agents in minimal change nephropathy is controversial. This implies that the benefits are unproved, whereas a definite, sustained effect has been shown in controlled trials.³ There are, however, side effects associated with these agents, and the authors are correct in stating that their use should be carefully considered. The consensus statement lists two clear indications for second line treatment. (1) Relapse while taking prednisolone >0.5 mg/kg on alternate days plus one or more of (a) unacceptable side effects of corticosteroid treatment; (b) high risk of steroid toxicity—for example, in boys approaching puberty or in diabetes; (c) unusually severe relapses (hypovolaemia or thrombosis); and (d) inadequate facilities for follow up or concern about compliance. (2) Relapse while taking prednisolone >1 mg/kg on alternate days. The recommended dose of cyclophosphamide is 3 mg/kg/day for eight weeks. The report describing fewer relapses in children treated with cyclophosphamide for 12 weeks was limited to patients with steroid dependent disease.⁴

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- 1 Mason PD, Pusey CD. Glomerulonephritis: diagnosis and treatment. *BMJ* 1994;309:1557-63. (10 December.)
- 2 Report of a workshop by the British Association of Paediatric Nephrologists and Research Unit, Royal College of Physicians. Consensus statement on management and audit potential for steroid responsive nephrotic syndrome. *Arch Dis Child* 1994;70:151-7.
- 3 International Study of Kidney Disease in Children. Prospective controlled trial of cyclophosphamide in children with nephrotic syndrome. *Lancet* 1974;ii:423-7.
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Eradication of *Helicobacter pylori* in management of peptic ulceration

Evidence supports eradication only in patients who have helicobacter and peptic ulceration

EDITOR,—C O Record emphasises the prevalence of *Helicobacter pylori* infection in patients without peptic ulcer disease,¹ but this in no way diminishes the possibility that the bacterium is an important causal factor in ulcer disease. Secretion of acid is also common in patients without peptic ulceration, but we doubt if that has prevented Record from successfully using drugs that suppress such secretion. Neither acid nor helicobacter infection are the sole cause of peptic ulceration, but both are likely to be important causal factors in a multifactorial disorder. Most ulcers can be healed and kept healed by the suppression of either helicobacter or acid.

Record uses hypochlorhydria in the early stages of helicobacter infection as an argument against a role for the bacterium in the genesis of duodenal ulcer disease, which occurs in patients with normal or increased production of acid. In chronic helicobacter infection, however, evidence suggests that the bacterium promotes secretion of both gastrin and acid.²

We agree that there is no ideal regimen for eradicating helicobacter, but Record's assumption that four weeks' treatment is required is unnecessarily pessimistic. Standard triple treatment is recommended to be given for two weeks,³ as is the licensed dual treatment of omeprazole and amoxycillin. Promising one week regimens have also been reported.⁴

Record's discussion of whether eradication cures the disease is superficial. Record cites a single study, published only as a letter.⁵ Since 94% of the patients were positive for helicobacter at the time

of relapse the study is irrelevant to the efficacy of eradication of helicobacter in preventing relapse. Record neglects the substantial body of trial data showing that eradication of the organism is followed by a major reduction in, or even absence of, relapse in patients with both duodenal and gastric ulceration.⁴

Record implies that all 20 million carriers of helicobacter would have to be treated for the burden of gastroduodenal disease in the community to be altered. The evidence, however, supports eradication only in patients positive for the bacterium who have peptic ulceration. Results in non-ulcer dyspepsia are unpredictable and often disappointing, and the efficacy of eradicating the bacterium as prophylaxis against gastric cancer remains to be established. We believe that Peter C Rubin's commentary is correct: "If a person with peptic ulcer disease is shown to have *H pylori* then eradication is indicated."¹

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- 1 Hawkey CJ, Record CO. Eradication of *Helicobacter pylori* should be pivotal in managing peptic ulceration. *BMJ* 1994;309:1570-2. (10 December.)
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- 4 Tytgat GNJ. Treatments that impact favourably upon the eradication of *Helicobacter pylori* and ulcer recurrence. *Aliment Pharmacol Ther* 1994;8:359-68.
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Gastric metaplasia should be considered too

EDITOR,—In maintaining that *Helicobacter pylori* does not cause peptic ulceration C O Record draws an analogy with the presence and effect of bacteroides in diverticular disease: the presence of bacteroides does not mean that the organism is the initial cause of the diverticulitis, the initial cause being the presence of diverticulosis.¹ Likewise, *H pylori* cannot exist in the duodenum without pre-existing gastric metaplasia of the duodenal mucosa and duodenal ulceration does not occur in the absence of gastric metaplasia. Despite *H pylori* being eradicated, gastric metaplasia remains unchanged, leaving a suitable environment for possible recolonisation.² More attention should be drawn to the elimination of gastric metaplasia and restoration of normal duodenal mucosa as well as the successful eradication of *H pylori*.³

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- 1 Hawkey CJ, Record CO. Eradication of *Helicobacter pylori* should be pivotal in managing peptic ulceration. *BMJ* 1994;309:1570-2. (10 December.)
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Management of stroke patients

EDITOR,—The two points of view in your debate on community care for stroke patients¹ are not necessarily in opposition. Organised stroke care is now recognised as desirable²; purchasers and

providers must ensure that a "seamless service" exists for patients with stroke.³ John Young does not seem to be arguing for a stand alone community stroke service but for improvement in the current disorganised state of community rehabilitation. While up to 70% of stroke patients are admitted to hospital, at least 30% are not, and some of the patients admitted could probably remain at home if better coordinated services existed.

To allow optimal outcomes all stroke patients need access to specialised rehabilitation, coordinated care, and secondary prevention; acute medical care may also increase in importance in the light of the international stroke trial and other current drug trials. Surely the answer is to have a comprehensive stroke rehabilitation service for each geographical area, with both hospital based and community based components? The hospital stroke rehabilitation unit would probably act as the base but should be coordinated with outreach services providing immediate assessment and ongoing rehabilitation for stroke patients in the community and follow up for people discharged from hospital whose needs are not met by other services such as day hospitals. The unit should also provide information for patients, carers, and other professionals about stroke care and local services and should be able to deal with the problems that patients and carers face. Clearly such a service would require close liaison between hospital services, primary care services, and community care teams, but such a service should largely answer the points raised by both Young and Lincoln.

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- 1 Young J, Lincoln N. Is stroke better managed in the community? *BMJ* 1994;309:1356-8.
- 2 Dennis M, Langhorne P. So stroke units save lives: where do we go from here? *BMJ* 1994;309:1273-7.
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BMA's representation of clinical and medical directors

Medical directors in Wales not represented

EDITOR,—I wish to correct the erroneous impression given in a report in *Medicopolitical Digest* that the BMA represents medical directors.¹ The new subcommittee of the BMA's Central Consultants and Specialists Committee may represent some medical directors of NHS trusts in England, but it represents none in Wales. At a conference held on 8 November the possibility of the BMA not representing medical directors was rapidly disregarded by the chairperson, although the obvious difficulties of such a relation were clearly recognised by many of those present from trusts outside Wales. The BMA is unwise to try to form a joint body of clinical and medical directors since their functions are as disparate as those of any two branches of our profession represented separately in the BMA's present structure.

Individual medical directors may be members of the BMA (as I am) and therefore represented by the organisation. In our official capacity, however, we in Wales believe that it would be a conflict of interest for us to be subsumed into a subcommittee of the body that represents the trade union interests of those with whom we are employed to negotiate on pay and conditions and whom we may even have to discipline. Besides this, some of the medical directors are not able to be represented directly by the Central Consultants and Specialists Committee, being general practitioners or academics. Perhaps the entire structure of the BMA needs alteration so that it matches all the changes taking place.

The current movement towards local pay bargaining will make the centralised structure designed to deal with central pay bargaining an anachronism. If the BMA feels threatened by this the way forward is within its own mechanisms and not by attempting to engulf medical directors. If medical directors have any ability to influence change on the wider front it is by giving advice within the system and leaving the political machinations to the BMA, whose task it rightfully is.

We regard ourselves as at least as well intentioned as the chairman of the Central Consultants and Specialists Committee and not a wit less aware. The committee has its own important role. Ours is new and different and needs to be entirely separate.

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1 Beecham L. New committee will represent clinical and medical directors. *BMJ* 1994;309:1376. (19 November.)

BMA's reply

EDITOR,—Mervyn Rosenberg's letter betrays some important misunderstandings about the role of the BMA and its craft committees. Certainly a major role of the craft committees is to negotiate terms and conditions of service for their constituents, but this is by no means their only function. The Central Consultants and Specialists Committee, for example, represents the views and interests of senior hospital doctors on a much wider range of issues that have nothing to do with terms of employment. These include medical staffing, NHS funding and the internal market, complaints procedures, information technology, and management structures. The committee is conscious that its policies on these issues will be truly representative of the views of the body of senior hospital doctors only if they are formed with input from clinical and medical directors, who are an integral and increasingly influential part of that body.

There has been mounting pressure from BMA members who are clinical and medical directors and who wish to see a mechanism to ensure their input to their professional association. The Central Consultants and Specialists Committee has responded to this by setting up the new subcommittee, which has attracted considerable interest and support. We acknowledge that there may be difficulties in the relationship between the new subcommittee and the Central Consultants and Specialists Committee and the BMA in its trade union role, and of course clinical and medical directors will continue to influence matters from outside the BMA. We do not wish, however, to seem to deny the existence of different points of view within the profession by cutting off this group of members from their professional organisation. After all, what group is likely to make a more important contribution to the BMA's attempts to "adapt to the cultural alterations currently taking place regarding health care delivery in general"?

Rosenberg is right to point out that the new subcommittee, as part of the representative structure of the Central Consultants and Specialists Committee, covers only those clinical and medical directors who are senior hospital doctors (the overwhelming majority). We are now looking carefully at aspects of our representative structure that may no longer reflect the changed NHS, and we may need to make changes in the longer term; the Central Consultants and Specialists Committee, however, has rightly acted to put a structure in place for its own constituents in the meantime.

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Getting started as a medical manager

EDITOR,—In their article on getting started as a medical manager J F Riordan and Jenny Simpson comment on several important issues facing senior clinicians involved in management.¹ We believe, however, that articles on management for doctors repeatedly omit one factor.

Learning by doing and getting to know your workforce are established methods in management training. In most major companies managers are required to spend a period of their training working with their workforce at every level. "Getting to know your colleagues" is the phrase applied to this exercise. It seems to be accepted among the NHS management, however, that consultants are the only people worth talking to. Junior doctors rarely see managers, let alone think that they have any experience of the problems associated with caring for patients. An interesting paradox thus arises: on the one hand, managers speak of teamwork, communication, learning by doing, etc and chastise the medical profession for not adopting these perceived virtues; on the other hand, they avoid contact with most of the workforce. Riordan and Simpson's article mentions how Dr B enjoyed working with the bright, newly recruited young managers; it seems that medical juniors, who may well have trained for a considerably longer time, are not thought of with such affection among medical management. This is insulting.

The time to expose doctors to new skills and ideas must surely be while they are still young and adaptable to change. NHS managers should attempt to apply the principles expounded in their "management speak" when dealing with junior medical staff. Truly integrated management promotes staff morale and corporate identity, which leads to increased loyalty and higher productivity. If we worked together from an early stage it would reduce the culture shock for both parties and allow a more gradual transition into management at the consultant level. Who knows, doctors might even learn to communicate and work as a team just as well as the NHS management.

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1 Riordan JF, Simpson J. Getting started as a medical manager. *BMJ* 1994;309:1563-5. (10 December.)

Authors' reply

EDITOR,—In our experience, the managerial attitude to junior doctors described by P J Drew and A Gilbert is still common. Fortunately, however, it is giving way in many hospitals to an understanding by managers of the important roles of junior doctors and other professionals and a willingness to work with them. Many management trainees work well with their junior medical colleagues with mutual benefit, although several have commented to us that they find it difficult to work effectively with junior doctors unless they have already received cooperation from their consultants.

As we stated in our article, we believe that clinical audit is an important entry point into the management process for many junior doctors. It could also be used by clinicians to encourage interaction between management trainees and

junior doctors, although in our experience it is not commonly so used at present. Management training courses on which junior doctors meet and work with members of other professions and junior managers are also effective in promoting the growth of teamwork with its attendant benefits for all.

We are confident that with the increasing use of these and other methods, progress will continue in breaking down the "tribal" barriers within our hospitals, with benefits to both staff and patients.

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Health promotion in general practice

Any beneficial effect was lost in background statistical noise

EDITOR,—We are confused about the methods that M E Cupples and A McKnight used in their study of health promotion in general practice.¹ The sole criterion for inclusion in the study was angina, and the protocol seems not to have excluded those patients with previous myocardial infarcts, in whom low concentrations of cholesterol have been shown to be beneficial.² The criterion chosen to indicate a successful outcome seems arbitrary and excessive: a more than 50% reduction in the incidence of angina in two years. Yet, even given this limitation, the death rate was halved in the treatment group in two years. The causes of death are not stated in the report, though cardiac diseases should be strongly suspected.

The study showed an influence on eating habits, yet no extra effect was seen on body mass index, which suggests that general overnutrition (mean body mass index of 27) and its associated risks were not affected by health education. The authors admit the lack of effect of education about smoking; they did not, however, validate their measurements of smoking for all patients by using serum cotinine concentrations while admitting that 6% of patients who claimed to be non-smokers lied, allowing errors of underrecording to be missed. It is interesting that the treatment group exercised more or claimed more exercise and an unaltered number of angina attacks while at the same time increasing their use of prophylactic treatment. The possibility of self prophylaxis by the treatment group before exercise seems to have been neglected. Again, exercise tolerance was not validated independently in the study. The feeling of reduced restriction, while not affecting overall rates of angina, suggests the possibility of a placebo effect. We question the assertion that the reduction in cholesterol concentration was significant as a 2.4% fall ($P=0.003$) is equivalent to a 5% reduction in risk in the general population, according to data gathered in the multiple risk factor intervention trial.³ Larger reductions might be expected in groups at higher risk.

The most interesting contrast, however, is between this study and the Stanford coronary risk intervention project, which showed, at four years, significant reductions in cholesterol and triglyceride concentrations, weight, and rate of progression of narrowing of the coronary arteries while also showing an increase in high density lipoprotein concentrations and exercise capacity with a halving of the rate of admission to hospital.⁴ This implies that the benefit to patients of reducing risk factors becomes unequivocal only at four years. This study lasted only two years, and any beneficial