ment of blood urea and electrolytes leads to an improvement in outcome of these patient. A more appropriate investigation to report would have been the number of patients commenced on an ACE inhibitor who had an assessment of renal function and serum potassium prior to commencement of an ACE inhibitor and one week after. This is the suggested practice according to evidence-based guidelines.[4]

Finally, the authors conclude that 67% of patients were not receiving treatment with ACE inhibitors. However, they do not indicate how many patients diagnosed as having heart failure had confirmation of their diagnosis by echocardiography. A community study has shown that only 50% of patients being treated for heart failure have echocardiographic evidence of left ventricular systolic dysfunction.[5] There is good evidence that all patients with symptomatic heart failure and impaired left ventricular systolic function will benefit from treatment with an ACE inhibitor.[6,7] Furthermore, the authors failed to report how many patients being treated with an ACE inhibitor had confirmation of left ventricular dysfunction. Therefore, some of these patients could have been prescribed these drugs inappropriately. Clearly, we need to identify uniform criteria for inclusion when studying patients with heart failure in primary care.

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Sir,

Mair and colleagues attribute the almost four-fold increase in prevalence of heart failure in their study (15 per 1000) (February *Journal,* p.77) compared with a previous London study[1] (3.9 per 1000) to the superiority of their computerized record systems. It also probably reflects the non-specificity and insensitivity of the clinical signs and symptoms used to diagnose heart failure.[2] The importance of echocardiography in confirming the diagnosis has been emphasized,[3,4] and in both studies, the majority of patients were not investigated in this way. With increasing access to echocardiography, the accuracy of diagnosis is likely to improve.

In our practice of 8131 patients, a computer search was made in February 1995 for all those patients with a recorded diagnosis of cardiac failure, and also for all patients on repeat prescriptions for loop diuretics. Records were examined manually and the following results obtained:

1. Prevalence of cardiac failure: 84 (10.3 per 1000 patients)
2. Number (%) on ACE inhibitors: 33 (39.3) seven others unable to tolerate
3. Number (%) who had had echocardiogram: 43 (51.20
4. Other patients with heart disease (e.g. previous myocardial infarction, angina or valvular disease) and on regular loop diuretics: 44 (i.e. possible cardiac failure)

In common with the above studies, the results suggests a substantial number of patients in primary care who merit echocardiography and consideration for ACE Inhibitor therapy. Where open-access exists, general practitioners must decide whom to refer for this investigation. Assuming a prevalence of around 1% and that half of these patients may not have had an echocardiogram, an average UK practice of 10000 patients will have at least 50 patients who are potential candidates.

The selection of patients, who are often elderly or relatively asymptomatic (more severe cases will self-select), will involve time, organization, and the acceptance of peoples' right to refuse unsought-after scans, blood tests or medication. However, with the increasing use of computerized disease registers and easy identification of 'high-risk' patients, the challenge for those in primary care is to find ways to offer effective interventions to those who stand to benefit.

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Medical audit in France

Sir,

Medical audit is a way of ensuring the quality of care in everyday practice. This type of evaluation is still insufficiently developed in France. The National Agency for the Development of Medical Evaluation (ANDEM) is a non-profit organization aimed at the promotion of evaluation methods in hospitals and ambulatory care.

Our audit concerned the practice of influenza and tetanus immunization in patients over 60 years of age by general practitioners. An external pilot committee designed and followed up the study. The initial guidelines were based on literature review and specialist consultation. These were established by a group of 50 practitioners as follows: for tetanus, patients aged over 60 should be immunized every 10 years; for influenza, annual immunization for patients aged over 70, or between 60 and 69 years presenting with one of the conditions considered as special risk if they develop influenza.

The initial data collection began in December 1991. Three hundred physicians from all over France were contacted by letter during the one-month recruitment period. Out of these, 151 accepted and performed the initial data collection. Overall, 102 (67%) out of the 151 physicians completed the entire 2-year audit cycle. Patient data were recorded for the first 30 consecutive patients over the age of 60 seen in the physician's office or at a home visit. In 1991, 2898 patients over the age of 60 were recorded, including 2046 over the age of 70 or with a risk factor for influenza. The initial data showed a