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

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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

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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

the missed pill rule, agreed by the National Association of Family Planning Doctors and the Family Planning Association in 1986,[1,2] and about many other aspects of pill taking. A submission for an amendment to the data sheets has been made to the Committee on Safety of Medicines.

Until such time as the packet inserts are revised, we should tell patients to read the section on missed pills in the new Family Planning Information Service leaflets. However, I would hope that we would continue to hand out the FPIS leaflets to every patient prescribed the pill, as the new versions incorporate the valuable findings of consumer research specially commissioned at the University of Strathclyde advertising research unit.[3]

SAM ROWLANDS

35-37 The Baulk
Biggleswade
Bedfordshire SG18 0PX

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Sir,

Dr Metson has drawn attention to the lack of uniformity in the advice given by the Family Planning Information Service (FPIS) in its most recent leaflet and the data sheets of the manufacturers of oral contraceptives (Letters, May *Journal*, p.226). Dr Metson generously does not attempt to blame anyone for this unsatisfactory situation. Nevertheless, I should like to explain how it came about.

It should be realized that when the pill was first introduced, many of the questions asked about its optimal use could not be answered, and, owing to its remarkable efficacy, questions about the effects that variations in use would have on efficacy could not be answered by direct experiment but have had to rely on indirect evidence, such as studies of cervical mucus, hormone assays and, in the last two or three years, ultrasound scanning. Twenty-eight years after the introduction of the pill, most people in this country are still unaware that starting the pill on the fifth day of menstruation accompanied by 14 days of additional precautions was never recommended in the USA, despite that country's vast experience of the pill. How many other rules of thumb that have long been established in this country are equally poorly founded?

About 10 years ago, the Family Planning Association (FPA) decided to recommend starting the pill on the first day of menstruation without additional precautions, and wanted the manufacturers to follow suit. At a meeting of the FPA's medical advisory committee, the manufacturers and a representative of the Committee on Safety of Medicine's secretariat, the latter refused to allow the manufacturers to adopt the recommendation that the FPA was already making, or, to be more exact, refused to allow the extrapolation of a principle that had already been shown to work in clinical trials of a low-dose pill to older and higher-dose pills. Ten years later, the discrepancy still exists as far as the older pills are concerned. It is unfortunate that the FPIS leaflet has introduced further confusion as a result of unilateral action before the manufacturers had been consulted. The manufacturers had already shown their ability to reach a consensus in 1977 when they produced a uniform text for the much fuller leaflets for patients that were soon to be produced. It is true that minor differences exist between the data sheets, but they do not reflect differences of any real substance.

Fortunately, relations between the FPA, the National Association of Family Planning Doctors and the manufacturers have become closer in the last two years, and a joint working party has drawn up a new provisional text, which will be considered by all of the manufacturers individually, but there are not likely to be any serious obstacles to its acceptance. The text contains the so-called 'seven-day rule' and a recommendation to start the first course on the first day of menstruation. The FPIS is free to say what it likes, but the manufacturers must wait to see whether or not the DHSS will accept the arguments in favour of these two recommendations and allow the manufacturers to incorporate them into their literature.

There will always be points of disagreement on medical matters, but I ask Dr Metson, and others to understand that it is not for want of any cooperation by the manufacturers that these discrepancies exist.

P. BYE

Schering Health Care Limited
The Brow
Burgess Hill
West Sussex RH15 9NE

Understanding Latin abbreviations

Sir,

Drs McBride and McLellan (May *Journal*, p.217) seem to have proved their own point twice over. The sign R_X means *recipe*, not *recipio* and *in* is redundant in *ter (in) die sumendum* and *quater (in) die sumendum*.

Misunderstanding may well be 'more likely among trainee general practitioners than principals', but is apparently not unknown among general practitioner authors.

L.K. FOWLER

Department of Health and Social Security
Medicines Division
Market Towers
1 Nine Elms Lane
London SW8 5NQ

Sir,

In the survey of the use of Latin abbreviations *mitte* has been translated as give. I was taught *do, dare, dedi, datum:* to give or to offer. Surely *mitte* comes from *mitto, mittere,* to send or to let go — so the pharmacist is requested to send or release.

T.A. LAMBROS

Springfield House
275 Huddersfield Road
Oldham OL4 2RJ

Sir,

I found the paper on latin abbreviations by McBride and McLellan of interest. It is a difficult subject to treat scientifically and all that was lacking to this end was a statistical comparison of the scores, but I am glad that it did not go this far.

I take issue with the offered translation of the R_X symbol. If it were Latin it would surely be *recipe* and not the infinitive. Its origins, however, are older than Latin and it is discernable in ancient Egyptian writings as the eye of Horus, a symbol of healing.

THOMAS F. GOREY

Ibn Al-Bitar Hospital
Co Parc
PO Box 8087
Al-Salihiyah Post Office
Baghdad, Iraq

Random case analysis and trainee assessment

Sir,

Dr Edwards (Letters, May *Journal*, p.229) draws attention to the use of retrospective random case analysis in his practice as an audit of patient care. I would like to describe the use of random case analysis as a method of formative assessment or 'educational' audit.

Random case analysis is a commonly used and powerful teaching technique in general practice which uses real cases as the principal source of material. During random case analysis sessions, areas in which the trainee is uncertain are discovered and, while some of these gaps