	Arterial	Capillary
Without anaesthetic for arterial puncture (n=29):		
Median pain score (interquartile range)	7.0 (5.5 to 8.0)	3.0 (1.5 to 4.0)
Median difference (interquartile range)	5.0 (3.0 to 6.0)	
Significance	P<0.001	
No of patients preferring either sampling method*	1	25
With anaesthetic for arterial puncture (n=26):		
Median pain score (interquartile range)	2.0 (0 to 3.25)	1.0 (0 to 2.25)
Median difference (interquartile range)	0 (0 to 2.0)	
Significance	P<0.02	
No of patients preferring either sampling method†	2	12

*Three patients had no preference.
†Twelve patients had no preference.

The table shows the results of the patients' pain scores and preferences of sampling technique. Arterial puncture without local anaesthetic was much more painful than capillary puncture; most patients preferred the capillary technique. Even with local anaesthesia arterial puncture was significantly more painful, with half the patients preferring the capillary technique; only two preferred the arterial technique. Mean differences (arterial minus capillary) were trivial and non-significant for partial pressure of oxygen (0.09 kPa, SD 0.59, P>0.2) and partial pressure of carbon dioxide (0.01 kPa, 0.3, P>0.7 and significant but clinically unimportant for acidity (0.007 pH, 0.02, P<0.01) and standard bicarbonate (0.64 mmol/l, 1.17, P<0.001).

Comment

Our findings indicate that radial arterial blood sampling is painful, and even with local anaesthesia the procedure causes more pain than sampling from the ear lobe. The pain scores for capillary sampling may have been lower in the patients given local anaesthetic because of a "carry over" effect—that is, patients who did not receive local anaesthetic found the whole process considerably more uncomfortable and marked up the pain scores for capillary sampling as an indirect consequence of this. In addition, a small but definite risk exists of local complications from arterial puncture.² As similar biochemical data are obtained from capillary sampling from the ear lobe this method should be used in routine clinical practice. The method of sampling may be particularly important to patients with recurrent respiratory illness such as asthma. Several studies have shown delay to be an important factor contributing to deaths from asthma.^{4,5} Reluctance to present to hospital because of a previous painful experience could be catastrophic.

We thank Dr James Falconer-Smith for helpful discussion and Mrs Helen James for typing the manuscript.

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Antiplatelet treatment in elderly people with transient ischaemic attacks or ischaemic strokes

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Strokes and transient ischaemic attacks become more common with advancing age, and their prognosis becomes worse. Because of the increase in the number of elderly subjects in most Western societies, atherothrombotic cerebrovascular disease is a significant health problem. It is important, therefore, to find effective treatments for both primary and secondary prevention.

The Antiplatelet Trialists' Collaboration found that the reduction in vascular events as an end point in patients with a previous stroke or transient ischaemic attack was 22%.¹ Antiplatelet drugs were equally effective in patients older and younger than 65 years, a

result that was also seen in the European stroke prevention study.² No study has, however, investigated the protective effect of antiplatelet drugs in patients older than 70 or 80. We analysed a subgroup of the 1306 Finnish patients participating in the European stroke prevention study to evaluate the effectiveness of drug treatment in different age groups.

Subjects, methods, and results

The European stroke prevention study investigated whether the combination of 75 mg dipyridamole and 330 mg aspirin three times a day was more effective than placebo in the secondary prevention of stroke or death in patients with previous ischaemic cerebral lesions. It was a randomised, placebo controlled, double blind study with parallel groups. Sixteen centres from six countries participated. The treatment groups showed a 33% decrease in the combined end point (the sum of stroke and death) compared with the placebo group.³ The study design has been described in more detail elsewhere.^{2,3} Of the 2500 patients recruited, 1306 were from a single centre in Kuopio,

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Effect of antiplatelet treatment on the risk of death or stroke in patients with transient ischaemic attacks or strokes in different age groups*

	Age (years)					All patients
	≤50	≤60	>60	>70	>80	
Aspirin and dipyridamole:						
No of deaths + strokes/total no (%)	2+7/901 (10.0)	8+16/287 (8.4)	28+34/365 (17.0)	12+15/156 (17.3)	1+3/20 (20.0)	36+50/652 (13.2)
Placebo:						
No of deaths + strokes/total No (%)	2+10/75 (16.0)	8+35/254 (16.9)	34+63/400 (24.3)	18+28/149 (30.9)	6+6/20 (60.0)	42+98/654 (21.4)
End point reduction (%) (95% confidence interval)	37.5 (32.2 to 42.8)	50.3 (47.4 to 53.2)	30.0 (27.1 to 32.9)	43.9 (39.1 to 48.7)	66.7 (52.6 to 80.8)	38.4 (36.3 to 40.5)
Significance (P value)	0.22	0.004	0.023	0.018	0.032	<0.001

*Intention to treat analysis.

east Finland, representing 52% of the whole study population. Of these, 40% had had a transient ischaemic attack and 60% a stroke as the qualifying event for entry to the trial.

The combined end point in statistical analyses was the sum of stroke and death from any cause. Results from all randomised patients were studied using intention to treat analysis. Survival curves were plotted by the actuarial method, and significance was calculated using Lee-Desu statistics.

The table shows the effect of age on the risk of stroke or death as the reduction in the combined end point by age group. There was a clear increase in the risk of stroke or death with increasing age in the placebo group. In patients younger than 50 the frequency of the combined end point during two years of follow up was 16%, increasing to 60% in patients older than 80. In the active treatment group, however, the frequency of the end point increased from 10% to only 20%. The reduction in the combined end point varied from 30% to 66.7%, with the highest percentage reduction occurring in the oldest age group. The difference between the treatment groups was significant in all age groups of 50 and over. The treatment effect was independent of the length of follow up in all age groups (Cox regression analysis, data not shown). The effect of treatment was probably not influenced by the adverse effects of the drugs used because the drop out rate due to side effects decreased with increasing age.

Comment

The incidence of ischaemic events increases with advancing age. Furthermore, the survival rate of elderly patients is lower than that of younger patients. This difference could be partly due to differences in the

risk factor profiles of old and young patients. Accordingly, the frequency of total end point events clearly increased with increasing age above 60.

This study clearly shows the efficacy of antithrombotic treatment in patients with a previous history of transient ischaemic attacks or a stroke, even in those older than 80. Although there was also a noticeable reduction in end point in patients younger than 50, this reduction was not significant, possibly owing to a small number of patients. We conclude that patients with transient ischaemic attacks and strokes should have secondary prevention with antithrombotic treatment regardless of age.

We thank Pirjo Halonen of the statistical centre of the University of Kuopio for his help with analysis.

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3 European Stroke Prevention Study Group. European stroke prevention Study: principal end-points. *Lancet* 1987;ii:1351-4.

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Correction

Provision of services for cleft lip and palate in England and Wales

An authors' error occurred in this short report by Alison Williams and colleagues (10 December, p 1552). The table heading should have read: "Numbers of repairs of cleft lip and palate undertaken by surgeons in England and Wales, 1991-2 [not 1992-3] inclusive."

A MEMORABLE PATIENT

A worthwhile 10 minutes

I was fully booked and running late when the receptionist asked me to fit a patient in. She said that he insisted on seeing me. No one else would do. She had offered appointments for other doctors that day or with me the next day but these were unacceptable. I had finally given in with bad grace.

He is 91, but fully alert, an ex-banker with the attention to detail (or obsessionism) that I have observed in other retired financial advisers. He has carcinoma of the bronchus, diagnosed two years ago. Despite radiotherapy he continues to cough up blood. He knows his diagnosis and has faced the future calmly. He copes with the slow deterioration bravely and in a matter of fact manner. He always wears a hat, in summer a proper panama, and consultations start with the ritual of him raising his hat to me (as a lady doctor) before carefully placing it on the spare chair. I know that he will take much more time than the allotted 10 minutes as he is slow because of age and illness and by inclination. By the time you reach the age of 90 and especially if you have reached the top of the financial tree you are used to running your own show. You expect people to listen to you and adapt to your needs. Normally I understand and expect consultations to take some time and try to see him at the end of the surgery when no one else is waiting. That day, however, I was tense when he arrived as I was behind with the surgery and I did not want to allow him to dictate the pace of our meeting.

When he arrived I began the consultation by telling him briskly that I could spare a few minutes only. He completed the hat ritual and settled in the chair. I then got

my first proper look at him. He looked thinner in the face and much more breathless than usual. He coughed and when he spoke his voice was rough and weak. He told me that he felt bad, that the antibiotics I had given him recently for a sore throat had helped at first but the symptoms soon returned, and he was finding it difficult to swallow. I examined his throat. It looked normal. He asked me if I thought more antibiotics would help and I said "no." He told me that he had been to the hospital the day before. The shadow on the lung was deepening, his haemoptyses were larger and more frequent, he could only have one final session of radiotherapy. Suddenly he said that he knew that he would not see his 92nd birthday. He was going to get his affairs in order. He asked if I agreed with this course of action and I concurred.

By that time I had forgotten my irritation at this extra patient. I had forgotten the other patients in the waiting room. I had forgotten the time. I realised I was in the presence of a brave man articulately contemplating the end of his life. Surely it was more important to listen to him for 10 minutes than anything else. I felt ashamed of telling him that I could spare only a few minutes at the beginning of the consultation and of hesitating to see him at his urgent request. He had come to see me at a time of his choosing to tell me in his own way that he knew he was dying. He thanked me as he took up his hat and left. But I should have thanked him for reminding me of the relative importance of a man considering his death and a busy general practitioner thinking only of her stress at running late.—FRANCES CARTER is a general practitioner in London