committed to health promotion, have included health promotion in recent NHS regional reviews, and this impetus is now spreading through the service to district and unit reviews. They have also strongly supported the World Health Organisation's strategy for *Health For All 2000*.^{9 10} Outside the DHSS the Prime Minister has shown concern for inner cities, though the health effects of some of her other policies may last for generations by further widening the health divide; and the Home Secretary has established a standing interdepartmental ministerial committee to combat alcohol misuse.¹¹

On the professional side, the Faculty of Community Medicine last year woke up to its opportunities and responsibilities and published its *Charter for Action on Health for All 2000*.¹² Elsewhere among health professionals there is greater awareness of health promotion, better coordination and planning, and increasing pressure for action on smoking,¹³⁻¹⁵ nutrition and coronary heart disease,¹⁶ and alcohol abuse.¹⁷⁻²⁰ There is also greater professionalism among health educators and increasing skill in evaluation,²¹ although the science, planning, activities, and evaluation of what happens in some districts leaves much to be desired. The Health Education Authority, despite the public relations disasters surrounding its birth, now has a central place in the structure of the NHS that can be built on if the "sturdy independence" claimed by its new chief executive truly exists.

What then needs to be done? Both houses of parliament must endorse the *Health For All by the Year 2000* strategy, allocate time to consider the recommendations for legislation, and ensure that in future opportunities exist to consider the health consequences of legislation. The Prime Minister should require all government departments to identify and review policies that may affect health. The chancellor should consider how fiscal policy can be used to promote health, and the DHSS should give greater priority to developing policy for health promotion and implementing and evaluating existing policy. The advice to other government departments should be augmented, and indefensible policies that bring international disgrace on British public health²²—such as the voluntary agreement on tobacco advertising and sponsorship—should end.

The NHS Management Board should make it clear that health promotion is to be the local priority, ensure that new resources are made available, and clarify the job of the Health Education Authority in relation to the rest of the NHS. The Health Education Authority and the NHS Training Authority must improve the quality and effectiveness of health promotion. The Medical Research Council should consider establishing two or three multidisciplinary units to work in health promotion. The job of the regional health authorities will depend on the arrangements agreed for the Health Education Authority, but they should at least provide multidisciplinary advice and monitor district activities.

Much health promotion must go on in health districts, which require resources and long term commitment from the authorities and better collaboration with other statutory and voluntary agencies. The detailed monitoring arrangements in districts will be heavily dependent on the outcome of the Acheson inquiry on the public health, but the district medical officer should be confirmed as responsible for improving the quality of the health environment and preventive services. The right and duty of unfettered but professionally sound public speech on matters affecting public health should be emphasised. Health education departments must be given proper resources, and doctors need to improve their preventive activities.

But action from the bottom will never be fully effective without support from the top. Doctors must seek to persuade their members of parliament of the importance of political action on health. Perhaps this would effectively counter the seductive and extensive lobbying of groups like the tobacco industry.

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What was the matter with Dr Spooner?

W A Spooner (1844-1930), fellow and warden of New College, Oxford, was an albino. He has become immortalised by his transposition of the initial sounds of words (spoonerisms), and his dysgraphia and dyspraxia have been described in detail.¹ Were they related to his albinism?

Our understanding of albinism has advanced appreciably in recent years. Depending on how their hairbulbs respond to incubation with tyrosine, complete and incomplete universal albinos are now called tyrosinase negative and tyrosinase positive oculocutaneous albinos²; and several other rarer forms of oculocutaneous albinism have recently been described.³ Not all ocular albinos have the classical X linked form of the disease described early this century:

some have the more recently described autosomal recessive form.⁵ About one third of all albinos in Britain have tyrosinase negative oculocutaneous albinism, one third have the tyrosinase positive form, and most of the rest are equally divided between X linked and autosomal recessive ocular albinism.⁶

Many albino babies show delayed visual maturation, appearing blind or nearly blind in the first few months of life. Parents need to be reassured that vision will develop once other causes of "blindness" have been excluded.

Distinguishing between tyrosinase negative and tyrosinase positive oculocutaneous albinism is usually impossible in early childhood because the hairbulb test result is usually negative in the first two or three years of life irrespective of the form of albinism. By the time the test becomes useful the two forms can usually be distinguished clinically. Their distinction is important as the visual acuity achieved by each of these groups is different. Those who are tyrosinase negative seldom achieve a visual acuity better than 6/60, and they usually have difficulty reading small print without the help of low vision aids. The children thus often find it difficult in normal schools even with additional tuition. In contrast, those with the tyrosinase positive form of oculocutaneous albinism usually achieve a visual acuity between 6/18 and 6/36, and their near vision is good. Most can manage in normal schools.

Refractive errors are common in albinos and if appreciable should be corrected as early as is practicable. Albino children with myopia and astigmatism often dislike wearing spectacles as the visual benefit may be small. Those with hypermetropia benefit from correction, which improves their near vision. Albinos have abnormal visual pathways and lack the central mechanism for binocular single vision.⁷ Strabismus is therefore common and should be corrected if unsightly. An early operation may, however, lead to a consecutive strabismus because of the absence of binocular vision.

In addition to their visual problems albinos often have a verbal intelligence quotient much poorer than their score for performance.⁸ They thus tend to do well at school initially, but many then fail to progress with writing, which they tend to do slowly and with some letters written backwards. Albinos with these particular problems should be introduced to keyboard skills early in their education. Spooner, who probably suffered from tyrosinase negative oculocutaneous albinism, had difficulties that were more serious and more bizarre than those of most albinos; he probably had some additional reason for his lapses.¹

Oculocutaneous albinos are troubled by photophobia and have to avoid burning their skin in the sun. Photophobia in older children can be helped by sun glasses, but young children often remove their glasses and have to be protected by a floppy hat and a hood over the pram. Contact lenses with an opaque scleral portion and painted irides have been tried but with limited success. In general, contact lenses are best reserved for teenagers and adults with appreciable refractive errors who do not wish to wear glasses. Protection of the skin is not usually a serious problem in Britain: clothing and ultraviolet barrier creams will usually prevent blistering and reddening.

Once a couple has had one child with oculocutaneous albinism they have a one in four chance of having another affected child. Prenatal diagnosis is now possible by examining fetal skin with electron microscopy⁹; this is probably not justified in Britain¹⁰ but may be in certain subtropical and tropical countries, where albinos are often social outcasts and

have a high incidence of skin cancers.¹¹ Parents of affected children need sympathetic counselling and need to be told not only of the genetic implications of the disorder but also of its effects throughout life. Parents often appreciate being able to discuss their problems with other parents of affected children, and the Albino Fellowship (16 Ronaldshaw Park, Ayr KA7 2TJ) fulfils this need for many.

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Angiotensin converting enzyme inhibitors in the elderly

Angiotensin converting enzyme inhibitors have been introduced for treating hypertension and heart failure.^{1,2} Both conditions are common in older people, in whom existing treatments are not always well tolerated or optimally effective. Angiotensin converting enzyme inhibitors produce symptomatic and haemodynamic improvement in older patients with heart failure and may prolong the life of those most severely affected.³ Despite theoretical reasons why they should not,⁴ converting enzyme inhibitors do lower blood pressure in the elderly and are generally well tolerated.⁵⁻⁸ Indeed, they produce greater improvements in the patients' quality of life than propranolol or methyl dopa.⁹ The blood pressure response to angiotensin converting enzyme inhibitors is not predictably related to pretreatment plasma renin activity,¹⁰ and, unfortunately, in some elderly patients the blood pressure fall may be excessive and potentially dangerous.

Severe hypotension one to two hours after the first dose of captopril has been widely recognised.^{11,12} After the first dose of enalapril hypotension may be delayed six to eight hours but is longer lasting (24-28 hours) and accompanied by renal, cardiac, or cerebral ischaemia.^{13,14} Several aggravating factors have been identified, but attempts to predict and prevent the hypotension have been disappointing.¹¹ Hypotension is most often seen in patients also taking diuretics or in those who are hypovolaemic or hyponatraemic.¹¹ Hypotension is more common in patients with cardiac failure¹⁴ but even in healthy elderly people a prominent fall in blood pressure may occur.¹⁵ As in the young, the hypotension is not usually accompanied by an increase in heart rate.¹⁵ Age related