the investigation of all aged demented patients since the yield of "potentially reversible" causes will certainly be low and the yield of "actually reversible" causes even lower. There are patients of all ages (including aged demented patients) in whom computed tomography is a valuable procedure, but they will all have to wait a very long time for their scans if we all follow what appears to be Professor Millard's advice and seek computed tomography scans for all our aged demented patients.

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¹ Smith JS, Kiloh LG. *Lancet* 1981;i:824-7.

Primary health care in residential homes for the elderly

SIR,—Dr Ann P Bowling's letter (2 January, p 48) raises some important points. It appears a general problem that Part 3 accommodation is now a meaningless term. A very large number of those admitted to homes are fit only for a hospital annexe, and require facilities and nursing care which are not available. Staffing is inadequate. The age of residents is much higher than even a decade ago, and many are more physically handicapped and mentally confused.

In a home for which I am responsible, as a visiting medical officer, staff are unqualified for nursing duties and an enema, a hot soak, or even supervision of an infrared lamp are claimed to be beyond capacity. A district nurse or physiotherapist is required. Cases are admitted purely on the whim of social workers, and there is never any medical consultation.

I think that there is no question that a weekly friendly, careful visit is of benefit to the residents. Unqualified staff are not always the best judge of who should be seen, and yet prefer to be arbiters of who should see the doctor. It has been claimed that residents should be treated as if they were in their own homes and seen only if they make a request. Many are too muddled to do anything of the sort, and the decision lies therefore not with the resident but entirely with the staff—not always in the best interests of the individual.

The regular visit of a doctor is often more beneficial than the administration of drugs and, with the elderly, weekly variations in pain, vitality, and mentality can be considerable. An aspect requiring constant thought is hypothermia, which is a contributory factor in debilitation and death. This is often neglected by staff.

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Blood pressures that fall on rechecking

SIR,—In his review of the significance of blood pressures that fall on rechecking (9 January, p 71) Dr D G Beevers suggests giving antihypertensive drugs to patients whose average diastolic pressure, after three clinic visits, exceeds 100 mm Hg. This could indeed be the decision reached by readers of the 1980 report of the Australian National Blood Pressure Study¹ or of the United States Hypertension

Detection and Follow-up Program,² which recommended the use of antihypertensive drugs for patients with diastolic (V) pressures exceeding 90 mm Hg; it cannot, however, be concluded from the report on the pilot stage of the Medical Research Council's trial of treatment of mild hypertension, to which Dr Beevers refers; the main phase of the latter trial is still in progress, and its results as yet incomplete.

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¹ Australian Blood Pressure Study Management Committee. *Lancet* 1980;i:1261-7.

² Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 1979;242:2562-77.

SIR,—In the leading article "Blood pressures that fall on rechecking (9 January, p 71) Dr D G Beevers states that "All blood pressures rise with advancing years. . . ." This is not true—quite the contrary, in fact.

While blood pressures usually rise in middle age—say 40-70—afterwards they often fall. This is probably due to progressive myocardial degeneration, rarely Addison's disease. In fact, it should be especially looked for when one is continuing hypotensive therapy in the elderly.¹

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¹ Barlow DTC. *Am Heart J* 1978;95:809-10.

Blood pressure reduction in the elderly

SIR,—I think that Dr C P Petch's conclusion to his letter (2 January, p 50) in reply to Dr F J Flint (14 November, p 1336) should read not ". . . unless one is prepared to follow up with meticulous care, the hypotensive regimen [in an elderly patient] should be continued" but "if one is prepared to follow up with meticulous care, hypotensive therapy may be continued."

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Retroperitoneal fibrosis associated with metoprolol

SIR,—The recent article by Dr J Thompson and Professor D G Julian (9 January, p 83) describing idiopathic retroperitoneal fibrosis in a patient who had been receiving a beta-blocking drug wisely sounds a note of caution about interpretation. Such drugs are now so widely used that the association may be only coincidence. Indeed, idiopathic retroperitoneal fibrosis is usually such a slowly progressive disease that it seems unlikely to have reached an advanced stage in the 11 months of exposure to the drug.

Previous reports of an association with similar drugs used to treat hypertension¹⁻³ have apparently overlooked the fact that idiopathic retroperitoneal fibrosis frequently causes hypertension,⁴ usually before the underlying disease is diagnosed. In these circum-

stances it is perhaps understandable that the disease is occasionally associated with the prior administration of hypotensive drugs.

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¹ Doherty CC, McGown MG, Donaldson RA. *Br Med J* 1978;iii:1786.

² Johnson JN, McFarland JB. *Br Med J* 1980;i:864.

³ McCluskey DR, Donaldson RA, McGown MG. *Br Med J* 1980;ii:1459-60.

⁴ Mitchinson MJ. *Br J Surg* 1972;59:58-60.

Captopril-associated lymphadenopathy

SIR,—Professor H Åberg and his colleagues (14 November, p 1297) report another side effect of captopril treatment. It is surprising that their first patient received captopril as the initial antihypertensive agent in view of the side effects reported previously with this drug. Some of these are serious and have proved fatal. They include agranulocytosis,¹ nephrotic syndrome (in some cases with immune-complex glomerulopathy),² hyperkalaemia,⁴ taste loss,⁵ and pemphigus⁶ and other rashes.⁷ The *British National Formulary* states that captopril is indicated in "severe hypertension resistant to other treatment," which I interpret to mean a good three- or four-drug regimen, including increased diuretic therapy,⁸ in a compliant patient. I do not feel that captopril should be used as a drug of first, second, or even third choice in uncomplicated hypertension.

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¹ Amann FW, Bühler FR, Conen D, Brunner F, Ritz R, Speck B. *Lancet* 1980;ii:150.

² Staessen J, Fagard R, Lijnen P, Amery A. *Lancet* 1980;i:926-7.

³ Hoorntje SJ, Weening JJ, The TH, Kallenberg CGM, Donker AJM, Hoedemaeker PJ. *Lancet* 1980;ii:1212-5.

⁴ Grossman A, Eckland D, Price P, Edwards CRW. *Lancet* 1980;ii:712.

⁵ McNeil JJ, Anderson A, Christophidis N, Jarrott B, Louis WJ. *Br Med J* 1979;ii:1555-6.

⁶ Parfrey PS, Clement M, Vandenburg MJ, Wright P. *Br Med J* 1980;281:194.

⁷ Anonymous. *Lancet* 1980;ii:129-30.

⁸ Dustan HP, Tarazi RC, Bravo EL. *N Engl J Med* 1972;286:861-6.

⁹ Ramsay LE, Silas JH, Freestone S. *Br Med J* 1980;281:1101-3.

Dental health in patients susceptible to infective endocarditis

SIR,—Dr Celia M Oakley introduced¹ a new concept into prevention of endocarditis when she recommended unselective prophylaxis for dental procedures (2 January, p 50) in order to protect patients without known heart disease.

This raises the difficult question of cost-benefit relationships. Smith and colleagues² found the incidence of endocarditis in the south-east of Scotland to be 16 per million. This indicates 80 cases per year in Scotland as a whole. However, only one quarter of endocarditis patients have had preceding dental treatment or dental infection.³ Records of the Scottish Dental Estimates Board show that in 1979 there were 325 570 courses of treatment involving tooth extractions. If extractions alone produced endocarditis the risk per extraction would be 325 470:20 or approximately 16 000:1. The 1981 cost of 3 g amoxycillin, without dispensing fee, was £1.74, giving a cost of £28 000 per case potentially

prevented. If dental procedures other than extractions are included the cost becomes considerably higher. In addition, there is the extra work for the dentist and his staff, and the occasional adverse reaction to amoxycillin.

Although amoxycillin allows a very attractive simple regimen its unselective use would thus be very expensive. But when antibiotic prophylaxis is restricted to the 5% of dental patients estimated⁵ to have a susceptible heart lesion the cost:prevention ratio is reduced to $1.74 \times 5/100 (325\ 470):1/2 (20) = \pounds 2\ 800:1$, if we allow for the fact that only half of endocarditis cases have known heart disease. These ratios are not the absolute risk of developing endocarditis when the patient is unprotected by antibiotics since some degree of prophylaxis is already practised. An estimate from the pre-antibiotic era was 500:1 for cardiac patients.⁶

Are there other strategies which might reduce the incidence of endocarditis? The provision of antibiotics for dental patients could be simplified. Although one hesitates to deny any pharmacist the dispensing fee, it would be more practical to recompense dentists for providing amoxycillin direct to the patient. At present he would have to pay the $\pounds 1.74$ from his fee-per-extraction of $\pounds 2.50$. Preventive dental techniques could play a part for younger patients with heart disease. Some endocarditis patients with no known disease may have had a bicuspid aortic valve or prolapsing mitral valve; detection of such cases could be improved.

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¹ Oakley CM. *Thorax* 1979;34:711-2.

² Smith RH, Radford DJ, Clark RA, Julian DG. *Thorax* 1976;31:373-9.

³ Mouldsdale MT, Eykyn SJ, Phillips I. *Q J Med* (new series) 1980;44:315-28.

⁴ Lowes JA, Hamer J, Williams G, et al. *Lancet* 1980;ii:133-6.

⁵ McGowan DA, Tuohy O. *Br Dent J* 1968;124:519-20.

⁶ Kelson SR, White PD. *Ann Intern Med* 1945;22:40-60.

Treatment of erythema multiforme secondary to herpes simplex by prophylactic topical acyclovir

SIR,—The properties of dimethyl sulphoxide to which Dr Juel-Jensen refers (5 December, p 1544) are well known but do not of necessity preclude the possibility of any other solvent penetrating human skin. May I make two comments?

Firstly, although the preliminary reports in Washington of topical acyclovir in the treatment of developed recurrent infections were "disappointing," the results in primary genital herpes were most encouraging (L Corey et al, Interscience Conferences on Antimicrobial Agents and Chemotherapy, 1980 and 1981). Studies of recurrent disease in which treatment is started very early in the illness are already under way and the results awaited with interest. Secondly, the drug can be shown to be in the plasma after application of 5% acyclovir in a modified aqueous cream base through human skin (unpublished data).

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Confidentiality and informed consent

SIR,—Mr D H Howe is attempting to flog the confidentiality controversy back to life (2 January, p 53). As a lay practitioner of life assurance who has spent many years on medical selection of risks I wonder if you would allow me the courtesy of your columns to put Mr Howe's comments into better perspective.

I am no expert in staff recruitment, but as I see it a prospective employer needs to assess a job applicant medically in order to answer two questions, which are: (a) is he medically suitable for the job he will be asked to do—for example, will his health permit him to turn up regularly—and (b) is he eligible to join a pension and life assurance benefit scheme which could provide up to four times annual salary on death in service? How, other than by asking for the applicant's medical history, can the employer begin to make these assessments? A casual clinical examination by a disinterested referee is not necessarily an adequate substitute for the testimony of a medical attendant who knows the applicant well. Recruiting staff is an expensive and, with present levels of employment protection, hazardous business and managers cannot afford to ignore the medical aspect of recruitment.

The same broad consideration applies to the selection of life assurance risks. The underwriter assesses as best he can the mortality to which each proposer is subject, and often he can do this only by collecting medical evidence. If the underwriter needs a good history to help with the assessment—and, remember, he is generally striving to pass as many cases as possible at normal rates—then the best historian is usually not the proposer or the casual medical examiner but the personal medical attendant.

By agreement between the BMA and the life office associations the consent wording in life assurance applications runs as follows: "I consent to the [company] seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health . . . and I authorise the giving of such information." I quite fail to see what more we could do to promote "informed consent to disclosure." If I may say so, I think that the confidentiality pot has been stirred overenthusiastically for too long by a tiny minority of the medical profession. I am convinced that the vast majority of doctors take the only possible view based on commonsense: at the end of the day a man must read what he signs, and we must pay him the compliment of assuming that he understands what it means.

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SIR,—Dr David Howe's letter (2 January, p 53) raises the issue of "the patient's consent to disclosure of medical information" and goes on to suggest that this may in some cases be given under duress. From my experience as assistant general manager, chief underwriter, and chief medical officer of a large life insurance company, I question the validity of this view.

It is the long-established practice of life assurance companies to underwrite proposals for life assurance on an individual basis, and it is often necessary to seek a report from the applicant's own medical practitioner in order to establish the appropriate premium level. Consent to approach the doctor is obtained from the proposer—the wording of the consent

has been agreed between the BMA and the life assurance associations. The proposer also provides the name and address of his doctor and I find it hard to believe that the proposer when signing the consent is unaware that inquiries may be made about his state of health. Moreover, since the issue of life insurance policies is so widespread—some seven million in 1980—the suggestion of duress is nonsense.

I would just add that as an employer as well as a chief medical officer I would be disturbed at the implications of a person with a serious medical condition applying for a job for which he is medically unsuited. If employment were always obtained without important medical information, there would be cases where employees could endanger themselves and others as a consequence of taking up unsuitable employment.

Dr Howe quotes one case only in which an applicant was refused a job because he wanted his medical details kept secret. The conclusion is obvious. Would Dr Howe like to travel in a bus, taxi, or aeroplane the driver or pilot of which was subject to epileptic fits or a candidate for a coronary? Members of the armed Forces are all subject to strict medical investigation, as also are airline pilots. Is that what Dr Howe calls duress?

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SIR,—Mr David Howe (2 January, p 53) raises the issue of confidentiality and informed consent to disclosure again—principally in the context of employment, but later he refers to insurance. I would like to put in a word, primarily about insurance and life assurance. Before doing so, may I support Dr Howe's view that this difficult problem merits re-examination; but, should this be undertaken by the Central Ethical Committee—or other BMA committee—I hope that the problem will be looked at from all relevant directions.

Next, to declare an interest, I am adviser to a health insurer, and as such am frequently seeking medical reports on both applicants and subscribers. I think that it is fair to say, however, that not only have I been a family doctor but that my present job brings home to me that there are other points to be considered.

Firstly, I would like gently to challenge Dr Howe's repeated use of the somewhat perjorative phrase "under duress." Information about one's health and future fitness has a special significance to both patient and doctor, but is inquiring about it really any different from, say, the taking up of a character reference? Is a potential employee "under duress" if he is told to give the names of referees who will vouch for his honesty—or otherwise? I would imagine that most family doctors would wish to do this when considering the appointment of a secretary or receptionist.

Next, if one follows the line that applicants for insurance or life assurance should not be asked to provide evidence of their state of health, nor should their medical advisers be asked to provide it, certain consequences must flow from such a policy. The obvious one is that all premiums will materially increase. Again, to bring the matter nearer home, would all the healthy BMA members who have taken out cover with PPP or BUPA be content to pay more, to cover fully the higher risks of colleague subscribers with known health prob-