The benefits of general practice computerisation include ease of practice management, safer prescribing, and a change from palliative to preventive medicine, as well as enhanced research facilities. Postmarketing surveillance should benefit, with the spread of the electronic yellow card allowing improved follow up and feedback and the opportunity to develop a record linkage database. As a result of the computer schemes these advantages are available to a larger number of practices.

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SIR,—Dr Mike Pringle (26 September, p 738) gave a necessary reminder of possible pitfalls in the offer of "free" computers to general practitioners, but he did not explore sufficiently the wider implications of this new initiative.

Until recently general practice computing has been fragmented and of variable quality, and, since even the market leaders had installed only 100 to 200 systems, it was irrelevant in any wider context. Now, with 2000 to 3000 AAH Meditel or VAMP systems due to be installed, it would seem foolhardy for general practitioners to invest in any other systems, both because economies of scale have meant that costs for renting from the two suppliers have fallen sharply and because they have become ipso facto the standard for general practice computing.

As a hospital specialist with an interest in maternity computing and a strong commitment to community based care, I have despaired until now of the way hospital computer systems seemed destined to draw antenatal care more and more firmly into hospital. With the prospect that general practice computing may become relatively standardised it seems worth while investing the resources necessary to pilot a community initiated computerised antenatal care scheme (the Milton Keynes electronic shared care computer project). In many other areas of clinical medicine—for example, cytology, diabetes, geriatrics, infertility, etc—any prospect of standardisation in general practice computing should also be strongly welcomed.

Many areas of clinical computer strategy now need to be reassessed to take full account of this exciting new development. This is especially urgent in obstetric care since next April's untimely Körner maternity deadline looks set to precipitate the purchase of centralised and shortsighted maternity computer systems in many regions.¹

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1 Fawdry RDS. Cattle markets or community care? Current trends in maternity computing. *Br J Health Care Comp* (in press).

SIR,—Dr Mike Pringle's concerns about commercial control of general practice computer data (26 September, p 738) are dismissed a little too readily by Dr M S Lawrence (17 October, p 995).

The review of the government sponsored Micros for GPs scheme indicated that it fell considerably short of the claims originally made by the companies concerned.¹ Although it may have helped the first steps towards computer literacy and organisation that all practices will eventually require, it was based almost entirely on prescribing, and the current generation of software does not go much further. After a year only 4% of practices could claim to have a viable computerised prevention scheme in operation.

But the AAH Meditel and VAMP schemes are all on a much larger scale, and for such an important initiative we should at least be clear what is on offer. Before selling my practice data to the drug companies I would want to know what my patients and practice will get out of the system—apart from legibly typed prescriptions. How accessible will the data be, not only to the highest bidder but also the health team? If systems can be designed to enter complex data with minimal training, they can also be designed flexibly to output and format complex reports and audits. The software currently on offer has fairly crude reporting facilities at present.

Secondly, a few fields for blood pressure or cervical smears do not constitute adequate ascertainment, follow up, and display of risk factors for cardiovascular disease, cancer, or chronic illness. If a fraction of the effort which has gone into prescribing had been spent on this aspect these systems would look a little more useful to the practices as well as the drug companies.

The drug companies want this information badly. Surely general practice is in a position to dictate not only the terms of contracts but also the content of software. For all but prescribing, it is currently mediocre and inaccessible to the practice team.

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1 Department of Health and Social Security. *A prescription for change—a report on the longer term use and development of computers in general practice*. London: HMSO, 1986.

Monitoring medicines: opportunity knocks

SIR,—Two of your recent leading articles related to monitoring of adverse drug reactions call for alternative views to be aired.

Dr Glyn Volans (3 October, p 797) suggests several measures to improve safety monitoring of over the counter medicines, but they only cloud the main issue. If patients suspect that adverse reactions to such products have occurred then they should consult a doctor as for any other illness not suitable for self treatment. Patient education should be devoted to this end. The doctor can then decide on reporting and managing the clinical problem, which is now no different from a suspected adverse reaction to a prescription medicine. Asking other agencies to screen possible reactions will produce only confusing and false information. This strategy does, however, reinforce the need for informed and efficient medical services at both general practitioner and hospital levels for dealing with such reactions.

And this is where the second leading article falls down: Dr Mike Pringle (26 September, p 738) loses an opportunity to encourage the development in Great Britain of a postmarketing surveillance system for medicines that could meet many long felt needs and would be the best in the world. Instead, he parades, as have others, luddite myths about the possible response to widespread computerisation of general practice. Confidentiality—such an emotional word—need not be a problem and, in fact, is secured by collecting data within practices. Activity will not be "diffused" or "fragmented" but rather encouraged and organised so that, for the first time, good clinical use can be made of all that information in Lloyd George's envelopes. The Micros for GPs experience is completely irrelevant to modern technology and systems, which offer clear advantages to doctors and patients as well as to medical knowledge. Time and patience are needed by doctors to acquire the necessary skills, but thereafter many efficiencies in time can be made.

Of course, data quality must be of the highest, and for the first time doctors are being offered training and review of their records to ensure this. The ethical behaviour of all the parties concerned remains important and requires detailed guidelines and supervision, all of which have been or are being provided. There remains to be worked out integration with other surveillance systems.

Many doctors are now making the commitment to computerise, and the entrepreneurs are investing heavily in helping them to do so. There is no shortage of protection and guidance from the sidelines so why not offer some encouragement to the players, who are embarking on a unique venture of profound medical importance? Why should medicine be so behind all our other activities in achieving the benefits of computerisation when it has an opportunity to do so that may not come again?

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Angiotensin converting enzyme inhibitors in the elderly

SIR,—Professor J L Reid (17 October, p 943) highlights the increased potential for adverse reactions in elderly patients who are prescribed angiotensin converting enzyme inhibitors. The use of inappropriately high maintenance doses in patients with heart failure may compound the problem. The data sheets clearly state that if clinical circumstances permit increases in dose should be delayed for at least two weeks (captopril) or titrated over two to four weeks (enalapril). In our experience many doctors increase the dose more rapidly, perhaps influenced by the manufacturers' statements of the usual maintenance treatment: 25 mg thrice daily for captopril and 10 to 20 mg a day for enalapril. Inhibition of the renin-angiotensin system, however, occurs at much lower doses.^{1,2} For some patients the small initial dose may be sufficient for maintenance therapy.

We would emphasise the need for patience when starting an angiotensin converting enzyme inhibitor for the treatment of heart failure in the elderly. A good therapeutic response may be obtained from a low dose regimen, thus reducing the potential for adverse reactions in this high risk group.

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1 Sharp DN, Douglas JE, Coxon RJ, Long B. Low-dose captopril in chronic heart failure: acute haemodynamic effects and long term treatment. *Lancet* 1980;ii:1154-7.

2 Cleland JF, Semple P, Hodsman P, Ball S, Ford I, Dargie H. Angiotensin II levels, haemodynamics and sympathoadrenal function after low dose captopril in heart failure. *Am J Med* 1984;77:880-6.

Aluminium bone disease

SIR,—Dr D Maharaj and others reported the accumulation of aluminium in patients receiving regular plasma exchange therapy using albumin replacement solutions contaminated with aluminium (19 September, p 693). They suggested that our study¹ implied that the amount of aluminium delivered by infusion of albumin solutions is too small to present a risk of aluminium accumulation and its resultant toxic effects. This is not a conclusion we can accept.

From our observations in patients with acute renal failure we concluded that the major cause