

subjects remained normotensive at two year follow up. Over the same observation period, six of the 19 untreated patients remained normotensive, the remaining 13 requiring therapy.

A blind comparison in 25 of the patients' between blood pressure measurements recorded by a random zero sphygmomanometer and a mercury in glass sphygmomanometer showed close agreement when recorded simultaneously at the clinic but not with recordings made in the practices on or about the same day (mean values: in the clinic, random zero sphygmomanometer 153/90 mmHg versus mercury in glass 147/87 mmHg; in the practices, mercury in glass sphygmomanometer 170/100 mmHg).

While a number of factors including repeated observations may influence blood pressure recordings,^{9,10} this experience reinforces the argument of Jackson and colleagues⁴ that with a persistent diastolic pressure of less than 110 mmHg and in the absence of end organ damage, the period of observation before antihypertensive therapy is initiated should exceed the presently recommended three months.¹¹

Nothing is gained by premature treatment, and the possible perception of poor health and the consequent reduction in the quality of life¹² in asymptomatic patients should be considered before treatment is initiated.

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Yellow card reporting

Sir,

The United Kingdom's yellow card scheme, in operation since 1964, has proved to be one of the most successful spontaneous adverse drug reaction reporting systems. It was the only scheme to identify serious cardiac arrhythmias associated with terodiline.¹ However, it is widely accepted that there is underreporting of adverse drug reactions.²

In 1991 the Committee on Safety of Medicines received 20 272 reports.³ Sixty per cent of all yellow cards come from general practitioners,² hence general practice research is exceptionally well placed to study the subject.

A study was undertaken in a practice in Wolverhampton to determine how many adverse reactions an actively aware doctor could report in one month (the doctor looking for evidence of reportable reactions and also completing yellow cards). This was compared with the existing reporting rate for the west midlands region. During November 1991, a clinical diary was kept by a general practitioner in his vocational training year and a high level of awareness of adverse reactions was maintained. Over the same period the West Midlands Centre for Adverse Drug Reaction Reporting monitored the total number of general practitioner completed reports received and the number of general practitioners reporting reactions.

Of the general practitioners in the west midlands region (approximately 2790) 96 sent yellow card reports to the west midlands centre during the study period (nine general practitioners completed two yellow cards each, three general practitioners each made three reports, and the trainee sent four cards). By active surveillance, the trainee was able to detect four significant reactions using the criteria as set out on page 10 of the *British national formulary* (September 1991). The trainee conducted 361 consultations during the study period and therefore a reportable reaction was detected, on average, once in every 90 consultations. A mean

of 1.19 yellow cards was received from each general practitioner who reported an adverse drug reaction in the region which, considering the trainee's total of four yellow cards, gives a general reporting rate of 30% among those who completed a card.

Lumley and colleagues studied 100 general practitioners and found that only 13% of yellow cards which could have been completed actually were.⁴ It therefore appears that general practitioners in the west midlands report more reactions. This may be attributable to the presence of a local regional monitoring centre.

This study illustrates that increased doctor awareness could result in an improved adverse drug reaction reporting rate. Actively promoting awareness of the scheme among trainee general practitioners would mean that report of adverse drug reactions using the yellow card scheme is learned along with the other skills of general practice.

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Sex differences in morbidity in children

Sir,

The paper by van den Bosch and colleagues (September *Journal*, p.366) is interesting and important, particularly in relation to moderately serious and not serious illnesses in younger children.

A longitudinal study was carried out between 1985 and 1992 of children in our practice in Gorseinon, Swansea, in which 109 children aged 0-15 years with asthma and a matched control group of 109 non-asthmatic children were followed up.¹

The presence of bronchitis, upper