greater. Recent studies have indicated that mortality is increased in women with lower bone mineral density.²¹ Thus, in our series of elderly women there may have been fewer women with low bone density because of early deaths. If so, this would lead to an underestimate of the effects of the drugs.

VARIATIONS IN USE

The use of drugs affecting bone metabolism differed among countries, ranging from 3% to 20% in the communities studied (table II). The type of drug also varied, even after taking account of restrictions imposed by registration authorities. The greatest variability in use between countries was seen for calcitonin (8.5-fold difference) and oestrogens (30-fold). Even among women taking drugs for which we had sufficient power to detect a decreased risk of hip fracture, the proportion taking the drugs was relatively low (table II). The adjusted proportional fractures that were prevented (analogous to attributable risk) by taking these agents was therefore also low (2.2% for calcitonin; 1.5 for oestrogens and 2.9% for calcium). Thus, if the associations we describe are causal then these drugs prevented 3.6% of hip fractures. It is ironic that the number of women taking each drug was inversely related to apparent efficacy, so changing the treatment of those most at risk to more effective regimens would have saved twice as many fractures.

We conclude that drugs affecting bone metabolism including oestrogens, calcium, and calcitonins significantly reduce the risk of hip fractures. This supports their use in the prevention of hip fractures; for calcium and the calcitonins, treatment relatively late in the natural course of postmenopausal bone loss may be worth while.

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How useful do parents find home peak flow monitoring for children with asthma?

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Home peak flow monitoring is increasingly seen as standard practice in the management of adults and children with asthma.¹⁻³ We prescribe a peak flow meter to all children over 5 years old who attend our clinic with asthma. We ask parents to ascertain their child's best peak flow reading and we then assign a "danger" peak flow level (usually 60% of the child's best).

We decided to study how useful parents find home peak flow monitoring and in what ways they use their peak flow meters. We also assessed parents' understanding of home peak flow monitoring by testing their recall of their child's best and danger peak flow levels.

Methods and results

The parents of 50 consecutive asthmatic children over 5 years old attending our clinic were included in the study provided that they could write English and provided that they had attended the clinic at least once before since receiving a peak flow meter. They were given the following questionnaire to complete before

entering the consulting room: (1) What is the best peak flow level that your child has ever blown? (2) What is your child's danger peak flow? (3) How useful do you find your peak flow meter (very useful, useful, not very useful, useless)? (4) Now please write as much as you like about how the peak flow meter helps you look after your child's asthma.

Some parents were carrying a National Asthma Campaign card (with details of their child's best and danger peak flow readings). We emphasised the importance of not consulting the card while they completed the questionnaire. In a few cases we confiscated the card temporarily. A nurse was usually present while they completed the questionnaire.

Forty two of the 50 parents remembered their child's danger peak flow to within 10% of the correct value. The same number remembered their child's best peak flow level to within 10%. Thirty five parents rated the peak flow meter as very useful. Fourteen rated it as useful. One parent rated the peak flow meter as useless. Almost all the uses for home peak flow monitoring that were volunteered in writing by parents fell into one of three categories.

Forty four of the 50 parents cited the usefulness of home peak flow monitoring for judging the severity of an episode of asthma. Twenty three parents stated that it helped them judge their child's response to bronchodilators. Ten parents wrote that it helped them detect asthma when their child was asymptomatic. Four parents wrote about how reassuring they found a

normal peak flow reading to be—especially when their child was coughing.

Comment

In this study most parents valued their peak flow meter for its usefulness in the recognition of severe asthma attacks. That 42 of the 50 parents recalled their child's danger peak flow level to within 10% of the correct value suggests that most parents were capable of using the peak flow meter to recognise severe attacks.

Only 20% of families wrote about the usefulness of their peak flow meter for the detection of impaired respiratory function when their child was apparently well. Although we mention this potential use to parents, we prefer to teach them to assess asthma control by determining how much the asthma interferes with their child's daily life. We are not convinced that daily peak flow measurements in apparently well

children are worth the effort entailed. On the other hand, we shall continue to teach parents how to use home peak flow monitoring to recognise severe attacks of asthma. It is surprising that this use of home peak flow monitoring was not emphasised in the recently published international consensus on the management of childhood asthma.³ This was the use of home peak flow monitoring that was most valued by parents in our study and one that our study has shown can easily be taught to most parents.

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Natural course of benign coital headache

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Headache related to sexual activity has been recognised since the time of Hippocrates, but the occurrence of a distinct form of headache associated with sexual intercourse was first formally reported by Kritz in 1970.¹ The condition has been given a number of names, including orgasmic cephalgia, as it occurs usually at or near orgasm, and benign coital headache, owing to the lack of serious underlying disease.^{2,3} But not only is the condition unpleasant: it also has an unpredictable clinical course. The headaches may begin suddenly, continue for a time, then end abruptly; or headache may occur fairly regularly with sexual activity.²

Follow up periods in hitherto published series have not been long enough to determine the long range natural course of coital headache. We therefore report the results of an investigation of the clinical course in 26 patients followed up for up to 14 years.

Patients, methods, and results

During 1978-91, 32 patients (24 men, eight women) were seen in a private neurological clinic complaining of headache associated with orgasm. In January 1992 they were invited by letter to attend for follow up and interview focusing on the clinical course of their headache—that is, whether it was still occurring during sexual intercourse and what other kinds of headache distress there were. One patient had died of an unrelated cause.

Twenty six patients (19 men, seven women) received the invitation. The period of follow up ranged from six months to 14 years (median 6 years). Coital headache was divided into the three basic types described by Lance³ and Paulson and Klawans.⁴ Migraine and tension type headache were defined according to criteria of the International Headache Society.⁵

In all patients the headaches were very intense for five to 15 minutes, and in four patients the symptoms then disappeared and did not recur. In 22 patients the headache declined over one to 24 hours and recurred at subsequent attempts at sexual intercourse, performed within a period of up to six weeks. In four patients this period lasted three to six months. Thirteen patients experienced only one headache or one cluster of coital headaches whereas in nine men and four women the

coital headache pattern reappeared after a headache free period for up to 10 years. Six of these patients had more than three recurrent clusters.

Twelve patients had recurrent attacks of headache besides their coital headaches. Five patients (four men, one woman) suffered migraine without aura whereas seven patients (five men, two women) often had tension headache. There was a significant association between the presence of concomitant headache and the occurrence of more than one cluster of coital headaches (table).

Association between recurrent attacks of benign coital headache and presence of concomitant migraine or tension headache

	Coital headache	
	One cluster	Recurrent clusters
Migraine (n=5) or tension headache (n=7)	1	11
No migraine or tension headache (n=14)	12	2

p<0.001; Fisher's exact test.

Comment

A characteristic of benign coital headache is the vulnerability of patients to the headache on one occasion and not on another. Some patients have only one episode; others have several episodes which do not occur with a well defined periodicity or regularity. In the present study half the patients had experienced more than one period after an interval of up to 10 years. This underlines the need for long follow up.

We found a highly significant association between the risk of having more than one cluster of disabling coital headaches and the presence of a concomitant tension headache or migraine. Thus if a patient with migraine or tension headache once has an episode of benign coital headache he or she is at great risk of having recurrent attacks. Other patients, not ordinarily suffering from headache, who seek medical advice after a typical episode of coital headache can be reassured about the favourable prognosis of this disorder.

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