prevent some of the life endangering problems highlighted in Dr Bion's original paper.¹

We frequently transport critically ill patients, intubated and ventilated, some 40 miles over winding country roads to a regional neurosurgical centre. The Lifestat 100 (Physiocontrol) non-invasive blood pressure monitor is designed specifically for use in the field or in a moving vehicle. In our experience this monitor has given reliable recordings when used under such adverse conditions. Since the most important role of the attending anaesthetist is to ensure an adequate supply of oxygen to the tissues, pulse oximetry is used routinely in the ambulance. Both the Biox 3700 (Ohmeda) and the Criticare 502 (Criticare Systems Inc) that we possess provide a continuous display of both oxygen and pulse rate.

The use of this equipment is such a practical means of monitoring during transfer that we would not consider undertaking transport of a critically ill patient without it.

T M CRAFT
P H CHAMBERS

Department of Anaesthesia,
Milton Keynes General Hospital,
Milton Keynes MK6 5LD

1 Bion JF, Edlin SA, Ramsay G, McCabe S, Ledingham IMcA. Validation of a prognostic score in critically ill patients undergoing transport. *Br Med J* 1985;291:432-4.

Aspirin all round?

SIR,—Two reports have been published on the efficacy of prophylactic aspirin in preventing cardiovascular disease in British (30 January, p 313) and American doctors.¹ The results of these two studies conflict, and Professor Michael Orme discussed the possible reasons (30 January, p 307). We think, however, that a further aspect should be considered. The two studies differ in one major respect—the dosage interval. The American study used intermittent dosing—325 mg every second day—whereas the British study used 500 mg every day.

We think that the dosing interval is of major importance because of our findings concerning the synthesis of the two major cardiovascular prostanooids, thromboxane and prostacyclin. Both in healthy individuals and in patients with acute cardiovascular disease, such as acute myocardial infarction, a dose of 500 mg aspirin suppresses thromboxane production for at least three days.^{2,4} Prostacyclin production, however, is suppressed for only a few hours. This means that intermittent dosing with aspirin preserves the desired effect on thromboxane formation with minimal disturbance of prostacyclin production. The reason for this is aspirin's well known irreversible acetylation of cyclo-oxygenase, which inhibits thromboxane formation throughout the platelet's whole life span.⁵ In contrast, the endothelium can re-synthesise cyclo-oxygenase and could thereby quickly reverse the effects of aspirin.^{2,3}

Intermittent dosing of aspirin therefore has an important and probably beneficial effect on the cardiovascular system through suppressing thromboxane production with only minimal influence on prostacyclin production. This might have been important in the clinical outcome of the two studies.

PETER HENRIKSSON
KRISTER GREEN
OLE VESTERQVIST
OLOF EDHAG
GUNDARS RASMANIS

Cardiac Division,
Karolinska Institutet, Huddinge University Hospital,
S-141 86 Huddinge, Sweden

- 1 Steering Committee of the Physicians Health Study Research Group. Preliminary report: findings from the aspirin component of the ongoing physicians' health study. *N Engl J Med* 1988;318:262-4.
- 2 Henriksson P, Rasmanis G, Edhag O, Vesterqvist O, Green K. The efficacy of intermittent acetylsalicylic acid on the in vivo formation of thromboxane during acute myocardial infarction. *Cardiovasc Drugs Ther* 1987;1:247.
- 3 Vesterqvist O. Rapid recovery of in vivo prostacyclin formation after inhibition by aspirin. Evidence from measurements of the major urinary metabolite of prostacyclin by GC-MS. *Eur J Clin Pharmacol* 1986;30:69-73.
- 4 Green K, Vesterqvist O. In vivo synthesis of thromboxane and prostacyclin in man in health and disease. Data from GC-MS measurements of major urinary metabolites. In: Zor U, Naor Z, Kohen FI, eds. *Advances in prostaglandin, thromboxane and leukotriene research*. Vol 16. New York: Raven Press, 1986: 309-24.
- 5 Roth G, Stanford N, Majerus P. Acetylation of prostaglandin synthesis by aspirin. *Proc Natl Acad Sci USA* 1975;72:3073-6.

Home visiting by consultants

SIR,—Dr Graham Mulley's leading article (20 February, p 515) reminded me that when I was appointed as a consultant physician five years ago I found domiciliary visits of value as they introduced me to the small number of general practitioners who attended with me, made me aware of the physical nature of the district where I work, and kept me in touch with the surroundings in which my patients live. It quickly became apparent that making domiciliary visits was less efficient than seeing patients in the hospital and I found that if I offered an appointment to patients who needed to be seen urgently within one to two days I cut my domiciliary visits from two a week to one a fortnight.

As the article hints, there are some savings for the health service from this but a financial loss to me. To be more specific, if consultant geriatricians average 211 visits in a year they will earn an extra £7068.50 and if electrocardiography is performed at half of these an extra £1767.12 is added. If the average is 211 per year some must be doing the permitted maximum of 300, which will earn £10 050 a year plus the rate for electrocardiography if appropriate. This will be added to pension rights if performed in the last year of service. These are large sums by any standards and those sitting in large hospital clinics will wonder if they should be out on the road, driving to what is often a relaxed interview at the patient's home. This financial incentive to see patients at home appears excessive and possibly unnecessary. Many of the points picked up by a home visit could be assessed by a district nurse or general practitioner and forwarded to the consultant.

PETER WILKINSON

Ashford Hospital,
Ashford, Middlesex TW15 3AA

SIR,—The excellent leading article by Dr Graham Mulley (20 February, p 515) points out that domiciliary visits by consultant geriatricians may reduce the need for hospital admission but are time consuming and expensive in terms of consultation fees. In west Newcastle the consultant geriatricians perform few domiciliary visits, and most home assessment visits are performed by a team of junior hospital doctors attached to the geriatric unit at Newcastle General Hospital. The team comprises two senior registrars and two registrars spending equal time training in geriatric and general medicine and two senior house officers in geriatric medicine. Requests for home visits from general practitioners are processed by a geriatric services coordinator, and most visits are made within 72 hours.

During 1985 the team carried out 272 visits, with the senior house officers making 136 visits, the registrars 59, and the senior registrars 77. The

outcome of the home visits was as follows: 47 patients required emergency admission, 33 needed routine admission, 15 were offered respite care, 106 were referred to day hospital, 25 were subsequently reviewed as outpatients, eight were referred to other agencies, and eight required a further home visit. Surprisingly, there were 30 patients who required no further follow up. The outcome of the visits by senior house officers did not differ significantly from that of the registrars or senior registrars (χ^2 test, $p > 0.05$).

Home visiting is an important element of training for junior medical staff attached to the geriatric unit, not only providing opportunities for the primary assessment of elderly patients and their carers but also increasing awareness of social, psychological, and physical interactions in the elderly. Home visiting by junior staff may be a cost effective alternative means of extending geriatric services into the community.

J M GRIMSHAW
R M FRANCIS
D M BEAUMONT

Department of Medicine (Geriatrics),
Queen Elizabeth Hospital,
Gateshead NE9 6SX

Health care in a deprived community

SIR,—Having received many laudatory letters and comments in recent weeks from colleagues in other primary health care teams about our strenuous efforts, and to some extent success, in improving the preventive health care of a deprived community in Cleveland (16 January, p 173) we were extremely interested to read the critical letter from colleagues serving similar deprived communities in Wales (20 February, p 569). They felt uncomfortable about some aspects of our paper, and their discomfiture seemed to orientate around four major points.

Firstly, Dr Jonathan Richards and colleagues imply that our work would be welcomed by supporters of the government's white paper on primary care. That our servants at Westminster have chosen to promote (and we hope adequately fund) preventive aspects of primary care gives us cause for celebration since they are merely furthering concepts and trends that developed primary health care teams are already instituting and attempting to make them universal.

Secondly, Dr Richards and colleagues say that they cannot claim our success. We can offer little immediate comfort here since the work needed from the whole team (but especially the practice nurses and health visitors) to improve preventive care will be enormous, as ours has been. There is relief on a more distant horizon, however, when team members are no longer visiting patients with morbidity inducing whooping cough and measles in deprived settings or shouldering the burden of care of young hemiplegics or the ghastly preterminal and terminal care of patients with carcinoma of the cervix.

Thirdly, Dr Richards and colleagues claim that we have pressurised our deprived community into conforming to the higher standards of preventive care of their more endowed counterparts, even denying these families the "freedom . . . to decline the professional advice of the primary health care team." If the Merthyr Tydfil doctors study the seven "methods" that we used to improve the uptake of preventive care they will see that five of them were operational changes and implementation of new systems that involved change by, and even pressure on, team members rather than our patients. The more we familiarised ourselves with the gaps in preventive care the more it appeared that it was our inappropriate system of providing