teaching or medical research and the picture is, sadly, very different when one looks at the state of affairs in more typical situations. Indeed, irony of ironies, in the very same issue of *BMJ* as the letter by Dr Coigley and Nurse Barnes is an important report from Brighton (p 1556); of the hypertensives detected in that screening survey, only half had previously been diagnosed. The experience in Brighton in 1979 is almost identical to ours in Renfrew in 1972,² and an even more woeful picture has been found in London.³ The "rule of halves" still holds in this country: of the hypertensives of this nation, about half are detected; of those who are detected, half are receiving treatment; and, of those who are being treated, only half have adequate blood pressure control. There remains therefore a serious deficiency in the present methods of detection and care of patients, many of whom would benefit from antihypertensive therapy.^{4 5}

Concerted action by the whole medical profession is necessary but hospital doctors cannot help much as only a minority of the population attend hospitals. Special screening units such as mine may help but they are expensive and are primarily for research. The third option is that as about 75% of the population visit their doctor at least once in three years⁶ this is the most feasible place to detect and treat hypertensives. Our studies in three general practices in Scotland⁷ have confirmed that this method of management is acceptable and efficient.

Despite the impressive findings of the Stratford group, I am afraid that we still have a long way to go before the national picture is half as good as theirs. Everything in the garden is not lovely, and I am unrepentant for my original comments (3 November, p 1137). Research-minded general practices are few and far between and their data on the state of detection must be biased, if only because of their abnormal excellence.

Why is it that one is always frightened to criticise general practice for fear of offending people despite the fact that, with notable exceptions, standards are often depressingly low? In hospital practice and in medical research one is constantly under a barrage of criticism both from without and from within, and this is to be welcomed as a stimulus and not denied hotly. We know our garden is not lovely.

It is a pity to see the pages of an international medical journal such as this containing personal comments about contributors to medical debates. I think this should be avoided. I do hope that the answer of William Pitt to Walpole when he was accused of the crime of youth does not obtain here (I am much older than Pitt was at that time): "The atrocious crime of being a young man . . . I shall attempt neither to palliate or deny, but content myself with wishing that I shall be one of those whose follies shall cease with their youth, and not of that number who are ignorant in spite of experience."

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¹ Beevers DG, Nelson CS, Duncan S, Padfield PL. *Postgrad Med J* 1976;32:683-6.

² Hawthorne VM, Greaves DA, Beevers DG. *Br Med J* 1974;iii:500-3.

³ Heller RF, Rose G. *Br Med J* 1977;i:1442-4.

⁴ Hypertension Detection and Follow-up Programme. *JAMA* 1979;242:2562-71.

⁵ Hypertension Detection and Follow-up Program. *JAMA* 1972;242:2572.

⁶ Beevers DG, Hawthorne VM, Sinclair RG. In: Berglund G *et al.* eds. *Pathophysiology and Management of Arterial Hypertension*. Molndal: AB Hassle, 1975:263.

⁷ Barber JH, *et al.* *Br Med J* 1979;i:843-6.

SIR,—We read with interest the account of the screening exercise carried out in Hove and reported by Dr J A P Trafford and others (15 December, p 1556).

In January 1977, with the help of the Medical Research Council, we screened patients in our practice between the ages of 35 and 64 years. This was in a caravan parked outside the practice premises. Unfortunately, snow at the end of the period made access from the surrounding villages more difficult and helped cut down attendances. The results were as follows. Patients attended—1067 out of 1174 in age range (90.9%); hypertensives (diastolic 90 mm Hg or over)—175 (16.4%); previously known hypertensives—85. By close co-operation with the unit and continuous updating of the addresses it was possible to contact the vast majority of the patients in the age group under study. This advantage would have been lost had strangers attempted the exercise.

The total cost was about £850 and less than £9.50 for each new hypertensive diagnosed. The majority of the new hypertensives were entered into the Medical Research Council's trial of the treatment of mild-to-moderate hypertension. So far as we know, there is little evidence to support routine treatment of symptomless hypertensives aged over 65 years. We are at present rescreening our practice, including new patients in the age group. The attendances at the unit are of a similar order. The costs have risen to about £1 for each patient screened. The patients diagnosed have been investigated and treated in general practice. This is a further large saving on the resources of the National Health Service compared with Hove, where they appear to have been referred automatically to hospital.

We understand that the MRC still has some vacancies for medium-sized practices in the trial and is willing to help screen patients from selected practices. We would suggest that if further funds are available for screening for hypertension the screening techniques developed by the MRC should be the basis for future developments as they are effective and economical.

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SIR,—The whole philosophy behind the paper of Dr J A P Trafford and others (15 December, p 1556) must be strongly challenged, for they are describing a foray into the community by a hospital-based team whose methods, assumptions, and findings run contrary to the way in which general practice is moving.

The original work of Hart¹ has shown convincingly that case finding in the course of normal general practice is the preferred method for patients with hypertension. What Hart did—and many others since have done—was to try to take the blood pressure of every patient (within set age limits) attending the surgery and after some time to contact the remaining patients who had no blood pressure reading in the notes. In this way he covered 98% of the age group 20-64 years.

We have recently done the same in our practice. After four years of trying to take the

blood pressure whenever patients attended, we were left with 707 who had no reading recorded in the notes. Our employed nurse organised the screening of these patients and within six months only 42 patients (2.1% of the total aged 30-64 years) had not come after three requests. The total cost of this final topping-up operation was £150 in 1977; the money was kindly provided by Glaxo Laboratories (to which we are extremely grateful) as part of a larger trial of the treatment of mild hypertension.²

Other reviews of the literature^{3 4} have also concluded that case finding in general practice is preferable. The most recent⁴ concludes that "where the purpose is to find and treat newly diagnosed hypertensive patients, then screening by general practitioners is likely to be a more cost-effective approach." There are, of course, other major advantages: "Follow-up and treatment are in the same hands, borderline values can be watched for a number of years, and an improved attitude to community welfare is generated amongst doctors and patients."⁵ General-practice-based case finding can also be a continuous process, which is a condition laid down as necessary for screening for disease.⁶

The implications for general practice in the Brighton team's work are considerable; particularly alarming is the commendation of a method of screening which detects hypertension "without undue burden on general practitioner services." The only thing which Dr Trafford and his colleagues have shown is that where general practice is badly organised (one-third of the records unusably inaccurate) the work of general practice will be taken over by energetic hospital teams, which will be prepared to spend far more money than is necessary or sensible in doing what can be almost entirely absorbed into the day-to-day work of a primary care team. It is quite clear that modern general practice can detect and treat almost every single patient with hypertension.⁷ Let us not lose general medicine by default and without good evidence, as we have lost domiciliary obstetrics and may well, if the proposals of the Joint Committee (15 December, p 1563) are accepted, lose much of paediatrics also.

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¹ Hart JT. *Lancet* 1970;ii:223-6.

² Joesbury HE, Phillips CA, Garrett RT, Wilkes E, Smith AJ. *Br Med J* 1976;ii:1476-9.

³ Adler MW. *J Roy Coll Gen Pract* 1976;26:171-6.

⁴ Christie D. *J Roy Coll Gen Pract* 1979;29:597-601.

⁵ Coope J. *J Roy Coll Gen Pract* 1974;24:161-6.

⁶ Wilson JMG, Jungner G. In: *Principles and practice of screening for disease*. Geneva: WHO, 1968.

⁷ Parkin DM, Kellert RJ, Maclean DW, Ryan MP, Fulton M. *J Roy Coll Gen Pract* 1979;29:590-4.

Peripheral nerve lesions in the muscle compartment syndrome

SIR,—Your leading article (6 October, p 818) describes the compartmental syndrome of local damage to the contents of osteofascial compartments of limbs crushed by pressure sustained in a variety of ways. You rightly emphasise that alcoholics, drug addicts, and victims of accidental poisoning may be injured in this way, the critical factors being assumed to be immobility and coma, which subject the victim to the sustained weight of the head or trunk lying on the arm, or of one leg on the other. It is important to recognise that not only are muscle and blood vessels injured by

the raised pressure, oedema, and ischaemia but that peripheral nerves are also vulnerable—sometimes with dire sequelae, as in the following case.

A 19-year-old boy, a known LSD and barbiturate addict, was found in coma in a flat, lying under the naked body of his girl friend, who was dead. He was found to have a left hemiparesis, and when he was eventually discharged from hospital after several weeks pain and weakness of the right leg became evident. He had a complete sciatic nerve palsy with extensive wasting, weakness, and foot drop accompanied by cutaneous hyperalgesia and "hyperaesthesia." These signs have failed to clear up after four years, and his life is plagued by intractable causalgic pain, the management of which is not helped by his premorbid personality—which has not materially changed since the incident.

Barbiturate overdosage was one of the drugs responsible for coma in this case, and the evidence was that he had been in this one "fixed" position for over 24 hours. One assumes that the high pressure in the posterior compartment of the thigh, probably combined with local compression of the nerve, produced irreversible ischaemic necrosis. There is abundant evidence of similar mechanisms in other peripheral nerve entrapments, the Saturday night palsy of the radial nerve being a familiar example. It is likely that even normal sleep can permit the compression of the arm or forearm by the head, and the pressure of 100-200 mm Hg in the arms is certainly an important if temporary factor in the carpal tunnel and cubital tunnel syndromes. We do not know how long such pressures are present before discomfort or paraesthesia awakens the normally sleeping subject; but the time, which may be a critical factor, will be increased by any hypnotic—perhaps even by a modest "night-cap."

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Medical charities, prevention, and the media

SIR,—We were pleased to see your leading article on the reluctance of British medical charities to fund educational and preventive initiative (22-29 December, p 1610). It is to be hoped that your comments will stimulate not only a constructive discussion of the issues raised but also changes in policy and practice. In passing we would suggest that the role of professional advisers is crucial—charities need advisers who are knowledgeable about education and prevention. There is, however, another aspect of this problem, which has been clearly illustrated in recent weeks—namely, the role of the media in fostering inappropriate ideas of how to make progress in health.

On 10 November the *BMJ* (pp 1173 and 1178) published the first major results from the Finnish North Karelia study aimed at reducing the ravages of cardiovascular disease by focusing on prevention (pp 1173 and 1178). Regrettably, very few newspapers or broadcasting organisations reported and discussed these complex but very important papers. It so happened that these were published during a period of euphoric and extensive publicity about heart transplants—ranging from Mr Castle's love of football to Mr Barlow's supper of cheese soufflé, cauliflower, and mashed potatoes. Such an imbalance in coverage by the media is, of course, highly damaging to public understanding of progress

in health. It is not surprising that the public in general and charitable foundations in particular should begin to develop some strange ideas about tackling the modern epidemic of cardiovascular disease. The National Heart Fund rushed to finance transplantation and was reported to be hoping to "persuade the government eventually to finance it on the health service."¹

The project in North Karelia was focused on preventive activities. Significantly, the actions taken were not restricted simply to exhorting individuals to behave themselves but ranged from conventional health education to measures to affect the price and availability of relevant foodstuffs. As readers of the recent reports will be aware, the precise effects of the programme are not yet known, but the prevalence of the risk factors was strikingly reduced and, more importantly, mortality from cardiovascular diseases fell significantly during the five years studied. There are difficult problems of interpretation. The Karelia papers show that mortality in the control area also fell, while Drs T Valkonen and M-L Niemi (5 January, p 46) point to the earlier decline in mortality in the more urban western countries. However, the key issue is that the toll from cardiovascular disease in Finland is falling and preventive initiative seems to have contributed, yet there has been little public discussion of this success story. If editors, producers, and journalists did not know about the Finnish results, the alerting mechanisms within the media are seriously at fault. If they did know, what prompted most of them to relegate the reports to the wastepaper bin?

We believe that the media have a strong influence on the agendas of public discussion and hence on many of the policies we eventually get, not least the funding policies of medical charities. There have been few clearer examples of distorted agenda (and consequently the likelihood of misdirected and inappropriate policies) than the recent coverage of heart transplants. The neglect of significant—albeit not glamorous—preventive initiatives and the consequences of this are aspects of "medicine and the media" which seem to deserve more attention.

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¹ *Guardian*, 16 November 1979.

Drug-induced oesophageal injury

SIR,—The features of drug-induced oesophageal injury have recently been well described by Mr F J Collins and others (23 June, p 1673) and in subsequent correspondence. We would like to point out some features observed in the following case which have not been noted previously.

A 43-year-old woman with longstanding symptoms of gastro-oesophageal reflux was admitted with a five-day history of epigastric discomfort and retrosternal pain exacerbated by swallowing. Her husband had noticed that she had developed bad breath despite regular cleaning of her teeth. For the previous three months she had taken emepromium bromide intermittently and had taken a course of eight tablets (two four times a day) 10 days before admission. On examination she was pyrexial (38°C), with a tachycardia of 112 beats/min and a leucocytosis in the peripheral blood of $14.3 \times 10^9/l$ ($14\,300/\mu l$). A mild acute-

phase reaction was present on serum protein electrophoresis but her chest radiograph and urine specimen were normal. Upper alimentary endoscopy demonstrated annular ulceration in the oesophagus from 25 cm to 30 cm from the teeth. Symptomatic treatment was given for one week, at the end of which time the patient was symptom free. A barium meal demonstrated a sliding hiatus hernia with reflux but no abnormality of the oesophagus.

We infer that the halitosis and signs of systemic disturbance arose from the iatrogenic ulceration of the patient's oesophagus, which was also the cause of her dysphagia. These findings are not characteristic of reflux oesophagitis and if found in association with dysphagia should prompt a search for another cause—in particular a drug history.

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Reflux oesophagitis

SIR,—I read with interest the letter from Dr B A Scobie, (17 November, p 1292) and would agree that a more detailed objective assessment of oesophagitis is required for a proper evaluation of medical treatment of the condition.

I would, however, like to draw his and your readers' attention to a paper in which a detailed grading of endoscopically determined oesophagitis was employed.¹ In contrast to Dr Scobie's experience, we see discrete shallow oesophageal ulcers rarely, the most common endoscopic manifestations of reflux being scattered areas of erythema and friability, mostly on the posterior wall of the terminal 2 cm of the oesophagus.

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¹ Reed, P I, and Davies, W A, *Current Medical Research and Opinion*, 1978, 5, 637.

The undiscovered country

SIR,—In your leading article "The undiscovered country" (15 December, p 1530) you quote Noyes as saying, in regard to life after death, "No one has returned from death and given an account of his experiences." It seems curious that in dealing with such an intriguing subject no mention is made of the single attested fact of resurrection of spontaneous origin recorded for us all in history—namely, that of Jesus of Nazareth. Our patients share with us understandable fears of the unknown, and we are in constant danger of projecting on to their crisis situations our own failure to come to terms with this critical reality. If there exists for us real hope, in the person of One who claims to be alive from the dead, One who has done precisely what Noyes claims not to have been done, then it would appear to be circumspect to examine the evidence afresh lest we miss the very thing calculated to give both us and our patients the peace of mind we sorely need.

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¹ Noyes R. *Psychiatry* 1972;25:174-84.