Points

Treatment of high blood pressure

Professor R J JARRETT (Department of Clinical Epidemiology, United Medical and Dental Schools of Guy's and St Thomas's Hospitals, London SE1 9RT) writes: In their otherwise commendable and properly critical account of the treatment of high blood pressure Dr R J Wilcox and others (16 August, p 433) could not resist going ex cathedra: "thus weight control is essential as it may be sufficient to control raised blood pressure." Studies of weight loss induced by various means have certainly shown concomitant falls in blood pressure, but these studies have generally been of excessively fat people, short, and too small to detect benefit in terms of morbidity or mortality. Furthermore, two recent prospective studies have clearly shown that the relative risk of both cardiovascular mortality and mortality from all causes in relation to blood pressure declines with increasing body mass index.[1,2] Both papers provide several references to earlier investigations which produced compatible findings. To quote Cambien *et al*, "The results presented in this paper strongly support the relevance of considering body mass index when studying the relationship between blood pressure and cardiovascular death. We suggest that the prognostic heterogeneity of hypertension in relation to other factors should be investigated more systematically in epidemiologic surveys and clinical trials to allow a better therapeutic strategy."[2] In the latter context, as Dr Wilcox and others commented, the Australian study showed an increasing benefit from treatment with decreasing body weight.[3] While an interaction with smoking was apparent in the Australian trial, it was not so in the Californian study.[1] Whither weight control?

1 Barrett-Connor E, Khaw K-T. Is hypertension more benign when associated with obesity? *Circulation* 1985;72:53-60.
2 Cambien F, Chretien JM, Ducimetiere P, Guize L, Richard JL. Is the relationship between blood pressure and cardiovascular risk dependent on body mass index? *Am J Epidemiol* 1985;122: 434-42.
3 Australian National Blood Pressure Study Management Committee. Prognostic factors in the treatment of mild hypertension. *Circulation* 1984;69:668-76.

Informed consent

Drs PETER MATHIESON and PETER WILKINSON (Ashford Hospital, Ashford, Middx TW15 3AA) write: Dr A V Pollock (9 August, p 390) raises the complex issue of the amount of information to give to patients when asking for informed consent. The doctor who asks for the consent is of crucial importance. At present this task is often delegated to the most junior member of the firm, who may have little experience of the procedure and its potential complications. If the admission was routine and the patient seen in the clinic by a more senior colleague that doctor may wrongly assume that the patient has been fully informed. It may be more appropriate for the consent form for non-emergency procedures to be split into two parts, the first to be witnessed by a senior doctor in the clinic, who will ensure that the patient is fully informed, and a second part filled in on admission and witnessed by the houseman to ensure that the patient is still happy to go ahead and that no questions are left unanswered.

ABC of Resuscitation

Dr D DALRYMPLE-SMITH (Bakewell DE4 1SQ) writes: I have enjoyed your ABC on cardiopulmonary resuscitation, but the articles were obviously all written by those with an interest in and access to advanced technology (defibrillators, etc). I suspect that the current campaigns for popular training in cardiopulmonary resuscitation in the community have been initiated quite correctly by those with flying squads and cardiac ambulances who want victims to be preserved until they can arrive with their skills. As far as I can determine, ventricular fibrillation, the only treatable cause of cardiac arrest, will not revert to an effective rhythm without electrical defibrillation (except occasionally in the first minute or so). As cardiopulmonary resuscitation does not produce a coronary blood flow anoxia in the myocardium is likely to make it unresponsive to any shock treatment after 15 minutes, so further help must arrive within that time. Is it then fair and reasonable to train first aiders and the general public in techniques bound to fail without the back up that is simply not available over most of Britain? (I appreciate that these comments do not apply to hypothermia and drowning.)

Complications resulting from misdiagnosing pseudogout

Mr P J SELL (Department of Orthopaedics, East Birmingham Hospital, Birmingham B9 5ST) writes: Dr Keith Radcliffe and others (16 August, p 440) show the importance of establishing the diagnosis in acute monoarthritis by aspirating the joint. However, in their four case reports they omitted to mention the range of movements of the affected joint, which can be of considerable help in diagnosis, crystal arthropathy permitting a greater range of movement than a septic arthritis, and the range of movement improves after aspiration. We have found the use of intramuscular non-steroidal anti-inflammatory drugs a useful clinical trial while awaiting the confirmation of the diagnosis by microbiological means if the patient's condition will permit this.

Influence of intrinsic sympathomimetic activity on respiratory function

Dr G T MCINNES (Department of Medicine, Western Infirmary, Glasgow G11 6NT) writes: Drs R J Northcote and D Ballantyne (12 July, p 97) conclude that "long term administration of pindolol has a less adverse effect on respiratory function than propranolol." However, it is unclear from their report whether the desired (antianginal) effects of the drugs were equivalent at the doses used. The results are of possible clinical relevance only if there was no significant difference between the pindolol and propranolol groups in control of ischaemic episodes. Even then, reasonable inferences concerning differences between the drugs in their respiratory effects can be made only if the prcision of the comparison is sufficient. Thus, there should be no overlap in the confidence limits for differences in antianginal efficacy and those for effects on respiratory function. Only if these considerations were satisfied would the results of this study provide useful additional information for the clinician. In the mean time, the only practical conclusion is that all β adrenoreceptor antagonists are likely to affect respiratory function adversely. Any presumed benefit or partial agonist activity remains speculative.

Onset of obesity in a 36 year birth cohort study

Dr ALAN A MORGAN (Ilford, Essex) writes: Ms Fiona E M Braddon and others (2 August, p 299) have certainly shown that nearly 80% of a group of obese 36 year olds were not obese at the age of 11 years and so childhood obesity is by no means the only factor in determining adult obesity. They have not, however, shown that the majority of obese 11 year olds are not obese at the age of 36 and therefore it would be unwise to adopt their conclusion that undue emphasis should not be placed on childhood obesity.

Captopril in elderly patients with heart failure

Drs JAMES and GILLIAN HOSIE (Glasgow G13 2SW) write: The conclusion of Dr Patrick J Murphy and others that captopril is well tolerated by the elderly (26 July, p 239) is not appropriate to general practice and authors should remember that the *BMJ* is read by both hospital and general practice specialists. In the authors' study patients were observed for the first three hours in the supine position. Except in a few special practices this cannot be achieved in general practice. Again, out of 30 patients, only 18 finished the study, and of those one died of myocardial infarction and one of vertebrobasilar insufficiency and yet another had a notable fall in blood pressure at the first dose, requiring leg elevation. Even in young healthy volunteers we have seen falls in diastolic blood pressure of 20-40% with angiotensin converting enzyme inhibitors. In a group of elderly patients prone to postural episodes we suggest that the opposite conclusion should be reached. Treatment with angiotensin converting enzyme inhibitors should not be started in the elderly with heart failure in general practice except in a few specialist centres.

Prognosis of patients discharged from a coronary care unit

Professor DAVID SHORT (Aberdeen AB9 2PL) writes: Dr H C Smyllie's paper (30 August, p 541) is a reminder that lack of evidence of infarction is not necessarily a basis for congratulation. This observation underlines the need to provide the maximum information on prognosis and future management to the general practitioner who has to look after a patient discharged from a coronary care unit. My inquiries show that discharge summaries and letters are often defective in this regard. For example, they often lack an indication of how long any drugs should be continued, how much exercise the patient should undertake, when he might expect to return to work, when he can resume ordinary driving, and whether outpatient review is planned. Another common omission is a copy of the latest electrocardiogram, which is invaluable as a basis for comparison in case further suspicious symptoms demand a repeat of this investigation.

Prevention of cardiovascular disease in general practice

Dr P A STANDING and others (Bury, Lancs BL9 0QP) write: As members of one of the health centres participating in this study (19 July, p 177) we wish to acknowledge the considerable funding for the project provided by the medical department of Bristol-Myers Pharmaceuticals. At a time when the UK pharmaceutical industry continues to attract much criticism we are pleased to record our appreciation of a valuable initiative for our patients, which otherwise would have been denied them. We would like to see further funding being provided by the NHS itself so that this screened population could be studied in greater depth and for a longer and more meaningful period.

Diffuse peritonitis and chronic ascites due to infection with Chlamydia trachomatis

Drs A EDWARDS and C BRADBEER (Department of Genitourinary Medicine, St Thomas's Hospital, London SE1 7EH) write: We strongly support Mr G M Cawdell in drawing attention to *Chlamydia trachomatis* originating in the genital tract as a cause of peritonitis in women (9 August, p 393). In fairness to Curtis and Fitz-Hugh it is important to note that the original syndrome combined observations made in 1930 by Curtis of the long term sequelae of gonococcal salpingitis with further observations in 1934 by Fitz-Hugh, who described the early acute presentation, which included peritonitis.[1,2] Curtis also acknowledged the likelihood of other infective causes of these features. It would be unfortunate if we were to discard this useful eponym, which serves as an aide memoire and does not restrict the clinician to a single genital tract pathogen as the cause.

1 Curtis AH. A cause of adhesions in the right upper quadrant. *JAMA* 1930;94:1221-2.
2 Fitz-Hugh T. Acute gonococcic peritonitis of the right upper quadrant in women. *JAMA* 1934;102:2094-6.