their weekly postgraduate meeting. A lecture was presented jointly by a respiratory physician and a community physician on the impact of smoking on the health of the local population, together with ways of tackling this problem. Following this all general practitioners were circulated with a letter inviting their practice nurse to participate.

3. Development of a course for the training of nurses in the theory and practical aspects of smoking cessation clinics. The district health education unit developed the course. This lasted for three days and involved teaching group work skills and techniques suitable for helping people stop smoking. One occupational nurse and 11 practice nurses were recruited for the course.

4. Establishment of the clinics. In January 1987 three clinics were established, one run by the district occupational nurse and two by practice nurses.

5. Evaluation of the clinics. Each patient completes an Addiction Research Unit smoking questionnaire at the start of his or her course of counselling and the follow-up questionnaire 12 months after completing their treatment programme. Thirty patients have now been referred to the clinic by their doctor: 10 men (33%) and 20 (67%) women. The mean age was 45 years (standard deviation 12) and the mean duration of smoking was 27 years (SD 12). Mean daily cigarette consumption was 23 (SD 12). Twenty-seven clients (90%) had attempted at least once to give up smoking in the preceding year; 21 (70%) considered that their health had been affected by smoking and 24 (80%) thought that their health would improve if they stopped smoking. One year after their smoking course three had changed address and could not be traced. Of the remaining 27 clients, three who refused follow up were assumed to be still smoking and a further 14 reported smoking the same as before (total 63%); seven (26%) reported that they had reduced their daily consumption of cigarettes (mean decrease in number of cigarettes smoked 75%, SD 15%); and three (11%) had given up. These initial results are similar to other general practice based studies.[4]

Lack of facilities, time or expertise is often considered a reason for delaying the introduction of a new preventive service.[5] This paper describes the establishment of a health promotion initiative using local departments of respiratory medicine, community medicine and health education. It represents a model of collaboration that can be repeated in any district and will be necessary if the potential of general practice as a health promotion setting is to be realized.

P. LITTLEJOHNS

Department of Clinical Epidemiology and Social Medicine
St Georges Hospital Medical School
Cranmer Terrace
London SW17 0RE

N. COOKE

St Helier Hospital
Wrythe Lane
Carshalton
Surrey SM5 1AA

References

1. Donovan C. Prevention in practice: a new initiative. *Br Med J* 1988; **296:** 312.
2. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.
3. Fowler G. Does health education in general practice work? *Health Educ J* 1986; **45:** 59-60.
4. Campbell IA. Stopping patients smoking. *Br J Dis Chest* 1988; **82:** 9-15.
5. Boulton MG, Williams AJ. Health education and prevention in general practice — the view of GP trainees. *Health Educ J* 1986; **2:** 79-83.

Hypertension guidelines

Sir,

The Lothian hypertension group's guidelines for the management of hypertension in general practice were published in 1984.[1,2] The group has now produced a second edition which takes account of the findings of the Medical Research Council trial on the treatment of mild hypertension[3] and the European working party's study on hypertension in the elderly.[4] The majority of the original recommendations remain unchanged, but the group now recommends that treatment should be considered when diastolic pressure is greater than 100 mmHg, especially in men aged over 45 years (the previous recommended level for treatment was 105 mmHg), and that there is a case for extending case finding beyond the age of 65 years to 70 years. With regard to drug treatment the original recommendations about first and second line drugs remain unchanged, but it is now considered that nifedipine or one of the angiotensin-converting enzyme inhibitors should be the first choice of third line drugs.

Copies of the second edition of the guidelines have been made available to all general practitioners in Lothian; further copies are available on application to myself, or Dr Doig at the Royal Infirmary, Edinburgh.

J.J.C. CORMACK

Ladywell Medical Centre
Corstorphine
Edinburgh EH12 7TB

References

1. The Lothian Hypertension Group. Guidelines in the management of hypertension in general practice — detection and assessment of hypertension. *J R Coll Gen Pract* 1984; **34:** 405-407.
2. The Lothian Hypertension Group. Guidelines in the management of hypertension in general practice — drug treatment of hypertension. *J R Coll Gen Pract* 1984; **34:** 460-462.
3. Medical Research Council Working Party. MRC trial of treatment of mild hypertension: principal results. *Br Med J* 1985; **291:** 97-104.
4. Amery A, Birkenhäger W, Brixxo P, *et al.* Mortality and morbidity results from the European working party on high blood pressure in the elderly trial. *Lancet* 1985; **1:** 1349-1354.

Rubella prevention

Sir,

In his editorial (May *Journal* p.193) Dr Hutchinson is right to identify it as the general practitioner's task to ensure that all young women reaching child-bearing age are protected against rubella infection. As providers of contraception and preconception care, general practitioners are in the best position to be responsible for identifying women who have slipped through the immunization net. Most young women are aware that they were 'probably' immunized at school but medical records are often inadequate to clarify the situation. With the new measles, mumps and rubella vaccine, we will face the problem of needing to know for sure that a woman was vaccinated 20 years before and I believe that most of our record keeping at present is inadequate for this. Patient held records, Smart cards or RCGP prevention cards might provide the answer, but unless we meet this challenge with certainty the benefits offered by the new vaccine will be lost.

PAUL KINNERSLEY

Department of General Practice
Rusholme Health Centre
Walmer Street
Manchester M14 5NP

Precautions after missed contraceptive pills

Sir,

Dr Metson (Letters, May *Journal,* p.226) draws attention to the varying out-of-date information in current data sheets for both combined and progestogen-only oral contraceptive pills with regard to missed pills. Family planning doctors have been trying to persuade manufacturers to update their data sheets in a uniform manner for some years. Earlier this year a meeting was attended by every pharmaceutical company manufacturing the pill and a consensus was reached about