by F Willett and colleagues, in which chest pain was accompanied by electrocardiographic changes.² As W M Castle and V E Simmons discuss, this patient had a retrospective diagnosis of Prinzmetal's angina,³ which the datasheet states is a contraindication to sumatriptan.

Stricker refers to recurrence of symptoms after rechallenge. This is of considerable interest, especially in case 2, for despite chest symptoms the patient apparently used the drug more than 10 times. In our clinical trials programme 15 patients who had experienced at least one episode of chest discomfort, pain, pressure, or tightness were formally rechallenged under intensive electrocardiographic monitoring. Five experienced the same symptoms, and two of these five also experienced the symptoms after placebo. In none of these patients was any electrocardiographic change detected.

During the clinical development programme for sumatriptan almost 6000 electrocardiograms were recorded. They were obtained during and after the administration of subcutaneous sumatriptan in more than 1200 patients and after oral sumatriptan in more than 400 patients and volunteers. There is no evidence of a link between the chest symptoms which occur in 3-5% of patients and electrocardiographic change or other evidence of myocardial ischaemia except in extremely rare cases such as that reported by Willett and colleagues.

Sumatriptan (both oral and subcutaneous forms) has been available in the Netherlands for over a year and is also registered in 21 countries worldwide. The 12 cases of chest pain that Stricker reports are not surprising in the context of extensive patient exposure.

Stricker also refers to an article by Chester *et al*, who concluded that the minor vasoconstriction after sumatriptan seen in vitro in human coronary arteries might be important in the presence of atheroma.⁴ Their data, however, do not support this conclusion. They in fact show that in atheromatous sections of artery the constriction was even less than that in "normal" segments.

From our extensive study of the cardiovascular safety of sumatriptan in large numbers of patients we can find no evidence that the chest pain is due to myocardial ischaemia except in very rare cases, as noted above. Nevertheless, we recognise that the cause of these chest symptoms must be established and we are undertaking a programme of studies to this end in both patients and volunteers.

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Treatment of natal cleft sinus

EDITOR,—H T Khawaja and colleagues conclude that widespread use of primary closure would improve the management of patients with uncomplicated natal cleft sinus.¹ Although trials such as this are useful in showing the superiority of one treatment over another, results are influenced by patient selection in a condition in which successful outcome owes much to clinical enthusiasm.² Such results must therefore be interpreted with caution before their general application is assumed. We

recently reviewed the case records of 229 patients undergoing both emergency and elective operations for pilonidal sinus of the natal cleft at Selly Oak Hospital, Birmingham, from 1986 to 1991. Our findings confirm that this condition is an important cause of morbidity in young people, for whom treatment is often unsatisfactory.³

Of 121 patients undergoing elective procedures, 20 were treated by simple excision and primary closure (by different consultants and senior registrars) and primary healing was obtained in only seven of these 20. Complete healing before discharge was documented in only nine cases, and nine patients defaulted from follow up. Better results were obtained in 29 patients whose defect was repaired with a transposition rhomboid flap (by one consultant with a special interest in this procedure): 20 of these wounds showed primary healing. Encouraging results have been reported with this technique,⁴ and a rotation flap also has the advantage of flattening the natal cleft and covering the area with good quality skin, which may decrease the likelihood of future recurrence.⁵

Of 108 emergency operations for pilonidal abscesses and discharging sinuses, 85 were undertaken by senior house officers, usually out of normal working hours (72 cases). Although outpatient follow up of these patients was often arranged, review was often unsatisfactory, with 30 patients defaulting and 30 being discharged before complete healing. This may be why 45 of those who had emergency operations for a discharging sinus had had at least one previous operation.

We believe that our findings are typical of the difficulties in treating natal cleft problems in a busy district general hospital. Considerable improvements in treating this common and often neglected condition could probably be achieved by simple measures, including a defined plan of management, better supervision of junior staff, and improved education of patients.

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EDITOR,—H T Khawaja and colleagues' short report suggesting that excision and primary closure of pilonidal sinus is cheaper and more effective than secondary healing is contentious.¹ Though we commend the authors for having successfully run a prospective trial in this infuriating condition, the numbers in each group (23 patients) are small and cannot support definitive statements on treatment policy.

Whether the wounds in the primary closure group were sutured in the midline or were offset is not stated. Why the wounds left to heal by secondary intention were packed for a week after surgery is unclear. Early use (after 72 hours) of Silastic foam dressing would have reduced or obviated the need for visits by a district nurse and so reduced costs.²

Details of cost analysis are not divulged. Pre-

vious large studies show healing by secondary intention to be 40-50% cheaper than primary closure,^{3,4} which is in direct contrast to the authors' findings.

No comment is made on the 26% of patients who underwent primary closure and subsequently experienced complications, other than that "healing of unsuccessful cases was not significantly different from that of the secondary healing group." No details are given about morbidity associated with breakdown of the wound, and we question whether a method with a complication rate of this magnitude is effective or even acceptable.

Follow up was limited to one year, but recurrence rates increase with length of follow up; most recurrences occur within three years.⁵

In conclusion, therefore, this trial, though having the advantage of being prospective, suffers from including few patients and fails to address the controversial points it raises; it cannot justify definitive statements concerning surgical management.

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AUTHORS' REPLY.—In the patients in our primary closure group the wounds were sutured in the midline. The wound cavity changes rapidly in shape over the first few days, which is why we packed the wound for a week after surgery before using Silastic foam dressing.

Use of resources was measured by patient days in hospital, visits to the outpatient department, visits by a district nurse, and days off work. The main measures of effectiveness were days to complete healing and recurrence at six and 12 months.

The previous study showing that secondary healing is cheaper than primary closure was a retrospective analysis, with follow up by postal questionnaire or telephone (77% response rate), of patients treated for either natal cleft sinus or abscess five to nine years previously.¹ Information regarding time to healing, time off work, and recurrence was not available from all responders. Those who had primary closure were kept in hospital for a mean of 8.4 days. In his review Allen-Mersh pointed out that primary healing was achieved within two weeks in over 90% of the patients included in 17 published studies.² He assumed, however, that such patients stayed in hospital for seven nights. The main cost differential between the two treatment groups was the length of stay in hospital. If the costs were recalculated with the patients who had primary closure being treated as day cases (as in our study) primary closure would be much cheaper than secondary healing.

Our paper clearly states the morbidity in the six patients in the primary closure group whose wounds failed to heal. The wound broke open after removal of sutures in four cases; two patients required early removal of sutures owing to wound haematoma and wound infection.

D P Berry and K G Harding fail to understand the essential message of our paper. We compared two commonly used methods of treating pilonidal

Outcome of excision of natal cleft sinus and primary closure compared with that of excision and secondary healing. Figures are medians (ranges)

	Primary closure		Secondary healing (n=23)
	Success (n=17)	Failure (n=6)	
Days in hospital	1 (0)* (day case)	1 (1-2)*	3 (2-3)
Days to healing	14 (0)* (removal of sutures)	37.5 (26-48)†	41 (29-51)
Days off work	17 (15-21)*	38.5 (28-49)†	42 (28-56)
Outpatient visits	2 (0)*	5.5 (4-6)†	6 (4-7)
Visits by district nurse	0*	3 (2-5)†	4 (4-6)

*p<0.001, †NS compared with secondary healing group.

sinus. Wounds that failed to heal after primary closure were then allowed to heal by secondary intention, and the outcome of these patients' treatment was not different from that of the patients in the secondary healing group except that their stay in hospital was shorter (table).

We advocate day case excision and primary closure of uncomplicated natal cleft sinuses. The treatment results in less discomfort for patients, earlier return to work, and better use of health care resources in 74% of cases. The remaining 26% of patients will have a shorter stay in hospital and will otherwise not be different from patients given "standard" treatment of excision and healing by secondary intention.

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Home accidents in elderly people

EDITOR,—We agree with the conclusions put forward in both the paper¹ and the editorial² on home accidents in elderly people but believe that they should have gone further. As falls in this age group are often multifactorial and many go unreported¹ all medical professionals having contact with the older population have a duty to reduce potential risk factors. As with many of the new reforms of the health service, this will ultimately fall on the primary care team and general practitioners in particular.

Medical risk factors are already assessed as part of normal working practice. Home visits presently made by general practitioners could provide an opportunity for screening environmental risk factors. We believe that the yearly review of all patients aged 75 and over should also be performed in the home, rather than in the practice premises, as part of such a screening programme.

In our department occupational therapists making home visits use these opportunities to assess and alter potential environmental risk factors. This often entails removing loose mats, nailing down loose carpet edges, and adding hand-rails. One other simple yet effective alteration in view of the large proportion of falls associated with poor lighting¹ is to change the light bulbs used to a higher wattage—for example, to 100 W.

Should we advocate adding a hammer, some nails, and some 100 W light bulbs to the medical

bags of all general practitioners and hospital doctors making home visits? The relatively small expense might save only a few admissions to hospital, but when one day in a hospital bed costs at least £150 it may be a sound investment.

The increased workload resulting from screening the home environment of all patients aged 75 and over may be unacceptable to general practitioners. Could this screening therefore be performed by community occupational therapists or health visitors, who already have experience in such matters? This requires further research to determine practicality and cost effectiveness.

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EDITOR,—Brian Livesley and Helen J Graham and Julia Firth make the point that more effort by the primary care services might reduce falls and fractures in elderly people living at home.^{1,2} An important theme in our recent randomised trial on preventing fractures by working with the whole community was that falls in elderly people may be a consequence of preventive measures.³ Attempting to create a safer environment for non-disabled people aged 70 and over seemed to increase the number of reported falls. Elderly people want independence, and to achieve this they often seem to demand of themselves a greater degree of mobility than they actually have. A limiting factor to what they will attempt is an unacceptable risk of falling. Thus reducing the risk of falling (either in reality or perceptually) seems to encourage an increase in mobility, either to the desired level or until the risk of falling becomes unacceptable.

It is obviously right to try to make the environment safer, but a relevant outcome for this policy is the achievement of independence and thus an improved quality of life rather than a reduction in falls. We do not attempt to overrestrict the activities of children because they might fall. We may have to rethink the extent to which we accept such risks for elderly people despite the grave consequences.

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Use of Lucozade and glucagon by ambulance staff in hypoglycaemia

EDITOR,—In 1987 the Department of Health and Social Security circulated a hazard warning notice to all health authorities regarding blood glucose tests done outside the laboratory.¹ We are surprised that J M Steel and colleagues did not mention this in their short report.² In the Merthyr and Cynon Valley Unit of Mid Glamorgan a formal policy was set up to meet the criteria suggested by the department. The policy covered training users, selecting and maintaining equipment, and quality control of meters and sticks. All staff who perform

blood glucose tests were trained, and all tests were done with Reflux S meters.

In 1989 Mid Glamorgan paramedical staff were included in the scheme. They use 50% glucose, glucagon, or oral carbohydrates. Quality control is even more important in the ambulance service in view of the effects of temperature and humidity on stored test sticks. These difficulties and the clinical conditions which can give misleading results are emphasised in training. Monthly quality control checks are carried out. For example, in one quality control exercise 162 ambulance staff were tested on their ability to diagnose hypoglycaemia on an unknown test sample. Altogether 159 staff obtained results within two standard deviations of the mean; the remaining three staff still correctly diagnosed hypoglycaemia.

All schemes must have adequate training and quality control.

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Monitoring Creutzfeldt-Jakob disease

EDITOR,—Systematic surveillance of Creutzfeldt-Jakob disease in the wake of the epidemic of bovine spongiform encephalopathy, as reported by R G Will and colleagues, is to be welcomed.¹ We recently identified the disease in a 78 year old woman and were grateful to the National Creutzfeldt-Jakob Disease Surveillance Unit for help in postmortem investigation.

We have some concerns, however, about the identification of cases and collection of data. To our knowledge, ours is the only case so far reported by a psychiatric department. Neurology departments have recently been targeted for this surveillance exercise. Will *et al* pointed out, however, that diagnosis of the disease in elderly people has apparently decreased, which could be explained by poor ascertainment of cases.² Someone in his or her fifth or sixth decade who develops an organic brain syndrome of subacute onset is likely to be referred for neurological assessment whereas an older person is much less likely to be so intensively investigated and, if referred anywhere, is likely to be referred to the old age psychiatry service.

Creutzfeldt-Jakob disease in elderly people is rare compared with other dementias, but the importance of making the diagnosis cannot be underestimated. We urge our colleagues working in the psychiatry of old age to be aware of the surveillance project and to contact Will and colleagues if they strongly suspect the diagnosis.

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