

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

1. Hart JT. Reduction of blood cholesterol levels in the population: can it be done? *J R Coll Gen Pract* 1986; **36**: 538-539.
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

inhalers do not work as well as their proprietary ones.

However, before concluding that generic inhalers are substandard, it is important to consider other possible factors. Asthma is a variable disease and when it deteriorates, the response to a set dose of bronchodilator is reduced. The patient's subjective assessment of this may be erroneous. Inhaler technique is also critical. With the passage of time, many patients cut corners, with a subsequent reduction in drug efficacy.

Of course it is important that generic equivalents should be scrutinized to ensure quality control. Drug companies with a vested interest will naturally discredit generic prescribing but until a double-blind controlled trial proves objectively that there is a difference, perhaps we should regard their claims with healthy suspicion.

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Sir,

Dr Antony is indeed correct in his finding (Letters, February *Journal*, p.78) that the brand product matters to the patient. In my own case of late onset asthma I had several miserable years on Ventolin (Allen and Hanburys) aerosol or powder, with bronchial irritation, unrelieved cough and running nose. Generic salbutamol gave even worse results, but I did very well with Salbulin (Riker), which on paper is chemically identical.

When I suspected that the propellants could be the cause of the trouble, Glaxo kindly looked into this for me, and advised that the propellants used in Ventolin and the corticosteroids Becotide (Allen and Hanburys) and Bextasol (Glaxo) are the same. There is, though, a difference in that the first two products contain oleic acid, while the latter does not. As I can take Becotide or Bextasol interchangeably, but not Ventolin, nor the bronchodilator/corticosteroid mixture Ventide (Allen and Hanburys) my difficulty still defies explanation.

An excellent summary of drugs used in bronchodilator inhalation therapy was sent out by Mersey Regional Drug Information Service (no. 61, September 1985), but this is only the bare bones of the problem, and in clinical practice I feel that much remains to be learned by both hospital prescribers and general practitioners.

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Practice receptionists

Sir,

In their interesting original paper (January *Journal*, p.14) Drs Copeman and van Zwanenberg indicate that despite the key role of receptionists in the primary care team only a small percentage of them have had any formal training. For many years the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR) has offered a certificate of reception following a course and an appropriate examination.

The problem for many of the mature married women who form the majority of general practitioner receptionists is that courses are either not available locally or require more time than they can spare. Nevertheless, the valuable AMSPAR training attracts up to 2000 candidates annually, many of these being young people leaving school and interested in a career in medical reception work.

There is now an active Joint Committee for Receptionists Continuing Education, the constituent bodies of which are AMSPAR, the RCGP, the General Medical Services Committee of the BMA and the Association of Health Centre and Practice Administrators. The Society of Family Practitioner Committees is also represented. The Joint Committee has an overview of in-service courses in relation to course organizers, course content and assessment.

Following the outstanding success of the 'Ms Piggy' courses the Committee now supports the practice receptionist programme which is nationally available to receptionists in post, while continuing to support other locally arranged courses which register with it. The Joint Committee issues a certificate of attendance to receptionists who satisfactorily complete a course. More than 2000 applications have been received this year already so that in the near future at least some level of formal training will be given to our loyal and hardworking receptionists, the majority of whom welcome the opportunity to meet with others to share problems and further their education.

The hope of the Joint Committee is that all practitioners will encourage their receptionists to undertake this local training and/or obtain the receptionist certificate of AMSPAR.

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Intimacy and terminal care

Sir,

Judy Gilley's fascinating article on intimacy and terminal care (March *Journal*, p.121) brought to my mind a very apposite passage from the fifteenth century *Book of Margery Kempe*.¹ In this work Margery Kempe describes her life and spiritual adventures, always referring to herself in the third person, usually as 'this creature'. After having 14 children, she and her husband taking a vow of chastity and agree to live separately. Years later, however, her husband 'fell down to the ground from the stairs, his head under him grievously broken and bruised, insomuch that he had in his head five linen plugs for many days while his head was healing'. Margery takes him back to live with her. The hardships of caring for her demented husband are to some extent eased by memories of earlier intimacy, in much the same way as happened with the couples described by Dr Gilley.

'Then she took home her husband with her and kept him years after, as long as he lived, and had full much labour with him; for in his last days he turned childish again, and lacked reason, so that he could not do his own easement by going to a seat, or else he would not, but, as a child, voided his natural digestion in his linen clothes, where he sat by the fire or at the table, whichever it were; he would spare no place. And therefore was her labour much the more in washing and wringing, and her costage in firing; and it hindered her full much from contemplation, so that many times she would have loathed her labour, save she bethought herself how she, in her young age, had full many delectable thoughts, fleshly lusts and inordinate loves to his person. And therefore she was glad to be punished with the same person, and took it much the more easily, and served him, and helped him, as she thought, as she would have done Christ Himself?

Problems like incontinence and its cost are clearly the same as for carers today. But memories of past affection and intimacy undoubtedly make the ordeal rather easier to endure.

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Reference

1. Butler-Bowdon W (ed). *The book of Margery Kempe: a modern version*. London: Jonathan Cape, 1940.