market, the rest of the scene gradually moved with them including the substantial proportion of drug users who preferred obtaining their prescriptions from less conspicuous chemist shops. Although the chemist proprietor reported in 1983 that the number of addict maintenance prescriptions he dispensed halved in the second half of 1982, after the publicity over Dr Khan's case, the thriving market in pharmaceutical drugs from the overspill from doctors outside drug dependency units continued to focus around this chemist shop even though most drug users obtained their drugs from chemist shops elsewhere. Such a shop was, of course, the natural focus for a scene that was becoming a major outlet for legitimately obtained prescriptions.

Conclusion

Although fieldwork in late 1982 was based on informal observation alone, opinions were also obtained from a substantial number of addicts well known to me and there was a general consensus among them on the subject of overprescribing by doctors outside drug dependency units. This, and my knowledge of the scene, suggest that an important change has occurred in Piccadilly. This is corroborated by the recent article on overprescribing doctors by Bewley and Ghodse.³

The focal part Piccadilly plays in the London pharmaceutical drug black market and the relatively small number of doctors outside drug dependency units who prescribe for addicts must be taken into account when evaluating the opiate overspill in Piccadilly. Not all doctors from Harley Street and the sur-

rounding area or doctors outside drug dependency units in general are injudiciously overprescribing to addicts. Nevertheless, it would seem reasonable to conclude from the substantial amount of pharmaceutical opiates appearing on the black market in Piccadilly prescribed by doctors outside the clinics, that a considerable proportion of opiates prescribed by medical practitioners from Greater London, the Home Counties, and the Harley Street and surrounding area in particular, is finding its way on to the black market in Piccadilly. As such, the situation gives cause for concern and would appear to need urgent attention.

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(Accepted 12 July 1983)

For Debate . . .

Do we need hypertensionologists?

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Hypertension is far and away the commonest medical condition that requires drug treatment. It is the most important single treatable risk factor for both coronary heart disease and stroke, which, combined, kill more people than all other causes. Despite this there are few specialists in British hospitals who list hypertension as their main interest. In the past hypertension specialists tended to be highly academic scientists, concerned mainly with the blood pressure of rats rather than humans. No fewer than four London professors of medicine were primary hypertensionologists. It is a pity, however, that this number has declined at a time when the treatment of hypertension is becoming more complex and more important. In most district hospitals patients with hypertension are looked after by general physicians, who are primarily concerned with other diseases. Occasionally, cardiologists, nephrologists, and even endocrinologists take a hand. Inevitably, patient care tends to be somewhat unsystematic.¹ In general, cardiologists have not chosen to adopt hypertension as "their disease." It is notable that Professor J R

Hampton did not mention high blood pressure and its treatment in his article on the future of cardiovascular medicine.²

The disparity between the prevalence of the disease and the number of specialists devoted to it suggests that action is needed to create a new specialty. Interest in hypertension is expanding across the world. In the United States of America many university centres and large hospitals now have independent divisions of hypertension or hypertension research centres. Many countries now also have national high blood pressure societies, and, not before time, the British Hypertension Society has been formed. In addition, there is the enormous International Society of Hypertension, and recently a major meeting was held in Milan of European hypertension workers that attracted about 1200 delegates. These organisations and meetings reflect the wide range of specialists, who approach hypertension from differing points of view. Sadly, few general practitioners are active participants, although those that are contribute a great deal.

General practitioner hypertensionologists

Most patients with hypertension need little investigation, and adequate blood pressure control can be achieved by simple means. Few patients need to be referred to hospital. In Britain,

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however, there is still a woeful state of underdiagnosis, inadequate follow up, and undertreatment of patients with hypertension, and something positive needs to be done. The average general practitioner has between 75 and 100 patients on his list who probably should be receiving drug treatment. It would be best if every large group of general practitioners were to have one of their number who took a main interest in hypertension. The value and feasibility of general practitioner case detection and treatment programmes have been discussed elsewhere.³ General practice is potentially a superb epidemiological laboratory, and the opportunities for research are enormous.

Hospital hypertensionologists

Some patients with hypertension need to be referred for specialist attention. Patients should be referred if their hypertension is severe or difficult to control, or if there is a suspicion of an underlying renal or adrenal disease. Preferably such patients should be referred to a physician with a special interest in hypertension. In district hospitals, employing no more than four or five physicians, the cardiologist specialist is probably the best candidate for this role, and such doctors should in future be trained as "hypertensionologists" as well. There is, however, a genuine need for some consultants whose main interest is high blood pressure, but they would probably be needed only in regional centres or teaching hospitals. Patients will require access to an expert radiological service—for renal arteriography and renal vein sampling—as well as to facilities for assaying concentrations of renin, catecholamines, and antihypertensive drugs. These centres are likely to have a major research commitment as well. But, above all, efficient blood pressure clinics are needed with short waiting lists.

Shared care with general practitioners should be encouraged so that patients may be returned to their family doctor at an early stage. It should be remembered that it is the efficiency of follow up and the control of blood pressure achieved that are the best predictors of outcome in patients with hypertension.^{4 5} Furthermore, treatment has been proved to be worth while.

Training

The training of junior hospital doctors in investigating and treating blood pressure needs to be well organised as they have to learn to manage patients with renal, cardiac, endocrine, and obstetric problems and must familiarise themselves with some aspects of clinical pharmacology. Many junior doctors in teaching hospitals may now be appropriately described as "hypertensionologists," but their career prospects are problematic as many do not fit easily into the hospital service's overrigid career structure. Though officially there is no such thing as "a hypertensionologist," those young doctors would be happy to take on the role of a physician with a main interest in hypertension provided that their career structure could be more secure. Others will move into general practice, where their training will mean that they have a real contribution to make.

The diverse membership of the national and international hypertension societies should be welcomed. There are few organisations that can act as a forum where nephrologists, general practitioners, endocrinologists, biochemists, physiologists, clinical epidemiologists, pathologists, pharmacologists, and cardiologists can meet with one combined interest. It is this diversity that makes hypertension such an exciting "... ology."

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What is the effect on blood pressure of cold and hot water baths?

The reaction to cold is generally an increase in peripheral vascular resistance and consequently a rise in blood pressure, provided that the heart is capable of maintaining flow in these conditions. The effect of hot baths on blood pressure is probably less consistent. Exposure to heat is associated with an increase in the plasma adrenaline concentration and the heart rate.¹ A fall in blood pressure resulting from vasodilatation is usual; occasionally profound hypotension may occur, as, for example, after subjects have been subjected to the considerable heat of a sauna.²—D A CHAMBERLAIN, consultant cardiologist, Brighton.

¹ Taggart P, Parkinson P, Carruthers M. Cardiac responses to thermal, physical, and emotional stress. *Br Med J* 1972;iii:71-6.

² Luurila OJ. Cardiac arrhythmias, sudden death and the Finnish sauna bath. In: Manninen V, Halonen PI, eds. *Advances in cardiology* 25. Sudden coronary death. Basel: Karger, 1978.

I have recently seen several female neonates with varying degrees of fused labia minora. Is this a normal finding?

Fused labia minora in neonates is not normal. It is not, however, serious, and its only real importance lies in the fact that it has been mistaken for a much more serious congenital malformation, such as absence of the vagina. The aetiology of fused labia is not precisely known. Some authors consider it to be congenital,¹ but most cases are acquired, perhaps as a result of a very mild infection in the area. Low oestrogen levels in childhood are a contributory factor. The affected child usually presents in the first year or so of life, and the

condition has previously been described in neonates.² The treatment is simple, and consists of the application of oestrogen cream to the line of the adhesions nightly for two weeks, the division of the adhesions with a fine probe, or firm avulsion of the labia, usually without anaesthesia.—G J LEWIS, senior registrar (obstetrics and gynaecology), London.

¹ Campbell MF. Vulvar fusion. *JAMA* 1940;115:513-5.

² Bowles HE, Childs LS. Synechias of vulva in small children. *Am J Dis Child* 1943;66:258-63.

What flooring is advisable for clinics? Is cross infection from verrucas and athlete's foot a serious hazard?

I know of no definite evidence that verrucas and athlete's foot have been caught from clinic floors. This is not surprising as the incubation period between infection and overt disease is considerable. What is surprising is the amount of dermal scales shed on clinic floors by patients removing socks, tights, and other garments. Therefore, thorough hygienic cleaning of the clinic floor is essential. The best flooring is plastic tiles that may be thoroughly washed and polished daily. If complaints of coldness on the feet arise during the winter a sheet of paper may be used. There is a plastic linoleum available that is possibly less cold on the feet and may be readily cleaned. Any carpeting must be thoroughly cleaned with a vacuum cleaner daily and, once again, a strip of paper should be used when removing clothing. The most important hygienic and aesthetic measure in keeping floors clean is daily, thorough cleaning.—ANDREW B SEMPLE, emeritus professor of community and environmental health, Liverpool.