their patients more quickly. In this district anecdotal evidence also suggests that when patients are consulted about which doctor they wish to see they often do not choose the consultant with the shortest waiting list.

J. BENNETT
L. WADEY
J. SETTERS

Brighton Health Authority
Brighton General Hospital
Elm Grove
Brighton BN2 3EW

Blood pressure intervention programme

Sir,

As part of an intervention programme on cardiovascular risk factors blood pressure was measured annually for patients attending a general practice at Heer.[1] We found 111 men aged 20–65 years with a systolic blood pressure higher than 150 mmHg and/or a diastolic blood pressure higher than 95 mmHg in 1975 and they were followed up until 1979. All patients received dietary advice and those with a diastolic blood pressure higher than 110 mmHg were given antihypertensive medication. Blood pressure values dropped after one year but increased towards the original level for the following three years. Smoking prevalence decreased from 64% to 51% after one year and remained unchanged after that. There was little change in weight and serum cholesterel levels.

Similar programmes such as the multiple risk factor intervention trial and the heart disease prevention project also showed a drop in blood pressure after one year, with values stabilizing thereafter.[2,3] Nevertheless, these programmes were criticized for lack of success. Our blood pressure intervention programme, carried out in a general practice, was even less successful. Some of the problems include the poorer equipment and organization in general practice than in a large epidemiological centre. The curative task has a higher priority in a general practice, and this too might affect the success of the programme after an enthusiastic start. There is also the problem that the programme is patient-oriented. Advising men to consume less salt and fat, stop smoking, consume alcohol moderately and take up jogging isolates them from their family who are not participating in the programme. After the initial effort by the patient, group pressure becomes dominant, and the success of the programme is temporary.

However, everyone could benefit from this programme. Similar programmes without individualization have been more successful, such as a community programme[4,5] and the regional approach of the North Karelia project.[6]

W.M. VAN ZUTPHEN
J. VAN REEK

University of Limburg
PO Box 616
6200 MD Maastricht
The Netherlands

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Health checks in general practice

Sir,

The papers by Dr Pill and colleagues (February *Journal,* p.53, p.57) illustrate the problems of postal invitations to a screening clinic in general practice — 34% of patients did not receive the invitation, and of those who did, only 53% attended. Their discussion focuses on whether such clinics have a place in general practice, and they emphasize the alternative of anticipatory care in the consultation. A different conclusion could be that it is the method of invitation rather than the screening clinic itself which is flawed.

In an inner city practice we have recently used regular consultations to invite middle aged men to a well person clinic, at which the practice nurse advises about reduction of risk factors for heart disease, and applies a screening score to identify those at highest risk. Of 120 men invited in the last year, 84 (70%) attended. Those who did attend were given far more time for discussion of heart disease prevention than would be practical in a general practice consultation.

There are dangers in putting unrealistic demands on the consultation. One study has shown that practices with a policy of opportunistic screening for blood pressure and cervical cytology were no more effective than practices with no screening at all.[1] Time is available in the consultation to issue an invitation for a health check, but there may not be sufficient time for effective screening and health promotion.

ANDREW WILSON

Department of General Practice
University of Nottingham
Queen's Medical Centre
Clifton Boulevard
Nottingham NG7 2UH

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Sir,

The articles by Dr Pill and colleagues (February *Journal,* p.53, p.57) are extremely topical and should be compulsory reading for the Government. The papers confirm what most of us have thought for some time, that health checks are taken up by the 'anxious healthy' and largely ignored by those most in need. Indeed, my own practice has recently offered 'lifestyle' appointments to middle aged men and although we made no detailed analysis of the attenders and non-attenders our impression would certainly support this view.

The Government's recommendations in the white paper on primary health care for greater 'consumerism', and American style health maintenance organizations can only lead to a greater proportion demand for health care from relatively young and fit but anxious individuals resulting in an escalation of costs, taking private insurance out of the reach of the less well off and creating a two tier society. Resources will necessarily be diverted from the elderly, chronically ill, disabled and poor, leaving them as second class citizens, and the caring ethos which the National Health Service has epitomized for the last 40 years will be overturned.

J.R. HUGHES

Havant Health Centre
Havant
Hampshire PO9 2AQ