Authors' reply

EDITOR,—The most important focus of our paper was to critically evaluate the assumptions that were required to make screening cost effective.¹ It would seem that Dr Borch-Johnsen and colleagues agree. Their paper, however, did not adequately examine the specificity and sensitivity of screening; furthermore it examined screening and treatment versus no specific treatment.² This latter approach should be considered obsolete since the effects of angiotensin converting enzyme inhibition to reduce progressive renal failure have been shown.³

We concluded that the incidence of hypertension before, at the onset of, or just after the development of microalbuminuria should be determined. We did not define hypertension. The level of blood pressure recommended for treatment is debated; some advocate that an increase in blood pressure from baseline is as important an indication for starting antihypertensive treatment as is a specific level. The difficulties with measuring blood pressure have long been identified; none the less, doctors diagnose hypertension every day and start treatment. If hypertension is diagnosed and treatment with an angiotensin converting enzyme inhibitor is started then there is no need to test for microalbuminuria.

Regarding the low predictive value of microalbuminuria, the model assumed that true microalbuminuria was predictive of renal failure (all patients eventually progressed). The positive predictive value of 0.3 referred to the appropriate diagnosis of a single test. The model's baseline assumption was a positive predictive value of 0.8. The authors' practice (multiple tests by more than one method) differs considerably from the consensus recommendations.⁴

The authors say that microalbuminuria will flag persons at high risk, presumably for cardiovascular disease. Markers for vascular disease now include homocysteinemia, insulin levels, and polymorphisms in a variety of genes. These tests for the most part add cost but provide little additional benefit unless specific, proved treatment is instituted.

There was concern about the use of quality of life adjustments. We agreed with the authors' concerns.¹ There is much debate on this approach, but we felt that ignoring health preference status was a greater error. We welcome further studies in this area.

We thank the authors of this letter and acknowledge their scientific contributions. However, we believe that it is important to be critical of all assumptions before accepting the practice guidelines.

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1 Kiberd BA, Jindal KK. Screening to prevent renal failure in insulin dependent diabetic patients: an economic evaluation. *BMJ* 1995;311:1595-9. (16 December.)

2 Borch-Johnsen K, Wentzel H, Viberti GC, Mogensen CE. Is screening and intervention for microalbuminuria worthwhile in patients with insulin dependent diabetes mellitus? *BMJ* 1993;306:1722-5.

3 Lewis EJ, Hunsicker LG, Bain RP, Rohde RD, for the Collaborative Study Group. The effect of angiotensin converting-enzyme inhibition on diabetic nephropathy. *N Engl J Med* 1993;329:1456-62.

4 Mogensen CE, Vestbo E, Poulsen PL, Christiansen C, Damsgaard EM, Eiskjaer A, et al. Microalbuminuria and potential confounders. *Diabetes Care* 1995;18:572-9.

Doctors should check datasheets

EDITOR,—I found Adrian Parkinson's short article on the importance of taking a drug history extremely interesting.¹ Last summer, a few days after we had returned from the Dominican

Republic, my 6 year old son had a grand mal seizure on waking from sleep. He had been completely well previously. During the few hours that he was in hospital he was seen by three doctors; I told each of them that he was taking chloroquine, and each of them reassured me that the chloroquine was irrelevant. My son recovered rapidly and was allowed home the same day. Later that week, when he was due to take his next chloroquine tablet, I checked the datasheet and found convulsions listed as one of the recognised side effects. Furthermore, when I calculated the dose in mg/kg I found that my son was taking a dose (as prescribed by the pharmacist) that was just below the dose at which death had been recorded in children.

We all stopped taking our chloroquine, and subsequent electroencephalography yielded normal results. When I expressed to the hospital my concern that the drug might have caused the fit, drug concentrations were measured, but they could not be interpreted as there is apparently no normal range for children. Since then there have been numerous reports on television about the side effects of antimalarial drugs. The hospital did not, to my knowledge, complete a yellow card on my son.

There is no value in obtaining a full drug history if one does not look at the datasheet and determine whether the patient's presenting symptom could be related to the drugs he or she is taking. In addition, when there is a high probability that a particular side effect is related to a drug then a yellow card should be completed. Surely it is the responsibility of the medical profession to identify the side effect profile of commonly used drugs rather than leave this to television programmes.

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1 Parkinson A. It's always important to check. *BMJ* 1996;312:420. (17 February.)

Treat patients with kindness during magnetic resonance imaging

EDITOR,—We were concerned to read Helen Rosenthal's personal view, in which she described her harrowing experience of magnetic resonance imaging and likened the technique to the Auschwitz gas chambers.¹ Her view is contrary to the impression we have gained of our patients' satisfaction with this imaging modality. We are currently investigating the use of echoplanar magnetic resonance imaging to assess fetal development.² One aspect of the research is a longitudinal study of normal fetal growth from 20 weeks to term. Our main concern before embarking on the study was the potential dropout rate. This has not been a prob-

lem, the technique being well tolerated by most of the volunteers.

The volunteers undergo ultrasonographic fetal assessment before magnetic resonance imaging, and we therefore constructed a questionnaire to assess the acceptability of magnetic resonance imaging compared with ultrasonography. The volunteers were asked to indicate anonymously on a visual analogue scale of 100 mm whether they agreed or disagreed with each of seven statements. Thirty two volunteers were studied. One refused to undergo magnetic resonance imaging because she "did not like the look of it."

The mean duration of the procedure was about 20 minutes for the ultrasonography and 24 minutes (range 9-38 minutes) for the magnetic resonance imaging. Table 1 shows the results obtained with the questionnaire and their interpretation.

From these data we conclude that, despite an overwhelming preference for ultrasonography, the vast majority of volunteers felt relaxed while undergoing magnetic resonance imaging. In particular, there was total disagreement with Rosenthal's suggestion that "time seemed endless" and "the knocking sounds were overwhelming." Throughout the procedure our volunteers are attended by the friendly staff at the magnetic resonance centre in Nottingham, but Rosenthal seems to have been abandoned during the procedure. If most radiology departments adopt this practice then an audit of patients' opinions of the technique with and without attendants is imperative. Undoubtedly a minority of patients find the technique unacceptable, but much of the patient's distress can be overcome by an old, well established technique: kindness.

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1 Rosenthal H. Inside the oven. *BMJ* 1996;312:319. (3 February.)

2 Mansfield P, Morris PG. Echo-planar imaging. In: Waugh JS, ed. *NMR imaging in biomedicine*. New York: Academic Press, 1982:143-4.

The nature of general practice

General practitioners are best placed to decide priorities

EDITOR,—It is hard to accept the arguments set out in Per Fugelli and Iona Heath's editorial on the nature of general practice.¹ Comforting though it is to hang on to the accepted wisdoms

Table 1—Results of questionnaire asking patients to indicate on visual analogue scale* whether they agreed or disagreed with statements about magnetic resonance imaging (MRI), and interpretation of results

Statement	Mean (SD) score	Interpretation
I preferred ultrasonography to MRI	31 (24)	Ultrasonography preferred
I felt claustrophobic in the MRI scanner	72 (26)	Claustrophobia an uncommon problem
I felt relaxed having the MRI	26 (31)	Most patients felt relaxed
The MRI scan was noisy	52 (27)	No overall opinion on average
I felt uncomfortable having the MRI	75 (23)	Most patients were comfortable
The MRI was not as expected	56 (26)	No overall opinion on average
The MRI took longer than expected	67 (23)	The duration of MRI was acceptable

*Score of 0 mm indicated emphatic agreement, 100 mm indicated emphatic disagreement, and 50 mm indicated no particular opinion.