We undertook in March 1992 an audit of lithium use during inpatient psychiatric treatment at Porirua Psychiatric Hospital, New Zealand. Clinical files were examined for 30 patients randomly selected from 62 patients prescribed lithium. Although lithium concentrations were monitored satisfactorily, pretreatment tests were inadequate in four patients whose lithium treatment was initiated during the past year, and monitoring tests were satisfactorily completed in only 16 patients. A patient with an ejection systolic murmur noted on physical examination had no electrocardiographic recording before starting lithium. Four patients had no physical examination, assessment of heart rate and rhythm, or measurement of serum creatinine concentration for four years during continuous lithium treatment; two of them had a raised serum creatinine concentration at the last measurement but creatinine clearance was not measured. No reason for use of lithium could be found in six patients' files. In only one of the 30 files was there documentation that the patient had been informed of the reason for the use of lithium and the need for regular salt and water intake. None contained documentation that the patient had been informed of toxic effects and what to do should these occur.

Another concern in the use of lithium is its potential to induce anomalies of the cardiac valves and major vessels if taken during the first trimester of pregnancy. Of the 10 female patients whose files were examined, four were premenopausal and had not undergone a sterilisation procedure. A negative pregnancy test had been obtained before starting lithium for three of the four, but in no file was there documentation that the possible effects of lithium during pregnancy or the need for adequate contraception and planning of future pregnancies had been discussed with the patient.

We encourage the use of published recommendations for monitoring lithium treatment¹ and endorse the need for documentation in the patient's file that important information about lithium has been given to and understood by the patient.

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Treating small cell lung cancer

EDITOR,—I disagree with Robert Souhami and believe that, though small cell lung cancer may often be a disseminated disease, an above average survival in patients who have undergone surgery of the primary tumour should be considered to be the result of case selection only if a large scale randomised trial has ruled out an effect from surgery.¹ Such a trial should be considered to be a priority in the search for progress in the treatment of small cell lung cancer.

When I worked in Malmö in the beginning of the 1980s three patients—more than 10% of an unselected group—had undergone resection of the primary tumour before they were given combination chemotherapy (F E von Eyben *et al*, third world conference on lung cancer, Tokyo, 17-20 May 1982).² They remained alive for a substantial period after the chemotherapy was stopped. A few years later I gave the same chemotherapy regimen to another series of patients not treated surgically, and despite an impressive objective response none of these patients was cured.

Long term follow up of patients treated only

with surgical resection of the primary tumour shows that a small proportion may be cured by this modality alone. Other studies of small series of patients who underwent surgery before chemotherapy show above average survival—that is, three times the survival associated with chemotherapy alone. Accordingly, a randomised trial should study the gain achieved by adding surgery to treatment with chemotherapy. As the few data available consistently suggest an improved survival from this combined approach, I await the results with great interest. Control of the primary tumour, which is often bulky, is an important aspect of treatment. The optimum role of surgical resection of the primary tumour among the many options for treating small cell lung cancer should be determined.

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Monitoring ambulatory blood pressure in general practice

EDITOR,—David J Webb and colleagues rightly warn against indiscriminate and uninformed use of ambulatory blood pressure monitoring in general practice and using instruments of doubtful accuracy.¹ Though true, this should not obscure the need for a better method of making important clinical decisions, often entailing lifelong treatment, than the present system of random clinic readings with a mercury sphygmomanometer.

The recommendations of the British Hypertension Society that patients with a diastolic pressure of 96-110 mm Hg should be asked to attend at least six times over three months and that those with an average pressure of ≥ 100 mm Hg should be treated² is not only expensive in terms of clinic time and patients' time but may still not exclude the fifth of patients whose blood pressure outside the surgery is normal but who react specifically to measurement in the clinic.³ Some patients fail to attend for follow up and have to be reminded. Others, whose blood pressure is just under the level for treatment, are recalled in a year's time; if their blood pressure is then found to be back in the problem range they start on another group of assessment visits. It is not surprising that many patients are found to be receiving treatment unnecessarily.⁴

Webb and colleagues point out that normal values for ambulatory monitoring have yet to be established. Much work needs to be done, but an informed guess on the basis of the largest population study so far reported is that a reasonable cut off for treatment would be a mean 24 hour diastolic blood pressure of 90 mm Hg.⁵ The assumptions made in such an estimate are not greater than those necessary in applying the results of clinical trials to current practice. Blood pressures obtained during ambulatory monitoring will eliminate "white coat hypertension" and are better predictors of target organ damage than casual measurements.⁶ They are also valuable in assessing the adequacy of control during treatment.⁷ Finally, they allow the identification of patients whose blood pressure does not drop during sleep, who are at increased cardiovascular risk.⁸

We have used an ambulatory monitor (Spacelabs 90207) in our hypertension clinic over the past year as an adjunct to traditional methods of assessment. It has given us a much clearer understanding of what it is we are treating and confidence that we are giving effective treatment to the right patients. It is

the most important advance since Riva Rocci introduced the mercury sphygmomanometer nearly 100 years ago.⁹

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Bovine spongiform encephalopathy and risk to health

EDITOR,—In response to Paul J Harrison and Gareth W Roberts's editorial on spongiform encephalopathies¹ E Coyle and Ian Harvey rightly suggest that systematic collection of data on Creutzfeldt-Jakob disease is essential to assess any potential risk from bovine spongiform encephalopathy.² This recommendation was originally made by the Southwood committee, and since May 1990 the Department of Health and the Scottish Home and Health Department have funded the systematic surveillance of Creutzfeldt-Jakob disease throughout the United Kingdom at the Western General Hospital in Edinburgh. As part of this inquiry a case-control study is being carried out on all cases with particular reference to dietary history, occupational history, and other putative risk factors.

There has been no evidence of any change in the epidemiological characteristics of Creutzfeldt-Jakob disease since the advent of bovine spongiform encephalopathy, and a paper on this will shortly be submitted for publication. Although the scientific evidence suggests that any risk to the human population from bovine spongiform encephalopathy is probably remote, the prolonged incubation period for the spongiform encephalopathies indicates that it will be many years before a risk to public health from bovine spongiform encephalopathy can be finally excluded.

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Fulminant hepatitis B in infants

EDITOR,—S V Beath and colleagues report on three infants with fulminant hepatitis B born to hepatitis B virus carrier mothers positive for antibody to hepatitis B e antigen (anti-HBe).¹ In our clinic recently two patients—one 3 months old