tance of the oropharynx^{21 22} and stomach, and of preserving gastric acidity, should be defined. Selective decontamination of the digestive tract may be helpful, however, in preventing infection in long stay patients with trauma who are being ventilated and in removing organisms during outbreaks. What selective decontamination of the digestive tract has done is to open new approaches for investigating and possible intervention of an intractable problem.

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Anticardiolipin antibody

A cause of a tendency to thrombosis

It is now over five years since our description of the thrombotic syndrome associated with anticardiolipin (antiphospholipid) antibodies—perhaps an appropriate time to reflect on the questions this syndrome has raised.¹⁻¹⁰ How important is the syndrome? What is its aetiological role in myocardial infarction, stroke, recurrent abortion, and other thrombotic conditions? Is the tendency exacerbated by other factors such as the contraceptive pill or smoking? What is the mechanism of thrombosis? When should patients be tested for the antibody and what should be done for those with high titres?

The syndrome is characterised by a tendency to thrombosis—both venous and arterial—and, in women, a tendency to recurrent abortion, almost certainly related to thrombosis of the placental blood vessels. Often these patients have a long history of recurrent deep vein thrombosis; sometimes they haunt the anticoagulant clinics with prothrombin ratios that are difficult to control. The thrombosis may also affect renal, ocular, cerebral, and other vessels. More seriously (and distinct from other hypercoagulation disorders), patients may develop arterial thrombosis—transient ischaemic attacks, strokes, “early” myocardial infarction, or peripheral arterial occlusion. Some patients have distinctive “livedo reticularis” on the back of the hands or on the legs.^{2 8} Thrombocytopenia occurs in some patients, and some patients develop abnormalities of the heart valves.¹¹ The cause of the thrombotic tendency is still unknown.^{12 13}

For most general practitioners the most likely contact with the syndrome is in obstetrics. High titres of antiphospholipid antibody reflect a high risk for spontaneous abortion, some women suffering a dozen or more episodes. The reported proportion of women with recurrent abortions due to antiphospholipid antibodies varies widely.¹⁴ In one careful study 27% of women with two or more unexplained abortions

and 42% with three or more had antiphospholipid antibodies.¹⁵ Possibly 21% of cases of early coronary artery disease are associated with the syndrome.¹⁶ Such figures, coming as they do from specialist centres, may be skewed towards overdiagnosis, but they still make a powerful case for including testing for antiphospholipid antibodies in all women with unexplained fetal loss.

Our feeling is that the most florid forms of the disease will be seen by the neurologist. The neurological features are variable (chorea, amaurosis, headache, petit mal), but an appreciable number of patients develop strokes.¹⁷ Detailed investigation including magnetic resonance imaging often shows multiple cerebral infarction, and, if untreated, a number of patients develop multi-infarct dementia,¹⁸ but how important this cause is in a common condition is unknown.

Until we know the causes of the condition the optimum treatment is uncertain. Perhaps patients with high antibody titres and no clinical features should be given low dose aspirin, and those who have had one or more thrombotic episodes should be given anticoagulation with warfarin, often for prolonged periods. The use of steroids, immunosuppression, and so on to reduce antibodies has given disappointing results. Thus from all points of view—epidemiological, aetiological, and therapeutic—this newly described syndrome remains a mystery; rarely has the phrase “more research is needed” been more apposite.

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Hearing problems of elderly people

Every elderly citizen should be offered an audiogram

From birth onwards a gradual deterioration in hearing seems inevitable. Hearing for higher tones is lost earlier, and more severely, than hearing for lower tones (figure). The rate of deterioration declines after the age of 70.²

Average audiograms for each decade of age from large population survey¹

The high prevalence of deafness in the elderly is well documented.³ At least a third of all people over the age of 70 are deaf enough to require a hearing aid; the fraction is about a half in those over 80. Herbst and Humphrey explored impairment of hearing in the elderly living at home, concluding that deafness of a degree to justify a hearing aid is "usual" beyond the age of 70.⁴ Earlier this year Dafydd Stephens presented a paper to the Royal Society of Medicine that reported a survey of people aged 50-65 and showed that almost a quarter needed an aid—though only a quarter of them had actually been issued with one.

Calculations from the findings of the Office of Population Censuses and Surveys on disability in Great Britain in 1988 show that over two million people aged over 60 are aware of hearing difficulties,⁵ making deafness the second most common disability in the elderly. Furthermore, many people with some hearing loss are unaware of it; probably over four

million elderly people in Britain would be helped by a hearing aid. Again the estimate is that only about a quarter have one.

What happens when we fail to identify and help those deaf enough to need an aid, commonly defined as those with a loss of 35 dB or more at speech frequencies in the better ear? The deaf gradually become detached from everyday life. Family chat, shopping, and social outings gradually become difficult and embarrassing and are finally avoided. Such people often become increasingly difficult to live with—asking for remarks to be repeated, getting the wrong end of the stick in conversations, and turning the radio or television on so loud that others are annoyed. And Rabbitt's studies showed that it was much more difficult to cope with the same degree of hearing loss as age advanced.⁶ Yet helping the deaf need not be costly. The main source of hearing aids in the NHS is through a bulk buying arrangement with the Mersey Health Authority, and the cost of a basic aid is about £15-20.

Should the elderly be screened for deafness? In an advanced nation on the threshold of the 1990s every senior citizen should be offered an audiogram, and this should be repeated periodically so that the issue of a hearing aid can be suitably timed. Every NHS general practitioner has a named list of people for whose medical welfare he or she has accepted responsibility. Some half of all practices now have computers and are using these to invite specific groups of patients to come for appropriate attention, such as immunisation and cervical cytology screening. Even simple clinical assessment can be highly effective. Ideally, however, elderly patients should be examined by pure tone audiometry. A growing number of practices have audiometers, and suitably instructed practice nurses are ideally placed to record audiograms.⁷ Audiometry should be seen as an essential facility in general practice—for example, to monitor glue ear, to meet the need for audiometry for workers in noisy occupations, and to investigate and counsel patients with tinnitus.

In its recent campaign "Hearing Aids—the Case for Change" the Royal National Institute for the Deaf has highlighted the unsatisfactory provision of hearing aids in the NHS. The traditional procedure requiring the referral of patients to hospital ear, nose, and throat surgeons results in deplorable delays (sometimes over a year) for patients. It also greatly increases the waiting period for patients who actually need the attentions of ear, nose, and throat surgeons. Presbycusis is not a hospital disease, and for many elderly