although opioids have their own clinically relevant adverse effects.²

There is much current interest in the use of non-steroidal anti-inflammatory drugs as adjuvant agents with other analgesics after surgery. Several studies have shown that combining non-steroidal anti-inflammatory drugs with opioids provides superior analgesia with less total opioid required and possibly a reduction in side effects mediated by opioids, such as respiratory depression and sedation.¹ Furthermore, there is good reason to believe that giving non-steroidal anti-inflammatory drugs before surgery may result in a pre-emptive analgesic effect with a subsequent reduction in postoperative analgesic requirements and the associated adverse effects.¹ The results of controlled trials to substantiate this effect in humans are awaited. We suggest, therefore, that until there is stronger evidence for clinically significant impairment of wound healing, non-steroidal anti-inflammatory drugs should continue to be used for surgical patients without other contraindications as they have a useful role in the management of postoperative pain.

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Paradoxical bronchoconstriction and salmeterol

EDITOR,—James R W Wilkinson and colleagues¹ report on paradoxical bronchoconstriction in asthmatic patients after salmeterol by metered dose inhaler is surely wrongly titled.¹ As the authors themselves state, "the irritant is not the salmeterol itself." In addition, the view that salmeterol has a slower onset of action than salbutamol and may therefore allow such bronchoconstriction to become manifest is difficult to justify in view of the accumulated evidence that there is no significant difference in the rate of onset of bronchodilation in many comparative studies (Allen and Hanburys, personal communication).

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Oestrogen replacement therapy after hysterectomy

EDITOR,—We are writing in agreement with Tony Seeley's article.¹ We are currently analysing the findings of a multicentre study of women undergoing total abdominal hysterectomy for benign conditions. We have examined the case notes of 363 of 366 women who were recruited between April 1991 and March 1992. A total of 161 (44%) of the women had a bilateral oophorectomy with total abdominal hysterectomy.

Of the 161, 40 women were discharged from hospital without hormone replacement therapy, 11 of whom were under the age of 45. It is likely that

these women might expect to undergo a somewhat abrupt menopause in the absence of replacement therapy. Results of histology were available for all of these women, none of whom had any evidence of ovarian malignancy.

We found no evidence of the use of levels of follicle stimulating hormone to make decisions regarding the use of replacement therapy in this group. Epidemiological studies show that women who have had a surgically induced menopause have a small average increase in life expectancy due to a reduced risk of ovarian cancer, but this increase is, firstly, not a great deal longer than the time it might take to recover from the operation and, secondly, highly dependent on appropriate substitution of naturally diminishing ovarian function.^{2,3}

We suggest that all women who have had hysterectomy with bilateral oophorectomy should be considered for hormone replacement therapy before hospital discharge, to avoid the risk of development of symptoms of oestrogen deficiency.

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Managing hypertension in elderly patients

EDITOR,—M D Fotherby and colleagues provide important information on the management of raised blood pressure in older patients in general practice.¹ They show that both the proportion of patients treated and the thresholds for initiating treatment are influenced by the patients' age.

We recently conducted a postal questionnaire survey of stroke prevention in general practice; we asked questions on the importance of raised blood pressure as a risk factor for stroke and on belief in the benefit of antihypertensive treatment in reducing stroke in three different age groups (40-55, 65-74, ≥ 75). We sent questionnaires to 295 general practitioners in two health districts in one family health services authority in March, shortly after the publication of the results of the Medical Research Council's trial of treatment of hypertension in older adults² and guidelines on managing elderly patients with sustained hypertension.³ We received replies from 160 general practitioners (54%). Responders did not differ from non-responders in terms of age, gender, or size of practice, but fellows and members of the Royal College of General Practitioners were heavily overrepresented ($p < 0.0001$).

The table summarises the general practitioners' views about the importance of raised blood pressure as a risk factor for stroke and the value of treatment. The general practitioners regarded raised blood pressure as an important risk factor in

Number of respondents who thought raised blood pressure was a risk factor for stroke and believed that treatment was beneficial (n=160)

Patient's age	Raised blood pressure a risk factor	Treatment beneficial
40-55	155	155
65-74	149	149
≥ 75	128	106

the youngest age group and less important with increasing age. The number who considered treatment to be of benefit was significantly lower than the number who considered it to be an important risk factor for the oldest group ($\chi^2=5.13$, $p < 0.03$), but the figures were the same for the two younger groups. The general practitioners' views varied with their own age: a significantly higher proportion of younger practitioners (< 46) regarded treatment of raised blood pressure in both older age groups (65-74 and ≥ 75) as of potential benefit.

Our results support the call by Fotherby and colleagues,¹ echoed by O'Malley and O'Brien,¹ for clear, authoritative guidelines on treating raised blood pressure in elderly people. Factors such as risk-benefit considerations, workload, and sharing uncertainty in clinical decision making with the patient seem also, however, to influence general practitioners in their decisions regarding such patients.³ Guidelines are unlikely to change general practitioners' behaviour rapidly unless systematic audit is implemented. Further research is needed to define cost:benefit and risk:benefit ratios from the perspective of the health service and patients and to understand the complex interactions between general practitioners and their elderly patients.

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Naming names

EDITOR,—In her report of the trial of Dr Nigel Cox for attempted murder of a patient Clare Dyer refers to another case in 1990 in which a senior house officer faced a similar charge.¹ The trial at the Old Bailey was discontinued when the prosecution withdrew the charge. Dyer names the doctor in that case, which is unfortunate and unnecessary. The events leading up to the trial, which dragged on for two years, caused this young doctor considerable anguish. As it was decided that there was no case to answer he should be allowed to put it behind him, which is not possible if his name (an unusual one) is disclosed every time the case is referred to. This could also affect the attitude of colleagues and even appointment committees. My comments arise from one particular case but might apply to others.

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Unprofessional behaviour

EDITOR,—The personal view concerning professional sexual assault struck a troubled and angry chord with me.¹ As a senior house officer in obstetrics I was persistently physically and