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## Coronary heart disease and occupational class in Sweden

Although relative material deprivation still exists among important segments of the population in the industrialised Western countries, widespread poverty is now a thing of the past. Nevertheless, social class differences in health are still being reported. In Sweden the reduction of social class differences has been an express political aim of the Social Democratic Party, which has been in power during most of the past five decades. Medical care is equally available for all at a low cost, and life expectancy is among the highest in the world. In these circumstances, social class differences in mortality might be expected to decrease.

On p 1497 Rosengren *et al* report a longitudinal study of urban middle aged men, which shows that both the incidence of coronary heart disease and overall mortality from it may still clearly be shown to be related to social class. During a follow up period of nearly 12 years 12% of unskilled workers died and almost 9% suffered a major coronary heart disease event, compared with 6% and 4% respectively among the highest social class of higher officials, managers, and professionals. These differences could be explained only in part by other factors.

## Opioid peptides cause symptoms in liver disease

Opioid peptides are the naturally occurring counterparts of opiate drugs. The concentrations of two of these peptides, methionine enkephalin and leucine enkephalin, are raised in the plasma of patients with liver disease. To determine whether increased opioid peptide activity contributes to some of the clinical manifestations of liver disease Thornton and Losowsky (p 1501) gave nalmefene, a specific opioid antagonist, to 11 patients with cirrhosis. They all suffered an immediate opioid withdrawal reaction. The nine patients with primary biliary cirrhosis experienced considerable relief of their intractable itching and became less tired, and in eight of them jaundice was modestly reduced. The authors conclude that blocking opioid receptors alleviates some of the metabolic disturbances of liver disease.

## Computerised clinical summaries

Without a workable system for paperwork the practice of good medicine or clinical research becomes difficult. Our traditional methods for dealing with clinical paperwork are in danger of being overwhelmed, and the problem may worsen if we also try to collect data for clinical audit or resource management: the workload will increase, the delays grow, and the data become less reliable. How can we help our dwindling secretarial workforce cope?

On p 1504 Llewelyn *et al* describe how a clinical summary can be produced quickly and easily by copying standard text in a special format and editing it on a computer screen. The computer can then copy any information required for other purposes—such as research or clinical audit—from this single summary, which does not need to be retyped but only kept up to date. A comparison over three months showed that the new summaries were quicker to produce than conventionally typed summaries and that a much higher proportion were sent out within a week of discharge.

This simple technique could solve many of the problems which face us at present and even provide new opportunities in clinical practice, medical education, and research.

## Dose response relation to oral theophylline in severe chronic obstructive airways disease

Simple respiratory function tests such as peak expiratory flow rate and forced expiratory volume in one second correlate poorly with symptoms in patients with severe chronic obstructive airways disease. Such patients are often discharged from clinics as virtually untreatable because these variables do not improve. On p 1506 Chrystyn *et al* describe a study of 33 patients with chronic obstructive airways disease. They looked at a range of measurements in response to various doses of oral theophylline and found minimal changes in peak expiratory flow rate and forced expiratory volume in one second but much larger changes in some other variables and a substantial improvement in walking distance. They argue that these results show that clinically relevant changes may occur that are not reflected in tests routinely available in the clinic and that clinicians should, perhaps, believe patients more when they say they feel better. Clinical research in chest medicine may need to be reassessed as in the past much of it has relied on the simpler measurements.

## Heroin inhalation and asthma

The hazards of intravenous heroin abuse are well known, but the practice of heroin inhalation ("chasing the dragon") is considered by many to be fairly innocuous. The experience of Hughes and Calverley (p 1511) has shown that, on the contrary, heroin inhalation may provoke rapid onset of severe or even fatal bronchospasm in young adults with severe asthma. Such subjects may develop severe hypoxaemia and even respiratory arrest soon after inhaling heroin. As drug abuse is often concealed or denied they emphasise that doctors need to be aware of this possibility in patients at risk of substance abuse who present with worsening asthma with no other explanation. Subjects with asthma who wheeze after inhaling opiates are at risk of developing acute severe asthma, which could be fatal.