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 nationwide database. As a result of the computer schemes these advantages are available to a larger number of practices.

**ARLEN DEAN**

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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 be extremely hard 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 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 seem 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, infarct, 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 change. This is especially urgent in obstetric care since next April's untimely Körner maternity deadline looks set to precipitate the purchase of centralised and shortestighted maternity computer systems in many regions.1

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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.

**ERIC SNELL**

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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 consistently 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 or 10 to 20 mg a day for enalapril. Inhibition of the renin-angiotensin system, however, occurs at much lower doses.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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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 study2 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