

not allow enthusiasts to belittle our achievements by setting unrealistic standards.

Most general practitioners were never taught to adopt the broad principles of primary health care because they were trained by specialists; hence change will come slowly until a new generation is leading. It is neither scientific nor helpful to judge yesterday's actions by today's criteria.

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### Epilepsy

SIR,—Reading Dr A K Scott's algorithm on the management of epilepsy (31 March, p 986), I longed to be back in neurology. It is so easy! Setting aside the agonising decisions over what is and is not a fit, and when to treat, with all the profound implications this may have for the patient, we are left with a practical guide suitable for most patients.

It is the remaining minority, however, who populate most clinics, and it is for these epileptics that management plans are needed. Using the plan given we would soon get stuck at "Are fits controlled?—No. . . . Give other drugs." Round and round it would go in a cycle of positive feedback as all the available drugs are tried alone and in combination.

I see a computer in a consulting room with smoke billowing out of it as the micro-circuits overheat and eventually explode, leaving a bemused patient with no one left to turn to except an old time doctor, whose painstaking approach to "difficult" patients (by encompassing physical, mental, and social aspects) provides treatment, insight, and support.

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### Effect of health visitors working with elderly patients in general practice: randomised controlled trials

SIR,—The importance of randomised controlled trials in assessing the effectiveness of interventions by hospitals and community care cannot be overstated. Dr N J Vetter and others show the difficulties of carrying out such trials in the community in a way that clear and valid inference may be possible.

The question is not whether health visitors are of any help to the elderly but where they are of most value. The variety of measures in the trial indicates the uncertainty as to the effects of such attention. Two areas were identified where there were statistically significant differences between control and intervention groups—the use of services (home helps, attendance at lunch clubs) and reduced mortality. Inevitably we find the mortality effect, although unexpected, more important. Since there was no a priori hypothesis of reduced mortality, this finding must remain speculative, especially since the data in table I may be manipulated to give other interpretations.

In Gwent the differences between the two groups lie in reduced mortality in the intervention group (12% compared with 21%) but also the increased percentage of elderly who were worse (37% compared with 28%). Credit

taken by health visitors for reducing mortality should be moderated by an explanation of why a greater percentage of the elderly in the intervention group were worse.

Two strategies in interpretation come to mind. (1) Omit from the analysis those dying—(on the grounds that the objective is to improve quality rather than quantity of life) and analyse the three remaining groups; there is an excess of "worse" outcomes in the intervention group, but this fails to reach statistical significance. ( $\chi^2$  with two degrees of freedom = 2.52). (2) Combine the worse and dead group—(on the basis that improvements both in quality and quantity of life are the objective). The analysis then shows a non-significant difference between groups ( $\chi^2$  with two degrees of freedom = 0.29).

We find it difficult to interpret the findings of this trial, particularly since the results for the rural area do not seem to agree with those for the urban area. In addition, we were unable to determine what was meant by intervention, nor was it clear that the definition was common to both groups.

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SIR,—I agree with Dr Clayden and Dr Newman that there are several ways of interpreting the mortality and disability data, though I consider a test for trend more appropriate than a  $\chi^2$  test. Taking their first approach with the Powys data, we find that the intervention group shows an advantage over the control group (Cox's test for trend,  $\chi = 2.1$ ,  $p = 0.36$ ), but as other disability related measures did not support this we did not report it.

When the underlying cause was examined the excess in the control group of the Gwent cases was mainly in the bronchopneumonia/bronchitis categories (two interventions, 12 controls), though there were differences in the numbers of people with fatal myocardial infarction (nine and 14 respectively). Other major categories showed no important differences. The difference in deaths from bronchopneumonia could have been brought about by the health visitor ensuring that people at high risk obtained antibiotic cover or influenza immunisation.

For the Gwent group an intervention causing a reduction in mortality might well result in the group being more disabled. I regard this as an advantage to the intervention group.

The difference between the rural and urban areas is clarified by information on the problems detected by the two health visitors at their initial assessments (table).

The Gwent health visitor identified many more problems in the group she was working with than the Powys health visitor. This was particularly noticeable for social, environmental, and carer difficulties. It seems unlikely that this reflects a true difference between the two populations.

*Problems detected among elderly patients by health visitors in Powys and Gwent on first being assessed*

Type of problem detected	No of problems		No of individuals with problems	
	Powys	Gwent	Powys	Gwent
Physical	175	539	125	204
Mental	13	31	11	30
Social	1	31	1	30
Environmental	1	57	1	48
Carer difficulties	0	40	0	38

Indeed, one of the major environmental factors studied in the independent assessment—poor housing—was found to be more of a problem in Powys, with 10% of houses of the respondents without a fixed bath as opposed to 5% in Gwent, and 4% without a flush toilet in Powys compared with 0.2% in Gwent.

A study of the informal carers showed a similar degree of objective and subjective difficulty in both practices. It seems fairly certain therefore that the Gwent health visitor was better able to detect and describe these non-medical problems than the one in Powys rather than that there were real differences in the two populations.

I think that this study shows that the intervention by the health visitors was different in the two areas. This has implications for the future training of health visitors working with the elderly.

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### Tremor

SIR,—We think that Dr J E C Hern's algorithm (7 April, p 1072) should distinguish between two types of lithium induced tremor. The first is, as he writes, a coarse tremor and occurs with impending and actual lithium toxicity. This appears to have both cerebellar and parkinsonian components and is often associated with incoordination, spasm of facial muscles, twitching of muscles and limbs, hyperactive reflexes, and more general systemic signs of toxicity.<sup>1</sup>

The second and more common type is a fine tremor usually occurring within normal therapeutic concentrations, either transiently within a few days of starting treatment or later as a long standing side effect.<sup>1</sup>

With the coarse tremor it is mandatory to decrease or stop the lithium. With the fine tremor there is evidence to show that it is partly related to serum concentration,<sup>1</sup> and a slight decrease in dose may be beneficial, as suggested by Dr Hern. Often, however, this may precipitate a relapse in the patient's condition, and in these cases propranolol has been shown to be effective, often without the need to reduce lithium concentrations.<sup>2</sup>

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<sup>1</sup> Johnson FN, ed. *Handbook of lithium therapy*. London: MTP Press Ltd, 1980.

<sup>2</sup> Kirk Baastrup PC, Schou M. Propranolol and lithium induced tremor. *Lancet* 1973;ii:1086-7.

### A romp around the United Kingdom research centres

SIR,—Mr Richard Wakeford (7 April, p 1086) criticises our letter (17 March, p 858) on the grounds that the cost we used in our calculations to determine "value for money" among publications (that is, cost per student per year) was not that which obtained the benefits (that is, papers) because additional funds, such as those from the MRC, were not counted.

This apparent paradox can be resolved by asking the question, "The cost to whom?" In this case it is to the main paymaster, the University Grants Committee, though it is important to note that the money comes to