

and that can establish intensity-duration curves from 0.1 to 30 ms, for a muscle and corresponding nerve. The procedure takes no more than three or four minutes, and can be repeated as required. Such measures of neuromuscular excitability are a valuable tool for the practitioner.

I obtained intensity-duration curves for a muscle and nerve in 1000 consecutive patients consulting one general practitioner for non-acute conditions from 1 October 1989 to 1 April 1990. A retrospective analysis of patient records (627 women and 373 men; mean age 48 years) was carried out, including clinical follow up and repeat testing. Among these a group of 102 ambulatory hypertensive patients were identified. Of these 35% showed hypo-excitability, indicating that prescription of a beta-blocker or diuretic drug was required and 25% showed hyper-excitability and would benefit, in the first instance, from an angiotensin converting enzyme inhibitor or calcium antagonist. The 40% of hypertensive patients whose neuromuscular excitability was not clearly perturbed, would better tolerate one of the older centrally acting antihypertensive drugs.

These results demonstrate that measuring neuromuscular excitability can help general practitioners to monitor the global metabolic repercussions of an illness and its treatment.

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Cholesterol level testing

Sir,

In 1992 we audited a cholesterol testing programme. The practice's records were examined from before and after the introduction of a protocol (in 1988 and second half of 1990) and the results pooled. Of the 198 patients tested the mean age was 49 years and 65% were men. Almost all of the tests were carried out by a practice nurse. The results, according to the categories used by Cooper and Cocksedge,¹ were normal (less than 5.2 mmol l⁻¹) in 34% of cases, borderline (5.3 to 6.4 mmol l⁻¹) in 36%, raised (6.5 to 7.9 mmol l⁻¹) in 24% and very high (8.0 mmol l⁻¹ or more) in 5%. Significantly fewer patients had

raised cholesterol levels than found by Cooper and Cocksedge.¹

Forty five per cent of patients tested had no cardiovascular risk factors. Retesting was often misdirected: 26% of patients with cholesterol concentrations below 6.5 mmol l⁻¹ were retested, contrary to the practice protocol, while 27% of patients with concentrations between 6.5 and 7.8 mmol l⁻¹ and 45% of those with concentrations above 7.8 mmol l⁻¹ were not retested, necessary according to the protocol to monitor the effect of dietary change. Elderly patients (65 years and over) and those without established risk factors were often tested — 22% and 29% of those tested, respectively. The mean cholesterol concentrations of all 198 patients was 5.8 mmol l⁻¹, similar to that found in large population surveys in the United Kingdom.^{2,3} The value of this retrospective study was reduced by the incompleteness of patients' notes — in 107 cases the notes did not record whether the patient was a volunteer or had been invited, making adherence to the protocol impossible to assess. We detected no impact of the protocol on practice.

It is difficult to know how to test and treat only patients who stand to benefit most from cholesterol level reduction. The Dundee risk-disk⁴ with the Coronary Prevention Group guidelines⁵ may help general practitioners to use limited resources effectively by indicating which patients need special care and which only need general advice. The risk-disk produces a score based on smoking status, blood pressure measurement and estimated or measured cholesterol concentration.⁴ The patient's score is then compared with the general population to indicate his or her risk relative to others. Patients without a personal or family history of coronary heart disease only have a cholesterol test if other risk factors indicate that they are likely to benefit substantially from cholesterol reduction.

The level of cholesterol-attributable risk for which testing and special care are offered can be set according to the resources available. All patients have their cardiovascular risk quantified while only those who require it are tested. The multifactorial assessment of individuals' risk, together with the population-based measures that Cooper and Cocksedge advocate,¹ such as dietary change, is the most effective way to combat cardiovascular disease.

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Recording ethnic origin

Sir,

I recommend recording patients' ethnic origin by asking them for their country of family ethnic origin. This can help identify those at increased risk of carrying or likely to suffer diseases known to be more prevalent in certain racial groups. It can also give an indication of cultural background which may reflect the health needs and expectations of a cultural group.

The classification recommended by the Commission for Racial Equality gives racial groups which range from white to groups which imply nationality, such as Pakistani or Indian.¹ The advantage of recording by country of family ethnic origin is that it gives an immediate clue to current health requirements. For example, recording Somalia at the present time suggests that I am dealing with a refugee, and I can be prepared for the patient's health needs. Recording 'black African' would provide negligible information for the assessment of health needs and no indication of language requirements.

This approach has been implemented in my practice for two years and I have found no resistance from patients. It has not proved difficult for third generation families to give country of family ethnic origin and for mixed families to give two countries. The two countries are recorded with the mother's country first, for example, Jamaica Nigeria. The answers patients give do not imply nationality and this is appreciated by many patients. Practice computers should hold a list of countries and regions to avoid free text entries and the Read codes² should include a gazetteer of countries, written as proper nouns for the coding of ethnic origin.

The health service is fortunate in that a birth in the United Kingdom can usually

be identified by the patient's National Health Service number so it is not necessary to ask for the place of birth.

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Quality of general practitioner referrals to outpatient departments

Sir,

I read with interest the paper by Jenkins (*March Journal*, p.111) which further highlights areas of possible improvement in referral letters from general practitioners to hospital specialists.¹ The article focused primarily on medical and surgical specialties and I would like to complement Jenkins' findings with those from a recently reported study investigating the quality of referral letters from general practitioners to psychiatrists.²

Two hundred and seventy referrals were made during a two year period to a general psychiatric outpatient clinic, by 52 general practitioners. Baseline information of the patient's age and sex were included in almost all general practitioners' letters. The presenting complaint was mentioned in nearly all letters and the reason for referral in 87% of letters. Current medication was commented on in 68% of letters, which was a lower percentage than expected. Background information, such as family history, social circumstances and past illnesses, were not often mentioned.

The deficiencies found in referral letters from general practitioners to psychiatrists are, therefore, similar to those found by Jenkins in referral letters to medical and surgical specialties. Recommendations are required for improving the standard of general practitioner referral letters to all hospital specialties.

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Automated external defibrillation

Sir,

Dr Colquhoun may be overestimating the potential for general practitioners to resuscitate their patients with an automated external defibrillator (editorial, *March Journal*, p.95). The Grampian region early anistreplase trial involved 29 practices (91 general practitioners) over 37 months.¹ Only 15 patients in the trial had a cardiac arrest before reaching hospital. Undoubtedly, further instances of cardiac arrest would have occurred in patients excluded from the trial, but the number of such cases was not stated. Nevertheless, the number of cardiac arrests per general practitioner was very small.

It would therefore seem unjustified for every general practice to have its own defibrillator as this would be rarely used. It would be much more sensible to use the defibrillator in the front line ambulance.

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Quinine for night cramps

Sir,

I found the report by Dr Dunn on the effectiveness of quinine for night cramps (*letters, March Journal*, p.127) most interesting. My own advice and treatment regimen, however, varies quite considerably but has proved successful, and I have never come across the phenomenon of withdrawal cramps described by Dunn.

As quinine sulphate is not easily available in Israel, I have prescribed quinidine bisulphate 200 mg tablets for the last 20 years. The patient is given a prescription for 20 tablets and advised to take one tablet within an hour of going to bed. Treatment is usually found to be beneficial within three days and a one week course is suggested. If there is no immediate benefit from the treatment the full course of 20 tablets is recommended. At the same time the patient is taught to exer-

cise the flexor muscles of the calf for a gradually increasing period of up to one minute.

I have not carried out a randomized, double-blind, crossover study as described by Dr Dunn, but my regimen appears to work. Quinidine sulphate is a chemical isomer of quinine sulphate, and its action seems no different for the treatment of night cramps.

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Family planning services

Sir,

It is now 18 years since general practitioners began to receive item-of-service payments for the provision of family planning services to their women patients. At that time, at the conference of local medical committees, family doctors made it clear that they wanted to opt out of the prescription of condoms.

In 1993, most general practitioners in Exeter and the surrounding district think otherwise. A survey of 188 doctors has revealed that of the 140 who replied, 124 were in favour of being able to supply condoms free to their patients, 15 were against and one was uncertain. It may be that consideration of the risk of the acquired immune deficiency syndrome (AIDS) is responsible for this change.

The community family planning clinics are seeing record numbers of women and men who are choosing the condom as their main method of contraception (Exeter and District Community Health Service Trust, Annual report of the family planning service, 1993). In addition, the clinics are able to provide the recommended 'double Dutch' method of oral contraceptive pill and condom together, to those at risk of sexually transmitted diseases as well as pregnancy. Provision of both is essential if we are to tackle the challenges of the *Health of the nation*.¹

It is time that general practitioners were also able to offer condoms, ensuring a comprehensive family planning service for all.

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