obese subjects than in controls of normal weight ($p<0.0001$), and there was a correlation between Lp(a) and fibrinogen concentrations ($r=0.523$), Lp(a) and cholesterol concentrations ($r=0.273$), and Lp(a) concentration and body mass index ($r=0.210$).

We conclude that the increased values among obese patients and a significant correlation with other important risk factors for atherosclerosis show that Lp(a) concentration can be considered to be a "trouble marker" of coronary heart disease.

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Management of convulsions with fever

SIR,—In 1990, during one of the periodic analyses of the activity of the Regional Drug Information Centre (CRIF),[1] we noticed an increase in the number of queries from practitioners and parents of children with a history of convulsions with fever concerning the most recent indications for management. Stimulated by this desire for information, and to update the National Institutes of Health Consensus Statement of a decade earlier,[2] a consensus conference on the management of children with fever-associated seizures, similar to the recent British workshop,[3] was held at the Mario Negri Institute in Milan on 22 February 1991. The 16 invited participants included paediatricians, paediatric neurologists, and clinical pharmacologists.

Before the meeting the main papers published during the past decade on diagnosis, treatment, and management and an ad hoc meta-analysis of clinical trials on prophylaxis in febrile convulsions were circulated. The guidelines on which an agreement was reached were amazingly coincident with those reported in the *BMJ*,[3] even on the points where consensus was more difficult to reach (hospitalisation after a first convulsion, routine investigations, long term prophylaxis). This is such a rare model of agreement that it could be worth considering its formal submission to other national groups to assess the possibility of reaching an even broader consensus and therefore the formulation of an international consensus on which to base not only therapeutic practices but also recommendations for clinical and epidemiological research.

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SIR,—The report on the guidelines for the management of convulsions with fever unfortunately omits a few important points.[1] Many of us tend to forget simple tests when we manage "febrile fits." Children with febrile convulsions have about the same risk of bacteraemia as children with fever alone. Blood cultures confirmed occult bacteraemia in at least 5% of children with simple febrile convulsions.[2] The figure will be higher in complicated or prolonged convulsions. I suggest that blood cultures should be done for all children with febrile convulsions admitted to hospital or seen in casualty departments.

Rectal diazepam has become popular without any controlled trials. Unfortunately no placebo controlled study of its usefulness has been done.[3] Some evidence suggests that drug induced respiratory problems are seen predominantly in short term treatment.[3] It will be dangerous in inexperienced hands.

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Inner city psychiatry

SIR,—Dr T H Turner's letter on inner city psychiatry[1] and the response from Drs David V James and Lyle W Hamilton[2] raise several interesting points, specifically about psychiatric liaison schemes in magistrates' courts. For the past seven months I have helped to run a psychiatric liaison service at three magistrates' courts in south east London. I do not regard the function of the scheme as being diversion from custody and into hospital. Mentally disordered offenders can be just as inappropriately placed in a therapeutic institution as in penal surroundings.

Rather, I see my role as acting as a filter, screening out those requiring admission to hospital and doing this more quickly than might have occurred in the past. In the time that my scheme has been operating there have been 12 admissions, including one voluntary admission (from 83 referrals), to four hospitals. Thus most of those referred to the liaison service do not require admission, and surely those who do have as much right to receive appropriate psychiatric treatment as their counterparts in the community.

For diversion from custody schemes to be truly beneficial to clients the provision of community resources will have to be increased to meet the needs of those requiring more than just a conventional outpatient appointment. If the emergence of court psychiatric liaison schemes compels us to cast a critical eye over the adequacy and appropriateness of our existing psychiatric services then so much the better. The recommendations to be made by the Reed committee (a joint review of health and social services for mentally disordered offenders by the Department of Health and the Home Office) are awaited with interest; I will also be interested to see the resolve with which they are implemented.

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Adolescent self harm patients

SIR,—In their study of adolescents who attended an accident and emergency clinic after deliberate self harm Mr Frank G O'Dwyer and colleagues showed that those who had had a psychiatric consultation or had other follow up arrangements were better assessed.[1] Such arrangements also seem to have affected the treatment options as a poorer assessment tended to result in either admission or discharge.

We recently conducted an audit of emergency psychiatric referrals to an inner London teaching hospital.[2] We found that inadequate referral letters were significantly related to non-attendance at the emergency clinic. We concluded that routine discussion should occur between accident and emergency officers and the registrar in psychiatry to facilitate better assessment and more appropriate referrals. We also considered that structured referral letters improved the adequacy of information relayed—an idea similar to Mr O'Dwyer and colleagues' checklist.

A disturbing fact that emerged from Mr O'Dwyer and colleagues' study was the inadequate assessment of mental state, particularly with regard to suicidal intent. This reflects poorly on our training process as all students are taught the importance of such an assessment. Checklists are good as an aide memoire and for medicolegal purposes but do not teach a questioning or empathic approach. This adds weight to the current debate about medical education and how critical thinking and active learning should be encouraged.[3] To succeed in education we need to teach that learning is a continual process that does not end after final examinations but continues through our own development and our interaction with colleagues.

Psychiatrists need to be proactive in their role in accident and emergency departments, and junior medical staff should consult them more than they do. Informal education, especially the opportunity to observe psychiatrists at work and to be able to discuss cases with them, should complement any formal education programme.

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Tattoos

SIR,—In recommending a solution to the problem of removing tattoos Sam Ramsay Smith makes two arguable assumptions: that doctors are appropriate educators and that they respond to financial incentives.[1] Several studies have shown that reliance on doctors as health educators is misplaced[2-4]—for example, in a recent survey of young people in the north east we found that only 11% had learnt anything about AIDS from their doctor, 32% had learnt from a school health educator, and 97% from television (R Madhok, paper submitted for publication).

Most general practitioners are sufficiently busy healing the sick, and financial incentives alone will not motivate them to carry out other public health tasks. They must perceive the task to be important and relevant to their role and one that they can discharge effectively. Increasing the financial reward has failed to improve the reporting of communicable disease.[4]

With regard to removing tattoos, young people need accurate, relevant, and timely information