This week in BMJ

US second class postage paid at Rahway, NJ. Postmaster: send address changes to: BMJ, c/o Mercury Airfreight International Ltd Inc, 2323 Randolph Avenue, Avenel, NJ 07001, USA.
US (direct) subscription $250.00.

Published by the proprietors, the British Medical Association, Tavistock Square, London WC1H 9JR, telephone 071 387 4499 (editorial fax 071 383 6418). Printed by BPCC Magazines (Milton Keynes) Ltd, Milton Keynes. Typesetting by Bedford Typesetters Ltd, Bedford. Registered as a newspaper.

Low dose oral contraceptives reduce cerebral thromboembolic risk

The hormonal content of oral contraceptives has been reduced substantially during the past two decades. A main concern regarding the pill has been its possible influence on thrombotic risks. In order to quantify the influence of low dose oral contraceptives on the risk of cerebral thrombosis Lidegaard (p 956) has carried out a case-control study of 497 fertile Danish women who experienced a cerebral thromboembolic attack during 1985-9. He found that 50 μg and 30-40 μg oestrogen pills conferred relative thrombotic risks of 2·9 and 1·8 respectively. Minipills offered no increased risk. He concludes that oral contraceptives of the 1990s are significantly safer than those used previously and that 30-40 μg preparations are associated with a 50% reduced risk compared with oral contraceptives containing 50 μg oestrogen.

Cervical screening might be stopped at 50

Cervical screening reduces the incidence of and mortality from cervical cancer and all women aged between 20 and 64 (60 in Scotland) should have tests every three years, though every five years would still be acceptable to the Department of Health. Many women are at low risk but still use a large proportion of the resources for screening. On p 967 Van Wijngaarden and Duncan show that cervical premalignant disease is a condition typically predominant in young women and that cervical intraepithelial neoplasia occurring de novo is unlikely to develop in women over 50 who have been screened every three years. Assuming these findings are confirmed elsewhere, the authors suggest that cervical screening might be stopped at 50 provided that an adequate history of negative results from smear tests every three years is available. The repercussions on management of resources in screening could be far reaching should such a policy be adopted nationally.

The wrong people are often immunised against influenza

Influenza epidemics occur sporadically but result in thousands of excess deaths. Annual influenza immunisation, although giving only partial protection, is recommended for people, especially the elderly, with chronic cardiovascular, pulmonary, and renal disease, diabetes and other endocrine disorders, and immunosuppression. Little is known, however, about immunisation rates in these priority groups. Nicholson studied immunisation in elderly people living at home in Leicestershire (p 974). Around half the study population had one or more indications for vaccine and the prevalence did not increase with age. Less than half of the respondents with indications for vaccine had been immunised, and almost a third of those who had been immunised did not have a relevant chronic illness. Improved targeting of at risk groups needs to be introduced to make best use of resources and avoid unnecessary deaths.

Stress management is not clinically useful in hypertension

Reducing blood pressure with drugs in patients with mild primary hypertension does not substantially reduce the risk of coronary heart disease. Various behavioural methods of controlling pressure have therefore been advocated, many entailing some form of stress management based on relaxation. Johnston *et al* (p 963) compared a widely used form of stress management with mild exercise in 96 patients with mild hypertension who had been habituated to the measurement of blood pressure. Stress management had no detectable effect on either the patients' resting blood pressure measured in the clinic or their ambulatory blood pressure. Stress management may help to lower blood pressure at the time of measurement in patients who are not well habituated to the procedure, but such reductions are unlikely to be clinically important. The results of this study do not support the widespread use of stress management to treat patients with mild hypertension.

Lumbar puncture may be dangerous in bacterial meningitis

Controversy exists about whether it is dangerous to do a lumbar puncture in children with bacterial meningitis. Rennick *et al* (p 953) found that many cases of cerebral herniation occur soon after lumbar puncture, suggesting that it does cause herniation in some patients. They also found that normal results on computed tomography do not mean that it is safe to do a lumbar puncture in a child with bacterial meningitis. If a child with suspected meningitis is so ill that antibiotics will be given even if the results of the lumbar puncture are normal, they suggest that antibiotics should be begun immediately and lumbar puncture delayed until the child is fully conscious.

Money isn't following patients with learning disabilities

Over the past decade about half the patients with learning disabilities who would once have lived in long stay mental handicap hospitals in England have been transferred into the community (with lower proportions in Wales and Northern Ireland). Using data gleaned from the boroughs of Kensington and Chelsea and Westminster and extracted from the United Kingdom's four departments of health Glover *et al* show that local authorities have received far less from health authorities than the costs of caring for these patients (p 987). The authors worry that the remaining patients to be transferred are more severely disabled and will cost more to care for. Work done in North West Thames suggests that each severely disabled person transferred should have a "dowry" of £26 000 a year and a capital sum of £39 200. If this money is not transferred from the health service to local authorities, suggest the authors, then the government will tacitly be switching resources away from this vulnerable group of patients.

political skill. However, in today's consumerist and value for money society other skills and resources are required, which only the college can provide. For although the college may sometimes lack political skill, it always insists on an academic approach. The GMSC has no shortage of intellectual prowess in its own sphere of activity, but it needs a partner with an academic credibility to complement its own political skill. This credibility can come only from a body such as the Royal College of General Practitioners, which does not have to compromise its innovative ideas by knowing that it could not secure support in the annual conference of LMCs.

Clarion call

Plainly the time has come for the GMSC and the Royal College of General Practitioners to work together and present a united front to a government which demands more and more of us all but consistently fails to resource general practice with the means to carry out the job. Those with continuing suspicion of the college must realise that it is made up of general practitioners just like themselves, with the same contract, the same frustrations, and the same concern for patients. The pain of 1990 and all that the new contract brought must now be put behind us. Dr Ian Bogle, chairman of the GMSC, has opened a new debate on the future.[6] If any of his ideas are to come to fruition the help and cooperation of the college will be needed.

Anyone who believes in general practice but who left the college because of disagreement with policy should now rejoin. All those new principals who sat the examination in order to get a job but never paid their subscription should pause and reflect. One reason that they enjoy the status of being a general practitioner principal is the activity of that very college that they have failed to join. I emphasise that I have never seen a time when professional unity was more essential.

I fear that a weakened Royal College of General Practitioners will weaken general practice as a whole. The only people who can restore the college to health are general practitioners. General practitioners must return to the fold, so that the college can recover morale, impetus, and finance for academic activity. This will not be achieved by cheering from the touchline.

1 Keighley BD. The RCGP: an inside view. *BMJ* 1980;**281**:1506-7.
2 Irvine DH. General practice in the 1990s:a personal view on future developments. *Br J Gen Pract* 1993;**43**:121-5.
3 Royal College of General Practitioners. *The future general practitioner: learning and teaching*. London: British Medical Journal, 1972.
4 Neighbour R. *The inner consultation*. Lancaster: MTP Press, 1987.
5 Neighbour R. *The inner apprentice*. Lancaster: MTP Press, 1992.
6 Bogle I. *General practice: which way forward?* London: GMSC, 1993.

(Accepted 17 March 1993)

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