TABLE II—*Ratings of specialist group (specialist psychiatrists and police) compared with those of non-specialists*

	Consensus rating high likelihood (7 cases)		Consensus rating low likelihood (5 cases)	
	High likelihood	Low likelihood	High likelihood	Low likelihood
Specialist group	48	5	4	35
Other groups	102	27	10	83
t Value (one sided p Value)	1·85 (0·05)		0·85 (<0·05)	

be reliably assessed and that agreement can be achieved among professionals. Whereas most professionals can spot low likelihood cases on video, specific experience in conducting these interviews gives greater accuracy in picking out higher likelihood cases.

In this experimental situation, child sexual abuse was assessed on the artificial basis of only the interview with the child. However, considerable emphasis is already placed on the interview with the child, and this will increase with the introduction of video recorded assessments in criminal as well as civil cases. Such interviews should be carried out by experienced professionals who are trained to perform the interviews.[6] This research indicates that it may also be necessary for such professionals to assess video recorded interviews carried out by others in order to help courts to determine the likelihood of abuse having occurred.

We thank our raters, Jane Hughes, colleagues in the academic department of the Institute of Child Health, and in particular Marjorie Smith and Elizabeth Monck.

1 Butler-Sloss E. *Report of the inquiry into child abuse in Cleveland 1987*. London: HMSO, 1988.
2 Davies G. Research on children's testimony—implications for interviewing practice. In: Hollin C, Howells K, eds. *Clinical approaches to sex offenders and their victims*. New York: Wiley, 1991.
3 Vizard E. Interviewing children: a review of theory and practice. In: Hollin CR, Howells K, eds. *Clinical approaches to sex offenders and their victims*. New York: Wiley, 1991.
4 Westcott H, Davies G, Clifford B. The use of anatomical dolls in child witness interviews. *Adoption and Fostering* 1989;**13**:6-14.
5 Vizard E, Tranter M. Helping children describe experiences of child sexual abuse—a guide to practice. In: Bentovim A, Elton A, Hildebrand J, Tranter M, Vizard E, eds. *Child sexual abuse within the family. Assessment and treatment*. Guildford: Wright, 1988:105-29.
6 *Working together under the Children Act 1989. A guide to arrangements for interagency co-operation for the protection of children from abuse*. London: HMSO, 1991.

(Accepted 18 February 1992)

Validation of medical history taking as part of a population based survey in subjects aged 85 and over

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BMJ 1992;**304**:1091-2

In geriatric medical practice and in epidemiological surveys doctors rely heavily on the information obtained from the medical history. In elderly subjects the accuracy of this information is questionable because of the possible existence of sensory or cognitive impairment. Also, elderly subjects may not be familiar with multiple choice forms, questionnaires, and informed consent papers.[1]

Two studies of the usefulness of history taking in elderly subjects found no evidence that the accuracy of factual information obtained from older adults, even those with moderate cognitive impairment, was less than in younger age groups.[2,3]

The accuracy or validity of the information obtained by medical history taking in subjects aged 85 and over has not been investigated to date. With the expected growth of this particular age group in the next decades, a significant part of gerontological-epidemiological research is directed at this group.

This study arose from a need to assess the validity of information obtained by medical history taking as part of a study of the total cohort of Dutch residents aged 85 and over in Leiden.

Subjects, methods, and results

The total cohort of residents aged 85 and over on the entry date of 1 December 1986 comprised 1259 subjects. Of these, 977 were visited at home by an internist (222 had died before they could be visited and 60 refused). All had a medical history taken and the minimental state examination performed.[4]

The medical history from 60 participants chosen randomly from four general practices was compared with the medical record of the general practitioner. Their age and sex distributions and examination scores did not differ significantly from those of the total study population (n=977) by χ^2 analysis. The distribution of the prevalences of the investigated disorders did not differ between the selected participants and the total study population. Three categories were distinguished for the most frequently occurring diagnoses and disorders: diagnoses and disorders reported both by the general practitioner and in this study, those reported by only the general practitioner, and those reported in only this study (table). For most diagnoses there was a good agreement. The general practitioners' record was more complete for some infectious diseases, malignancies, and heart failure. Urinary incontinence, visual and hearing impairments, and dementia were more frequently detected in this study.

Observed differences between information obtained by medical history taking and from medical records of general practitioners for 60 subjects aged 85 or over. Figures are number (percentage) of diagnoses

Diagnoses	Total	Reported by general practitioner and in study	Reported by general practitioner alone	Reported in study alone
Surgery	89	64 (72)	17 (19)	8 (9)
Infections	19	4 (21)	11 (58)*	4 (21)
Tuberculosis	5	4 (80)		1 (20)
Pneumonia	8	7 (88)	1 (12)	
Chronic obstructive airways disease	14	10 (71)	3 (21)	1 (7)
Malignancies	12	8 (67)	4 (33)*	
Cerebrovascular accident	9	7 (78)	1 (11)	1 (11)
Angina pectoris	13	9 (69)	3 (23)	1 (8)
Myocardial infarction	9	7 (78)	1 (11)	1 (11)
Claudication	6	2	2	2
Hypertension	21	17 (81)	3 (14)	1 (5)
Heart failure	11	7 (64)	4 (36)*	
Osteoporosis	6	4 (67)	2 (33)	
Fractures	11	6 (55)	5 (45)*	
Arthrosis	12	6	4 (33)	2 (17)
Non-insulin dependent diabetes	13	7 (54)	3 (23)	3 (23)
Depression	3	1	2	
Dementia	13	9 (69)		4 (31)*
Visual impairment	30	11 (37)	1 (3)	18 (60)*
Hearing impairment	25	10 (40)	1 (4)	14 (56)*
Urinary incontinence	16	1 (6)	1 (6)	14 (88)*

*For this disorder one category scores considerably better than the other on χ^2 testing.

Comment

In almost a third of all cases of dementia the diagnosis was not registered by the general practitioner, confirming the results of O'Connor *et al*, who found that general practitioners correctly identified about 60% of all cases of dementia.[5] The fact that many of the cases of sensory impairment, urinary incontinence, and dementia in patients were not known to their general practitioner should provide a strong incentive

for primary health care workers to identify these disorders, even when subjects do not draw attention to them.

Elderly people may not consult their general practitioner about hearing and visual impairments, urinary incontinence, or decline in cognitive function. This may be owing to the insidious onset of these conditions, acceptance of these types of symptoms as "normal" manifestations of the aging process, or embarrassment. Alternatively, elderly subjects might consider expensive medical treatment wasteful for the short period they have still to live, as the present cohort is the first to benefit from the welfare state.

We had considered identifying unknown cases of, for instance, chronic leukaemia, hypothyroidism, or myeloma. Except for the occasional deviation in laboratory results and two cases of hypothyroidism, no serious, previously unknown disease was found in the total study population. Most diagnoses were already well documented and known to the general practitioner.

We conclude that taking a medical history in subjects aged 85 or more provides an accurate and complete picture of the prevailing disorders at the time of the interview and of lifetime diagnoses.

We thank the general practitioners for their cooperation. This study was supported by a grant of the National Institutes of Health of the USA No RO1 AG06354.

1 Kelsey JL, O'Brien LA, Grisso JA, Hoffman S. Issues in carrying out epidemiologic research in the elderly. *Am J Epidemiol* 1989;**130**:857-66.
2 Davis PB, Robins LN. History-taking in the elderly with and without cognitive impairment. *J Am Geriatr Soc* 1989;**37**:249-55.
3 Rodgers WL, Herzog AR. Interviewing older adults: the accuracy of factual information. *J Gerontol* 1987;**42**:387-94.
4 Folstein MF, Folstein SE, McHugh PR. "Mini-mental state:" a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;**12**:189-98.
5 O'Connor DW, Pollitt PA, Hyde JB, Brook CPB, Reiss BB, Roth M. Do general practitioners miss dementia in elderly patients? *BMJ* 1988;**297**: 1107-10.

(Accepted 30 October 1991)

Does a truss benefit a patient with inguinal hernia?

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BMJ 1992;**304**:1092

Trusses are prescribed for elderly patients with an inguinal hernia because general practitioners consider the risks of surgery to be excessive, but there have been few investigations into the benefits and acceptability of the truss for the control of groin hernias. We report on 250 consecutive patients referred for surgical repair of a hernia, 52 of whom were fitted with a truss before attending outpatient departments.

Patients, methods, and results

A total of 52 new patients (50 men, two women) referred to two surgical outpatient departments for inguinal hernia repair over a six month period and who had been prescribed a truss before their attendance were assessed. We asked the patients when the truss was fitted, whether instructions were given on how to apply the truss, whether the truss was comfortable, whether they actually wore it, and whether they thought it controlled the hernia partially or completely. Finally, we asked the patients to put the trusses on and then examined them to see whether the truss controlled the hernia when the patient was standing.

The median age of the patients was 70 (range 35-90) years, and they had worn a truss for a median of 35 (2-240) months. Eleven (21%) patients had been prescribed a truss before referral to a surgeon. All trusses had been fitted by a surgical supplier but only 23 (44%) patients said they had received instructions on how to put on the truss, and 35 (77%) fitted the truss while standing up. The truss was worn most of the time by 49 (94%) patients, but 33 (64%) found the truss uncomfortable. Partial or complete control of the hernia was achieved in 16 (31%) patients: the truss did not control the hernia in 36 (69%).

Comment

Surgical repair is the best treatment for groin hernias and only in exceptional circumstances, when a patient is unfit for surgery or refuses an operation, should a truss be considered.

A fifth of our patients were prescribed a truss before seeing a surgeon, even though the delay between referral and a clinic appointment was only 8-12 weeks. Similarly, Ljungdahl found 17·8% of patients were fitted with a truss before consultation for hernia repair.[1]

The benefits of a truss are often overstated. Our results show that most patients found the truss uncomfortable to wear, but others have claimed that if it is fitted correctly a truss may relieve symptoms in up to 65% of patients.[1] A truss is rarely successful in maintaining a continuous control of a hernia, however, and most patients wear it only intermittently.[1] It was also a feature of our cases that the longer the patient had had the truss, the more unsatisfactory it had become. The poor hernia control in our patients was exacerbated by incorrect fitment as most applied the truss while standing. This reflects either inadequate instruction given by the fitters or poor comprehension by patients.

A truss increases the probability of complications, which include strangulation of the hernia, atrophy of the spermatic cord, and atrophy of the fascial margins. This allows the defect to enlarge and makes subsequent repair more difficult.[2]

About 40 000 trusses are sold annually in the United Kingdom, mostly supplied through retail outlets rather than hospitals.[3] Many patients are therefore provided with a truss either before or without the benefit of a surgical opinion. The mortality from elective hernia repair is now almost zero, and with improved local and regional anaesthesia virtually no patient need be refused operation on medical grounds.

We suggest that a surgical opinion should be obtained before a truss is prescribed. This should reduce the need for an antiquated surgical appliance which is uncomfortable and often fails to fulfil its purpose. This policy would also save money.

1 Ljungdahl I. Inguinal and femoral hernia. *Acta Chir Scand* 1973;**439**(suppl): 7-77.
2 Condon RF, Nyhus LM. Complications of groin hernia repair. *Surg Clin N Am* 1971;**51**:1325-36.
3 Goldman M. Trusses. *BMJ* 1991;**302**:238-9.

(Accepted 21 January 1992)

Correction

Effect of a heat and moisture retaining mask on exercise induced asthma

A typesetting error occurred in this short report by E J Stewart and others (22 February, pp 479-80). In the table the figures in the last two columns should be transposed.