quired. We believe that this cost is relatively small and is good value for money, if a clear diagnosis is made, and appropriate management is initiated. That after all, is what specialist departments are for.

We accept the convenience of general practice management, but until diagnostic ability improves, we suggest that many patients are being badly and unnecessarily treated. Training in minor surgical technique is only a small part of the necessary education — diagnosis and application of technique is equally important. The costs may make treatment in general practice appear attractive but the person who bears the expense, in the form of inappropriate treatment, is inevitably the patient.

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Care of patients with psychiatric problems

Sir,

I read with interest the editorial by Elizabeth Horder on care for patients discharged from psychiatric hospital.[1] The essential message to come out of the editorial was the importance of communication between general practitioners and psychiatric services. At present, care is often fragmented and information is not exchanged between the general practitioner and psychiatric services concerning their roles and the provision of ongoing care.

Continuity of care is important when dealing with patients who have chronic psychiatric problems. This continuity can be provided by close links between community psychiatric teams and the general practitioners in their area. Link workers can telephone or visit general practitioners on a regular basis. They can then receive information or referrals at an early stage and give an appropriate response.

Shared care has worked well in obstetrics for many years. The differing roles of the obstetrician, midwife and general practitioner have been utilized to the benefit of the patient. By cooperation, we can also provide broader and better care for chronic psychiatric patients.

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Coronary heart disease

Sir,

We read with interest the editorial by the chairman of the International Task Force for the Prevention of Coronary Heart Disease (February *Journal*, p.47) and share his concern that the mortality rates in the United Kingdom from coronary heart disease are among the world's highest. We too are anxious that all appropriate measures are used to help normalize cholesterol levels. However, Professor Lewis' comment that 'after 20 years of research there is no persuasive evidence that reducing plasma cholesterol to 4.9–5.0 mmol l^{-1} causes any untoward effect' is directly contradicted by a recent editorial in the *British Medical Journal*[1] in which it was suggested that multiple interventions in middle aged men with a moderate risk for coronary heart disease may do more harm than good. In the same issue there was also a call for a moratorium on the use of cholesterol lowering drugs.[2] In 1991, an overview of 16 published controlled trials of diet designed to lower serum cholesterol levels suggested that they were much less effective than once supposed.[3]

If our interpretation of the various studies is correct, only the Oslo study[4] has shown that the level of serum cholesterol and the risk of fatal coronary events can be definitely reduced without an associated increase in overall mortality. However, this study was carried out on a selected group of men with very high cholesterol levels (7.5–9.8 mmol l^{-1}) and very high dietary fat intake (average 44% of total energy, compared with an average of 35–37% in British men[5]). In addition, the diet was remarkably strict and there was also a concurrent reduction in cigarette smoking in the intervention group. As Ramsay and colleagues point out,[3] the study's results cannot be extrapolated to those with less severe hyperlipidaemia, to those with a more typical dietary fat intake, to women, or to the outcome with a standard cholesterol reducing diet. This latter diet,[6] in which total fat accounts for less than 30% of total calories, where the ratio of polyunsaturated fat to saturated fat is 1.0, where cholesterol intake is less than 300 mg daily and where calorific intake is reduced to achieve a desirable weight, has little effect on serum cholesterol concentration in subjects not living in institutions (mean reduction in cholesterol level of 2%, range 0% to 4%, over six months to six years).[5,7,8] At this level of efficacy the cost per life year gained through the use of such a diet would be about £62 000 for men and £310 000 for women; the use of effective lipid lowering agents would apparently increase costs approximately 10-fold.[9]

But it is over the safety of these drugs that there is most controversy. Although most of the available lipid lowering drugs are known to influence lipid levels favourably,[10] there is a lack of long term data showing them to reduce overall mortality rates. The increased overall mortality associated with clofibrate in the World Health Organization study[11] is well known and consequently this group of drugs is regarded with caution. On the other hand, the newest group of drugs, the 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, such as lovastatin and simvastin, would appear to be more hopeful, having a satisfactory side effect profile and showing up to 32% reductions in cholesterol levels within weeks (data on file, Merck Sharp and Dohme Limited). Up to 25% of the UK population may be eligible to commence treatment with these drugs (*Monthly index of medical specialities*, January 1992). However, in the first year of a study clinically evaluating lovastatin,[12] a worrying trend has appeared: it would seem that there is already an excess mortality rate in the treatment group.

In summary, the evidence suggesting that general practitioners may usefully reduce the cholesterol levels of those at moderate risk of coronary heart disease is conflicting and inadequate. The resulting confusion has been compounded by the many sets of guidelines for the management of hypercholesterolaemia, published by national and international advisory

panels.[6,13,14] Perhaps it is not surprising, therefore, that in a recent survey carried out among the doctors in this practice (Fooks T, unpublished results), very few areas of consensus emerged, despite the introduction of a hospital derived protocol. There is an overriding feeling of disquiet at the ethical and financial implications of starting large numbers of patients on treatments for which the evidence of their efficacy and safety is far from certain.

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Screening for diabetes — an alternative view

Sir,

Although the discussion paper by Julian Tudor Hart on the implications of increasing diagnosis and reducing drop out for future workload and prescribing costs in primary care (March *Journal*, p.116) was stimulating, well researched and well written, I think we should be cautious about accepting all his suggestions uncritically. Recent work undertaken in the Newfoundland Chapter of the College of Family Physicians of Canada suggests that the rule of halves may no longer apply in the case of non-insulin dependent diabetes, at least in this part of Canada.[1]

Two years ago, family doctors in 17 clinics in rural Newfoundland tested a random one in five sample of their patients aged 40 years and over for diabetes mellitus. The national diabetes data group's criterion of a fasting blood sugar equal to or greater than 7.8 mmol l^{-1} on two separate occasions was used. Of a sample of 2381 patients, 294 were known to have diabetes. Of the remaining 2087 patients, it was possible to test 1767 (84.7%). A total of 48 patients had a raised fasting blood sugar level on the first test; 41 consented to a second test, and 19 of them had a persistently high fasting blood sugar level. Before the testing, the prevalence of diabetes in the 40 years and over age group was 12.3%; the testing raised the prevalence to 13.1%. In this study there were 15 previously known diabetic patients for each new diabetic patient discovered. Perhaps the high prevalence of diabetes in Newfoundland has resulted in more testing, so that additional screening for non-insulin dependent diabetes is not needed here.

A critical application of Frame and Carlsons' criteria for screening[2] to non-insulin dependent diabetes in elderly people has been carried out by Trilling.[3] He concluded that there are three major obstacles to screening the elderly for non-insulin dependent diabetes: there is conflicting evidence as to whether early detection and treatment reduce complications; the attainment of euglycaemia in the elderly is difficult, compliance is poor and side effects are common; and the adverse effects of labelling people who feel well are uncertain.

Trilling considered that treatment of hypertension and obesity is warranted, whether or not non-insulin dependent diabetes is present. His views are supported by Froom,[4] who considered that hyperglycaemia is only one of several metabolic disturbances that are present in diabetes mellitus; hyperlipidaemia, obesity and hypertension may make more important contributions to cardiovascular complications than do persistently high blood sugar levels. He considered that pharmacologic therapy to control hyperglycaemia may be required to control symptoms, but its use in asymptomatic diabetic people is, for the most part, unwarranted.

While I am a great admirer of Julian Tudor Hart's work, and a disciple of his efforts in the detection and treatment of asymptomatic hypertension, I think more caution is required before his comments about chronic disease can be expanded to other conditions, such as diabetes, at least in the North American setting.

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Patient alarm bell

Sir,

Carers of elderly, sick or disabled people in the community are often afraid to leave their patient in case a call for help is not heard. Recently two carers in my practice brought to my attention a cordless door chime which they have found to be useful as an alarm.

The device is designed to replace the standard house front door bell, enabling the occupant to be, for example, in the garden yet able to respond to callers at the front door. It consists of a small push button transmitter unit which could be used by the patient, and a small lightweight chimer receiver unit, which could easily fit into the carer's pocket. Both are battery operated. The device has a range of 15–30 metres, and costs less than £15.

The device would enable carers to sleep in a different room, or to do some gardening, knowing their patient could alert them if assistance were required. These alarm bells are often advertised in Sunday supplement magazines. Perhaps others might find this idea useful.

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