development of the cataracts, and more prolonged exposure to the small amounts of systemic steroids derived from inhalation and subsequent ingestion may have prevented resolution. It remains possible, however, that the inhaled steroids may alone have been responsible for the cataracts. Further studies are needed to confirm if patients with asthma taking regular inhaled steroids with and without occasional reducing doses of oral steroids have an increased risk of developing posterior subcapsular cataract. Until results of such studies are available patients should continue taking their inhaled steroids.

The Committee on Safety of Medicines and Allen and

Hanburys, who market beclomethasone dipropionate as Becotide and Becloforte, have been informed about these adverse reactions.

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General practitioners' use of electrocardiography: relevance to early thrombolytic treatment

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Several recent trials have drawn attention to the benefits of thrombolytic treatment in acute myocardial infarction,¹⁻³ and the evidence strongly suggests that the earlier these agents are given the greater the benefit. In the British Isles general practitioners are ideally placed to ensure the early use of these agents as they are often the first people to see the patient and delay in admission to hospital is still commonplace. Some trials of thrombolysis in hospitals have adopted electrocardiographic criteria to diagnose acute myocardial infarction¹ while others have relied on clinical data.^{2,3} The few studies in general practice have used electrocardiographic data.⁴ The potential benefit of the widespread application of early thrombolysis⁵ suggests a future role for general practitioners in initiating treatment. The side effects, however, make confirmation of the diagnosis important, and the only practicable test available to general practitioners is electrocardiography. Therefore an assessment of the availability and use of electrocardiography in managing acute myocardial infarction in general practice is important.

Doctors, methods, and results

I studied the Hereford and Worcester area, which is administered by one family practitioner committee and covers a large rural area, two cities, the outskirts of Birmingham, and several industrial towns. The standard of general practice is high with 660 000 people on the lists of 348 general practitioners in 90 practices. The average list size (1900) is below the national average, and the use of deputising services is rare. All practices were sent a questionnaire recording the availability and use of electrocardiography in diagnosing acute myocardial infarction. Particular attention was paid to arrangements at different times of the day. Responses were obtained from 82 (91%) of the practices, or 306 (88%) of the area's doctors, an excellent response rate.

In total, 190 (62%) doctors working in 44 practices had access to an electrocardiograph, 85 (45%) of them recording an electrocardiogram in cases of suspected acute myocardial infarction during surgery hours and 50 (26%) doing so outside normal working hours. When doctors who did not own an electrocardiograph were included 28% of doctors recorded electrocardiograms during surgery hours and 16% outside normal working hours. Only 25 (13%) doctors routinely

carried the machine with them outside normal working hours.

Comment

Although the majority of doctors had access to an electrocardiograph, fewer than half of them recorded electrocardiograms in patients suspected of having had an acute myocardial infarction; outside surgery hours the proportion was even smaller. Only 13% of the doctors routinely carried an electrocardiograph with them outside normal working hours—returning to the surgery to collect one might be considered to be unwise with the high incidence of early arrhythmias in acute myocardial infarction and the importance of early thrombolysis. My results suggest that (quite rightly) many general practitioners rely on the clinical picture for diagnosis and are aware of the misleading electrocardiograms that may be recorded during the early stages of infarction. If electrocardiographic confirmation of the diagnosis is considered to be essential before treatment with thrombolytic agents is started outside hospital my results suggest that the widespread introduction of these agents into general practice will be delayed.

Whether the use of thrombolytic agents in general practice before patients are admitted to hospital is justified is debatable because of a lack of data and the side effects of treatment. Furthermore, the patients most likely to benefit from thrombolytic treatment outside hospital are those with the longest journey to hospital, and the risks of transporting such patients have not been adequately studied. Whatever method is used to diagnose myocardial infarction outside hospital the overwhelming responsibility of general practitioners is to ensure that patients receive appropriate thrombolytic treatment as early as possible. Whether this treatment will become commonplace in general practice requires further study, but my results suggest that a considerable modification in general practitioners' use of electrocardiography will be necessary before it can become widespread.

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