

reports,^{2,3} the levels shown in Table 1 were decided on. No action was taken with the 10 patients who had slightly raised levels of cholesterol or triglycerides and it was noted that many of the slightly raised triglyceride levels were secondary to obesity or to treatment with thiazide or beta-blockers.

Table 1. Details of lipid levels found in 31 patients with coronary heart disease.

Group	Lipid values (mM ⁻¹)	
Normal (n = 15)	Cholesterol	3.2 -6.5
	and triglyceride	0.79-1.97
Slightly raised (n = 10)	Cholesterol	6.6 -7.0
	or triglyceride	1.98-5.00
Moderately raised (n = 6)	Cholesterol	>7.0
	or triglyceride	>5.00

n = number of patients.

The six patients with moderately raised lipid levels had 15 children and the three children who were patients of the practice were screened immediately. Letters were sent to the other 12 children via their parents, telling them of the finding, reassuring them that this did not represent any change in their parents' health, but recommending them to see their doctor. Only four of these letters have been returned to us with screening results. Because the discussion of possible risks to their children caused some anxiety to the patients, we have not sent out reminders. We therefore have seven results from 15 children and these are all normal — no familial hyperlipidaemia has been discovered.

This practice has a cardiovascular prevention programme covering smoking, blood pressure, lipid levels, alcohol and exercise. The part dealing with lipid screening comprises seven stages:

1. Review patients known to have hyperlipidaemia and screen relatives.
2. Incorporate lipid screening into regular diabetic review.
3. Screen those aged under 60 years with coronary heart disease and, where lipids raised, their children.
4. Screen all hypertensive patients.
5. Screen those with a close relative known to have coronary heart disease when under 60 years of age.
6. Screen all smokers and the obese.
7. Screen all other adults.

Stage four is currently in progress and is facilitated by existing follow-up routines for hypertensive patients which often involve regular venepuncture. Stage five requires full ascertainment of family histories and continues on an opportunistic basis. None of this work would

be feasible without computerized records and to date 936 (72%) of the 1293 adults aged over 20 years in the practice have family histories on file and 732 (57%) have smoking status recorded.

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References

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2. The British Cardiac Society Working Group on Coronary Prevention. Conclusions and recommendations. *Br Heart J* 1987; **57**: 188-189.
3. Study Group, European Atherosclerosis Society. Strategies for the prevention of coronary heart disease: a policy statement of the European Atherosclerosis Society. *Eur Heart J* 1987; **8**: 77-88.

Record cards in general practice

Sir,
An essential aspect of good primary care is the development of good records, including the use of record cards. Indeed, in the Oxford region this is a requirement of training practices. There are few studies that demonstrate that record cards change behaviour.

I have undertaken a small project to evaluate the introduction of a record card on a random basis into the notes of hypertensive patients undergoing treatment. The trial was conducted over a nine-month period. I studied the recording of smoking habit, hypertensive complications and the results of three examinations before and after the period of introduction of the card (Table 2).

Table 2. Items recorded about hypertensive patients before and after introduction of a record card.

Items recorded	% of patients with record card (n = 68)		% of patients without record card (n = 44)	
	Before	After	Before	After
Smoking habit	28	56**	27	36
Complications	13	51**	30	39
ECG	9	12	5	7
Urine test	7	10	5	7
Fundus examination	6	22**	9	5

**P<0.01

Table 2 demonstrates that the introduction of a record card increases the recording of important risk factors associated with hypertension, even though these factors were mostly absent. The record card also prompted doctors to undertake other examinations more frequently, although this trend was only significant in the examination of fundi.

The introduction of a record card also meant that information about hypertension management could be extracted immediately from the notes instead of taking about nine minutes, on average, in notes without a record card.

A structured approach is necessary if primary care is to improve its management of chronic disease and the use of a record card is a simple and effective way of doing this. A record card can also allow more of this work to be delegated to practice nurses.

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Antenatal ultrasound in general practice

Sir,
In Alton we have been using a Pie Data 400 machine for the last two years for antenatal ultrasound and I would be interested to hear from anybody else who is using a portable machine in this way.

We have a part-time midwife who is employed by the district health authority and she holds five clinics a week. During the last two years she has carried out nearly 2000 examinations for routine gestational assessment of expected date of delivery at 20 weeks and for those women who bleed in early pregnancy. Each examination costs about £10, which is about half that of the same scan done in the local district general hospital 15 miles away.

I am particularly interested in evaluating women who bleed in early pregnancy (threatened miscarriages) and if any practitioners have information about their management of this condition, particularly with the use of a portable ultrasound, I would be grateful if they could get in touch with me.

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Generic inhalers

Sir,
Like Dr Anthony (Letters, February *Journal*, p.78), several asthmatic patients have commented to me that their generic