

The beneficial characteristics of the dihydropyridine calcium blockers, including the absence of negative inotropism and the neutral effect on lipids and insulin sensitivity, have rendered them popular first line agents in managing hypertension. Like other antihypertensives, appropriate cost-benefit analyses of their various actions are required before they are prescribed. However, inappropriate extrapolation from small, highly selected and methodologically flawed statistics should not preclude their use.

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Study in London confirms influence of ethnic group on treatment for asthma

EDITOR,—Enric Duran-Tauleria and colleagues report that children from ethnic minority groups were less likely to be prescribed drugs for their asthma than were inner city white children and those from English and Scottish representative samples.¹ Although reporting by parents may not be reliable or accurate,² particularly across ethnic groups, and the authors' investigation was limited to children aged 5-11, this work has important implications.

We took a different and perhaps broader approach, using the City and East London general practice database. We hold data on ethnicity, derived by proportional allocation of data from the 1991 census to the postcode distribution of patients on practice lists,³ and data on prescribing for asthma (prescribing analysis and cost (PACT) data) for all practices in east London from 1992 to 1994.⁴ Our results confirm that significantly lower rates of prescription of drugs for asthma occur in practices with higher percentages of patients of Afro-Caribbean origin and in practices with higher

percentages of people from other ethnic minority groups excluding Asians (table 1). We found no association, however, between ethnicity and the ratio of prophylactic to bronchodilator drugs prescribed (taken as a marker of appropriate prescribing for asthma).⁴

Although we did not control for confounders such as demography and social class, it could be argued that comparison between practices is valid because deprivation is homogeneous in the east end of London: the proportion of patients from different ethnic minorities varies from 10% to 64%. We were also hampered because PACT data are not linked to age, sex, and indication. If children from ethnic minority groups are being undertreated for asthma then the rates of admission to hospital for asthma for practices with high percentages of ethnic minority patients could be higher than those for other practices. Although increased rates of admission for asthma correlated with ethnic minority origin in Boston, New England,⁵ a controlled study that we recently carried out showed that this was not the case in east London (C Griffiths *et al*, unpublished findings).

While Duran-Tauleria and colleagues found a relation between Asian ethnicity and underprescribing of drugs for asthma, we found no such association (table 1). We have found that Asian ethnicity is a significant predictor of increased overall prescribing rates (J Naish *et al*, unpublished data), which may reflect increased workload in practices. In our view, the association between ethnicity, morbidity, prescribing, and practice workload should be studied further with the aim of ensuring equity in the provision of health services.

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Table 1—Spearman's rank correlation between rates of prescribing of drugs for asthma and ethnic origin of patients in 163 practices in east London

No of practices for which data available	Ethnic origin (%)*			
	White	Afro-Caribbean	Asian subcontinent	Other
Asthma drug (items/pt)	0.10 (P = 0.21)	-0.21 (P = 0.009)	0.04 (P = 0.62)	-0.34 (P < 0.001)
Prophylactic drug† (items/pt)	0.14 (P = 0.09)	-0.18 (P = 0.028)	-0.01 (P = 0.861)	-0.24 (P = 0.003)
Bronchodilator drug (items/pt)	0.10 (P = 0.232)	-0.23 (P = 0.004)	0.05 (P = 0.504)	-0.33 (P < 0.001)
Ratio of prophylactic to bronchodilator items	0.07 (P = 0.416)	-0.04 (P = 0.628)	-0.04 (P = 0.675)	-0.03 (P < 0.693)

*The 10 main census categories were used.
†pu = prescribing unit, which represents list size weighted for age: patients aged <65 score 1, those aged ≥65 score 3.
‡Included inhaled corticosteroids and cromoglycates.

Schistosomiasis in travellers returning from sub-Saharan Africa

Increase in cases may be due to use of more thorough diagnostic techniques

EDITOR,—John H Day and colleagues provide a useful reminder of the risk of contracting schistosomiasis in many tropical countries.¹ But to state that "cases of schistosomiasis seen at this hospital [the Hospital for Tropical Diseases, London] have increased in the past five years" is misleading: surely the possibility that more cases are being found owing to the use of more thorough diagnostic techniques should be acknowledged.

In the last five year period reviewed by the authors (1991-4) schistosome ova were found by the usual parasitological examination of stool, urine, and rectal snips and, in addition, in semen, bladder and vulval biopsy specimens, and cervical smears from patients with apparently minimal (or no) symptoms. In the earlier five year periods were the same intensive searches made for eggs? It would be interesting to know what symptoms call for the examination of semen and, in addition, which countries other than Malawi contributed to the tally of infected travellers.

The authors' data show that the result of the enzyme linked immunosorbent assay (ELISA) was positive in 81% of patients tested, not 75% as stated.

It is disappointing that the authors repeat the belief that infection in Lake Malawi is of recent origin. This is far from true, as shown by extensive reviews of the subject.^{2,3} Infection in the lake (Lake Nyasa, as it then was) was reported in the annual report of the medical department in 1913, and in the early 1950s Likoma Island was the site of one of the earliest experiments at control with mass chemotherapy with nilodin and at control of the snails with copper sulphate.^{4,5}

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Authors' reply

EDITOR,—Our figures are not misleading and, if anything, underestimate the number of cases of schistosomiasis because the criterion for including patients in our retrospective review was the finding of schistosome eggs. Treatment is often given on the basis of a positive result of a schistosome antibody enzyme linked immunosorbent assay (ELISA), which detects antibodies to schistosome egg antigens whether or not eggs are found. Protocols for investigation did not change over the period surveyed.

When samples were obtained from tissues such as bladder and vulva there would have been relevant indications for invasive procedures, but within the limits of a short report it was not possible to cite more detail. Semen was examined