in the natural course of the disease in an appreciable proportion of those screened.[1] When Dr Chisholm confirmed that negotiations on the new contract were continuing, he stated 'There is a willingness in the health department to admit that three-yearly checks are not the best way of offering health promotion to all patients, and that scientific evidence offers better ways' (*General Practitioner*, 8 May 1992).

I would like to report the findings of the first 1111 general health checks (out of 1448 eligible patients) performed in a single handed practice between September 1990 and March 1992. The age range of the patients was between 17 and 75 years old.

The number of new findings, together with the number of previously known findings is shown in Table 1. Screening identified more than four times as many unknown risk factors as known ones. The outcome of interventions undertaken for patients over the past 10 months includes 18 patients having reached their target weight; 20 patients having stopped smoking and a further 12 patients having reduced their cigarette consumption; 13 patients having reduced their cholesterol level from a mean of 7.65 mmol l^{-1} to 6.25 mmol l^{-1} following dietary interventions by the general practitioner or practice nurse; six patients having reduced their alcohol intake and two patients having stopped drinking alcohol altogether.

It is interesting to note the small number of people identified as having a raised cholesterol level (only 11 previously known cases and 21 new cases). However, cholesterol levels were checked only in those patients with a family history of premature heart disease, and in hypertensive and diabetic patients, or those with coronary heart disease. In studies where an unselective policy is used for cholesterol screening, the percentage of patients with a raised cholesterol level varies from 8.3%[2] to 45%.[3]

The impact of health promotion activities aimed at coronary heart disease prevention could be assessed at the three-yearly health check, and expressed in terms of change in risk factor profile. If three yearly health checks are abandoned before then, we will remain unaware of their value as a starting point for modifying risk factors.

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Table 1. Number of previously known, and new findings identified at three yearly checks.

	No. of patients	
	Previously known findings	New findings
Stress	2	45
Family history of CHD[a]	5	91
Overweight (body mass index >25)	3	207
Hypertension (>160/90 mmHg)	64	85
Smoker	7	130
Coronary heart disease	37	10
Diabetes[b]	14	3
Raised cholesterol level (>6.5 mmol l^{-1})	11	21
Excess alcohol intake (>21 units/week for men >14 units/week for women)	4	46
Total	147	638

CHD = coronary heart disease. [a]In a first degree relative under 60 years old. [b]Initial glycosuria and then raised fasting blood glucose levels.

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X-rays and pregnant women: a case report

Sir,

While on holiday in Spain a 30 year old right handed woman, 22 weeks pregnant with her second child, had a fall injuring her right elbow and forearm. She presented to a Spanish doctor who, after examining her, refused to order an x-ray on the grounds of her pregnancy and that there were no clinical signs of fracture. Although she had some swelling of the elbow she was able to flex and extend it.

On arrival in England a week later she went to a casualty department where the casualty officer refused to order an x-ray on the same grounds.

Two weeks later (that is three weeks after the injury) she saw her general practitioner (one of five in my practice) because of persistent pain and difficulty carrying out domestic tasks. Her general practitioner felt that although there were restrictions in the elbow joint and forearm movements an x-ray was not justified; she was referred to a physiotherapist. The physiotherapist was unsatisfied with her progress and referred her back to her general practitioner. The patient presented to the casualty department again before coming to the surgery but another casualty officer refused to order an x-ray.

Three months had passed since the initial injury when I saw the patient in the practice. On examining her, I found that she was unable to supinate and pronate the forearm and I became suspicious that bony injury might have been missed by those examining her before me. I ordered an x-ray, following it up with a telephone call to the x-ray department. An x-ray done the same day confirmed my fear, she had a fractured radial head. She was then referred without delay to the fracture clinic and following the successful birth of her child is shortly to undergo osteotomy.

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Strangulated umbilical hernia in a child

Sir,

Umbilical hernia is a common condition in infants and children. Wood reported an incidence of one in 5.4 from a sample of 573 infants studied in Bristol.[1] However, strangulation of the umbilical hernia is rare. The first reported case was in 1932[2] and only three cases have been reported in the United Kingdom since then.[3,4] A further case and its management are described here.

A boy was born at 36 weeks gestation and had a normal neonatal period except for a renal anomaly detected prior to birth. Subsequent investigation showed a bilateral dilated pelvicalyceal system without obstruction. A dimercaptosuccinic acid scan when the child was 21 months showed resolution on both sides. At the same time a large umbilical hernia was brought to medical attention at the hospital; this was easily reducible.

When aged two years and four months he was presented to his general practitioner with a slight change in the colour of the umbilical hernia. He was referred by letter for an urgent outpatient appointment. When he was seen in hospital five days later, he had a history of some redness at, and slight blood stained discharge from the umbilicus with no vomiting or constipation. Examination revealed a well hydrated, well perfused child with a peripheral pulse rate of 120 beats per minute. His abdomen was soft