

TABLE 1—The rate of all strokes in the treatment and control groups (No. 1000 patients years according to the age at the initial screening and the sex of the patients)

Table with 4 columns: Age, sex, Treatment group, Control group, Significance. Rows include Age (years), Males, Females, Both sexes.

TABLE 2—Types of cases in the treatment and control groups

Table with 3 columns: Treatment group, Control group, No. of cases. Rows include Stroke, Myocardial infarction, etc.

mortality—due to stroke, coronary artery death, ventricular failure, ruptured aneurysm, and hypertensive nephropathy showed a non-significant reduction in the treatment group.

SMOKING IN RELATION TO STROKE AND MYOCARDIAL INFARCTION

As most of the treatment group than the control group smoked (28% v. 21%), the incidence of smoking in those who had strokes and myocardial infarctions was examined in the two groups. Of those who had strokes, 39% in the treatment group smoked against 23% in the control group.

There was a significant excess of fatal cancers in the treatment group. Table V. The excess was entirely in cancers of the bronchus treatment group.

Discussion

In this population of elderly patients with hypertension blood pressure was reduced by 18.11 mm Hg for an average follow up period of 4.4 years. There was no effect on overall mortality or on the incidence of fatal or non-fatal heart attacks.

The absence of an effect on overall mortality was partly due to a non-significant increase in the death rate from cancer in the treatment group. These were mainly cancers of the bronchus. No reason can be given for this, and it is probably a fortuitous cluster.

The reduction in stroke rate was similar in men and women and in the two age groups 60-69 years and 70-79 years at randomisation. It was more evident in non-smokers, however, who showed a 50% reduction in overall stroke rate on treatment.

The inclusion of patients with low diastolic pressures (systolic only hypertension) might have combined different responses to treatment in subgroups with high and low systolic pressures.

Comparing the patients admitted to the trial with high and low diastolic blood pressure (≥ 90 mm Hg or < 90 mm Hg) showed a trend for a reduction in cardiovascular death only in patients with raised systolic pressures.

reorderable events were Drs D G Bevers, G Howitt, and J Mann. Dr Kim McPherson advised on statistical management. Professor Sir Raymond Hoffenberg gave advice on stopping the study. Dr G M Stewart coded the electrocardiogram. We thank Professor G Rose and Dr G Watt for advice on writing this paper.

References

- 1. Sirtori CR, et al. (1985) A comparison of a long-acting diuretic with the conventional diuretic... 2. Jackson J, Berry M, Jackson J, Wilson PM. The effect of hypertensive drugs...

Appendix 1

- 1. Are you troubled with headaches? rarely/never 2. Do you feel more tired than usual? sometimes

100 YEARS AGO

The Batho of Bedford is quite at home among the people, and knows them in sickness and in health. It gives some curious examples of the still prevalent superstitions as to charms against sickness...

Tumour of the stomach: attack: Focal central nervous system symptoms or signs occurring suddenly and disappearing within 24 hours. Amnourous (gums) was included but not so-called "arteriole foot" attacks such as drop attacks.

Appendix 2

- Self administered symptom questionnaire. Please tick (in the appropriate box) 1. Are you troubled with headaches? rarely/never

The mortality from all causes and from principal cardiovascular endpoints in these treated patients was nearly the same as that for patients who were not treated.

The trial was an observation controlled without placebo. The degree to which lack of blinding of observers might have led to bias in the identification of events must therefore be considered.

The greatest difference between the groups was in the incidence of strokes, and this was mainly apparent in fatal and non-fatal strokes. It is unlikely to be affected by observer bias.

The absence of placebo tablets also makes it more difficult to take account of the side effects of treatment. We were unable to detect any difference in the level of complaint of perceived symptoms from the questionnaires.

TABLE 3—Comparison of the number of deaths in the combined treatment and control groups in the European Working Party on High Blood Pressure in the Elderly study and in this study

Table with 3 columns: European Working Party, This study, No. of patients. Rows include All deaths, Cardiovascular deaths, Stroke deaths, Coronary artery deaths, Non-cardiovascular deaths.

The other major trial in elderly patients that was organised by the European Working Party for Hypertension in the Elderly (EWPHE). The mean age in the European trial was 72 against 69 in our study.

causes and for major endpoints in the two studies. Mortality from most causes in the European study was at least double that in the trial reported here.

Only one of the other published reports of trials of antihypertensive treatment directly addressed the problem in elderly patients.

The results in the Medical Research Council trial of treatment of mild hypertension are closely similar to those shown here in elderly patients.

Against this benefit must be set the cost of medical care and possible adverse effects. The considerable effort that was required by dedicated trial nurses to treat hypertension effectively in the elderly—such as sending out many reminders to attend and, where necessary, visiting the patients in their homes—might be difficult to reproduce in everyday practice.

The disability and suffering caused by severe stroke in elderly patients, however, is considerable, and if a reduction of 42% can be achieved in these hypertensive patients by acceptable treatment this may make a systematic attempt to screen the elderly worth while.

The participating practices were: Drs T S Warrander, J Lushman, Nurse P Thredgold, March, Cambridgeshire; Drs L A Pike, M E Clarkson, J G Cox, Nurse P Eggleston, Handsworth, Birmingham; Drs P H Donovan, P C Brown, M G Donaghy, M M Mille, A Mather, Stretton, Leicestershire; Hulme Health Centre, Cheshire; Drs J Tudor Hart and G Watt, Mrs M Hart, Nurse W Doyle, The Health Centre, Gillingworth, Gloucestershire; Drs N Goskar, Nurse M Roddall, Rugby; Drs M Ansell and A Grant, Nurse D Brown, Turmery, Cheshire; Drs S L Barley, P G Brown, S Burgoine, J McCorgan, V Vennell, Nurse M Walker, Sheffield; Drs M McBride, J High, P Brodley, Nurse T Connolly, Latch Health Centre, Chester; Drs S Bailey and J D Menzies, Nurse M Hui, Block Lane Clinic, Chadderton; Drs C A H Marr, R Orr, K Worrell, Nurse E Carter, Chadderton South Health Centre, Chadderton; Drs J Hughes, S Street, Dr S Snow, A H Watson, Nurse G Kibbey, Gillingham Health Centre, Oxford; Drs J R Cooke, J K M Cooper, G Cooper, M Kogge, K Handley, Nurse M Hanly, Bellingham Medical Centre, Cheshire; Drs J Casandra and T Heller, Nurses C McGuire and G Green, Sheffield.

The management and nurse training was carried out by Mrs M D Hanly and data processing and computing by Dr T S Warrander, who was also secretary. Mrs M Brughly. The pilot committee of the study who adjudicated

Good Practice

What is a good GP?

NICHOLAS L BISHOP

The government's consultation document on primary health care, published last April, put forward suggestions for encouraging good practice among family doctors. One suggestion was that a good practice award might be linked to factors such as personal availability, the range of services provided, and evidence of continuing medical education.

Many of my patient referrals are direct from GPs, and so there is ample opportunity to assess the various styles of practice. I carefully avoid the use of the word "quality" at this early stage, though this is the essence of the whole article. If one is to accept that there are different qualities of GP, and the title presupposes that there are, how does one distinguish the good from the not so good?

Perhaps the most striking and unexplained element of the relationship between the radiologist and the GP is the wide variation in the usage of imaging facilities by practitioners. This can range from one or two patients a month by one GP to several patients a day by another.

Think ahead

So my first requirement of a good GP is prior consideration of the usefulness of the examination that the GP is requesting. In many instances this necessitates a depth of radiological knowledge beyond

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that normally acquired by a trainee GP. How specific is a barium meal when diagnosing benign gastric ulcer? How good is ultrasound at excluding carcinoma of the pancreas? What is the importance of "clear lungs" on the chest x ray film when the patient has "hiccups"? If the referring doctor is not fully aware of the limitations of the test requested, then the doctor cannot make maximum use of the result. To acquire this knowledge it may be necessary for the doctor to encourage local radiologists to issue guidelines on the use of their department and press them to organise postgraduate meetings or workshops so that each can benefit. There is a tendency to believe that radiology is about interpretation of images only, and therefore GPs will gain little by attending tutorials or lectures. In practice the increasing number of imaging modalities now available means that instruction is needed in their appropriate use. Only if GPs remain aware of these developments and their advantages, their pitfalls, and their relative costs can they fairly expect these services to be available to them.

All this takes time, and many GPs are not sufficiently interested to learn new techniques, or they think that they already know enough about the old ones. Though few radiologists will sympathise with this attitude, most will remain happy provided sufficient information is given on the request form to enable the radiologist to make a decision about the best investigation. A good GP may even write a letter if the problem is particularly difficult or contact the radiologist by telephone so that questions can be answered. If the request is likely to be interpreted as inappropriate or unreasonable I would expect an explanation to be provided to justify it. This especially applies to requests for repeat studies where further documentation of a slowly progressive and essentially incurable condition is of little practical benefit to the patient. Indeed, it may do the patient a disservice if the examination is uncomfortable and falsely raises hopes of a cure.

Perhaps more than any other consultants radiologists lack feedback on their patients. We don't see them in outpatients departments, so the only opportunity we have to follow their progress is when they are re-examined. If a radiologist has had a lot of deals with a patient it is therefore helpful if that radiologist is referred the patient for subsequent examinations. Mentioning this on the request form will simplify the booking procedure and save the time of several radiologists becoming concerned in a complex case. It also provides the radiologist with a chance to see where he or she previously went wrong.

Thus from the radiologist's point of view a good GP gives prior thought to the subsequent management of the patient and how this will be influenced by the result of the examination. The GP will communicate these thoughts to the radiologist through a concise, legible request form and will be aware of the nature of the procedure requested, its approximate cost related to other forms of management, and its value to the patient in relation to any suffering it may cause. By attending postgraduate meetings the GP's knowledge will remain up to date. In an especially difficult case the GP will contact the radiologist personally to seek advice and when possible will provide feedback on the patient's progress.

Having learned and adhered to all these commandments the GP may still have time for halo polishing.

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