important and most relevant subject. The question of dosage perhaps merits some comment.

In his review, 'Aspirin as an antiplatelet drug', Patrono reached a consensus of a single loading dose of 200–300 mg followed by a daily dose of 75–100 mg 'based on findings that this dose is as clinically efficacious as higher doses and is safer than higher doses.' Given that simple recommendations are more likely to be followed, and we hope in this case on a fairly large scale, it might be reasonable to advise a single loading dose of 4 x 75mg tablets with a subsequent daily dose of 1 x 75 mg tablet. This regimen would present the minimum risk of adverse events (usually GI haemorrhage) with no evidence of reduced efficacy when compared to higher doses. In his review of the clinical pharmacology of Aspirin, Patrono points out that '...the daily administration of 30 to 50 mg of aspirin results in virtually complete suppression of platelet thromboxane biosynthesis after 7 to 10 days.' This results in the 'long-lasting functional defect in platelets, clinically detectable as a prolongation of the bleeding time.' As adverse effects are dose-related it seems wise to recommend treatment with the minimum effective dose.

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References

1. Moher M, Lancaster T. Who needs antiplatelet therapy? *Br J Gen Pract* 1996; **46:** 367-370.
2. Patrono C. Aspirin as an antiplatelet drug. *N Engl J Med* 1994; **330:** 1287-1294.

Who needs antiplatelet therapy?

Sir,

I certainly agree with the advice by Moher and Lancaster (June *Journal,* p.365) about the importance of giving aspirin to patients in the groups mentioned to prevent the risk of further myocardial infarction or stroke as far as possible.

In addition to the side-effects mentioned, I have come across tinnitus and nose-bleeds in patients on aspirin, although not on the low dose.

An unexpected benefit of aspirin therapy was a patient who developed haematuria, at first thought to be caused by the antiplatelet effect of the aspirin. Investigation revealed a previously symptomless carcinoma of the bladder.

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Data accuracy and completeness: general practitioner versus hospitals

Sir,

We read with interest the paper on the completeness and accuracy of data held on general practice computers in Scotland by Whitelaw *et al* (March *Journal,* p.181). The authors showed that, in a selected group of general practices, the data were 75% complete and were very accurate. They suggest that this compares favourably with hospital data.

We would like to point out that the Information and Statistics Division's most recent assessment of hospital data quality found 89% of main diagnoses and 86% of main operations (ICD09 and OPCS-4, at 3 digit level) to be correct in the 45–64 age group (the age range of the population assessed in Whitelaw *et al*'s study). This was based on comparisons of just over 2500 hospital discharge records (Scottish Morbidity Record (SMR1) scheme) from 42 Scottish hospitals with hospital case notes. Some of the hospitals achieved a data accuracy far in excess of the national average.

The study quoted by Whitelaw *et al* suggested 74% agreement of SMR1 with hospital case notes.[1] This was a small study performed in 1987 and there have undoubtedly been great improvements in hospital data quality since then.

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References

1. Kholi HS, Knill-Jones RP. How accurate are SMR1 (Scottish Morbidity Record 1) data? *Health Bulletin (Edin)* 1992; **50:** 14-23.

The use of antidepressants

Sir,

I was interested to read Drs John and Thakor's recent study (June *Journal,* p.363) on information distributed by FHSAs on the use of antidepressants. They suggest that the older tricyclics should be dropped as first line agents in preferences to SSRIs or Lofepramine on the basis that tolerability is approximately 6% better with the latter agents.

It needs to be pointed out that 80% of people tolerate trycyclic antidepressants entirely satisfactorily, and those that do no can simply be changed to SSRIs or Lofepramine as necessary. There are occasions when they may be as a first choice, for preferable example in individuals who are a high suicide risk or in those who are keen to avoid sedation. (I note that the study was partially sponsored by Pfizer Limited who market Sertraline.) If this were used as a first-line treatment instead of Dothiepin, the costs of treating depression would rise at least fourfold. Such a major shift in resources could only damage patient care in other areas. Obviously, this is unacceptable when there is any easy solution to the original problem and that is to use SSRIs only when necessary rather than as a first choice.

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Membership admission for the Faculty of Pre-Hospital Care

Sir,

As you are probably aware the Faculty of Pre-Hospital Care was launched in January 1996, and great interest has been shown in its endeavours and plans for the future. The Education and Assessment Committee of the Faculty Board have published the relevant academic and practical experience requirements for admission to the Faculty.

There will be an opportunity for individual assessment for admission to membership or affiliate membership of the Faculty under foundation membership clauses which will be opened until October 1996. Thereafter, admission will be strictly according to the criteria laid down by the Board.

I would be grateful if you could bring this information to the notice of your readers since there may well be a number of practitioners with many years of experience who wish to apply for admission under this special category but are unaware that this special recognition will cease in October of this year.

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