Hence, the dependent variable is not "hypertension", as this variable has never been observed directly, but "being classified as having hypertension", with case definition, case detection, and case ascertainment as the explanatory variables. The choice of the cut-off point determines the specificity and predicts the probability of being classified as hypertensive or not. Passive case detection in general practice is based on multiple measurements at multiple points in time, is specific, but underestimates the true prevalence because many persons are not ascertained. Active case detection in screening surveys ascertains all at the same visit. In the Groningen study, blood pressure was measured three times, at two visits. In the study of van Ree, blood pressure was measured at baseline screening, twice during the same visit. We ignored the other measurements in this study because it took place after a planned intervention with an unknown but intended effect on blood pressure levels. For the Lelystad study, the subjects treated for hypertension were excluded in the estimated prevalence, not included.

In our discussion of period trends in The Netherlands, we open by stating that the magnitude of the trend is "less credible" and possibly caused by older studies using more imprecise methodology. Obviously, it is better to study trends in the prevalence of hypertension within one study, provided that blood pressure measurements have been taken in the same way throughout the study and at multiple visits. However, the data presented by Bakx et al describe changes in the prevalence of hypertension in a general practitioner's patient population, in which a screening project was conducted during the study period, that aimed to trace (and treat) individuals with hypertension. The figures from the NUTH registry on hypertension are, to our knowledge, unpublished and hard to interpret without any information on age standardisation or confidence limits; the population covered is small and ageing. The figures are inconsistent; they might be used to support the claim that the incidence has been decreasing. Even if methods of diagnosis have remained unchanged, methods of case detection have changed over these two decades, depending on the consultation threshold and the awareness of the population and the general practitioner.

Furthermore, hypothesising that the prevalence of hypertension has not changed over time demands an explanation of, for instance, the strongly declining stroke mortality over time. From other countries it is known that hypertension has contributed to this decline. If this were not the case in The Netherlands, we would have to come up with an alternative explanation for the declining trend in stroke mortality. Pending further data, we cannot reject the period effect we observed, i.e. declining prevalence of hypertension over time.

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Tuberculosis among homeless people

Sin - With other colleagues I recently reported an x ray screening programme at a temporary shelter for homeless people in London set up by the charity Crisis. Active pulmonary tuberculosis was diagnosed in 1.5%. The authors thought this high rate a conservative estimate because many people with an x ray suggestive of tuberculosis were lost to follow-up - a problem occurring frequently in surveys of homeless populations.

In a subsequent study, Crisis undertook x ray screening in London day centres and hostels serving homeless people, many of whom were, or had been, rough sleepers. In an effort to maximise compliance, food vouchers were offered as incentives and an educational programme was provided for homeless people and their carers. Statutory and voluntary services in hospital and the community were contacted and their work was coordinated and facilitated. The methods are described in the Crisis report. A very high level of compliance with investigation and treatment was attained.

Active pulmonary tuberculosis was diagnosed in 2% (95% confidence limits 1.0-3.4%). This rate is 20 times that in the last mass x ray survey in London in 1983 and two hundred times the current tuberculosis notification rate in England and Wales. The urgent need for tuberculosis control programmes for homeless people has been affirmed recently and the Crisis guidelines provide methods for doing so. The high prevalence of ill health, including tuberculosis, in the homeless is well documented. Health commissioning agencies need to consider the special needs of homeless people when assessing their purchasing requirements.

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NOTICES


11th International Congress on Care of the Terminally Ill, 7-11 September 1996, Palais de Congrès, Montréal, Canada. For further information, contact: 11th International Congress Secretariat, Events International Meeting Planners Inc, 739 Victoria Square, Suite 700, Montreal (QC) H2Y 2J7. Tel: (514) 286-0855, Fax: (514) 286 6066.

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