chart for nearly a year and have found the following advantages:

1. Legibility.
2. Standarized recording of both positive and negative data.
3. Standardized approach to a common problem.
4. Can be used for audit.
5. Occasionally acts as an *aide-mémoire* for some important point omitted from history or examination.
6. The sheet could be used for research purposes, for example, mean time between onset of symptoms to presentation. Indeed the importance of research in general practice is emphasized in a recent College publication.[3]
7. The sheet could provide convenient format for computerization of data.

The disadvantages are:

1. The cost.
2. Suitable at present for A4 files only.
3. Practical problems arise as to where to store in A4 file.
4. Some parts of the chart are restricted in space.

Overall our experience has been favourable and we feel that the advantages far outweigh the disadvantages. Printed sheets of this kind are used extensively in some parts of the USA where I first encountered their use. We are pleased with the limited introduction of our printed sheets and hope ultimately to expand their use to some other common presenting complaints.

T. BRADLEY

The Health Centre
6 Old Colin Road
Poleglass
Belfast

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Infant immunization and Reye's syndrome

Sir,

I was interested to see in the current *1985 Members reference book* two adjacent articles on infant immunization[1] and Reye's syndrome.[2]

Like the practices involved in the study on infant immunization, I used to recommend junior aspirin or paracetamol for the minor side effects of immunization. However, the second article on Reye's syndrome reminds us of the possible association between aspirin ingestion in young children and Reye's syndrome.

The drugs and therapeutic bulletin (8 October 1984) contains an article on this possible association and I quote their conclusions:

'The possibility of an association between aspirin and Reye's syndrome has been raised and cannot be ignored, although the case is far from proven. While the issue remains unresolved, it seems sensible to recommend paracetamol rather than aspirin as an antipyretic in infants and children. Further epidemiological and laboratory studies are in progress.'

I would be interested to know what effect this has had on other practices' prescribing habits. My own view in spite of the association being unproven is that it is better to be safe than sorry.

I.M. PEEK

89 Highgate West Hill
London N6

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Report of a case of adder bite with near fatal result

Sir,

This case report is made to emphasize the need for a wider awareness of the management of adder bites.

Case report. The patient, a retired general practitioner in his sixties, was alone at a holiday caravan in the Yorkshire dales on a warm day in July. He knelt in the rough grass beside the caravan and immediately experienced severe pain in his knee. He inspected his knee and saw two tiny adjacent marks in the infrapatellar region. He then looked in the grass but saw nothing. During the following 12 hours his entire leg become grossly swollen and painful, and he felt nauseated, weak and faint. The following morning he still felt extremely unwell and decided to drive home to seek help. Not far from the caravan he blacked out and the car overturned causing severe damage to the vehicle but fortunately no injury to the driver. He was seen by a general practitioner who empirically prescribed hydrocortisone and then by a consultant surgeon at home. Neither doctor nor surgeon suspected the diagnosis of adder bite which was made two days later by a doctor with previous experience of snake bites. Recovery was slow but uneventful, the leg taking two to three weeks to return to normal.

Comment. This patient almost certainly suffered an adder bite to his knee with resulting severe symptoms of envenomation. It is of interest that three different doctors did not initially suspect the diagnosis of adder bite.

Although adder bites are rarely fatal they can be the cause of considerable morbidity.[1] This case demonstrates the need for both general practitioners and hospital doctors to be aware of the symptoms and management of adder bites especially in those areas of the country in which adders may be prevalent. Perhaps this could be achieved by circulating the information contained in an excellent review article by Reid.[2]

There are grounds for introducing a system of notification of such bites so that the true incidence of the problem may be assessed and the distribution of stocks of Zagreb antivenom organized effectively.[2]

T.C. GIBSON
D. KNOX

Royal Manchester Children's Hospital
University of Manchester School of Medicine
Pendlebury
Near Manchester M27 1HA

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Level of immunity to rubella in several group practices in Ireland

Sir,

Nine trainees in our final year on a three-year vocational training course in Ireland studied the immune status for rubella in females attending our practices in the age groups 14 to 40 years.

Two hundred and thirty-seven women were studied over a six-month period. Our results showed that 94.5% of all the women studied were immune to rubella. This is comparable to previous studies in the UK — for example, Rowlands[1] found 88% immunity and Rose[2] found 96% immunity to rubella. In our survey 4.9% of those who claimed to have had previous vaccination were non-immune.

The women's level of knowledge about the dangers of rubella on the fetus was found to be high and this was so throughout all age and socioeconomic groups. However, in the 14–20 year age

group, all of whom should have been vaccinated under the school vaccination programme, 19.1% stated they had not been vaccinated and 23.3% could not remember being vaccinated. The school was the main source of education concerning rubella in the younger age groups and television and radio most informative for the older females.

In conclusion we felt that, although the overall rates of non-immunity in our study were low, the serious effects of rubella infection in pregnancy warrant general practitioners offering routine immune status testing to patients. This would have to be part of a coordinated practice policy. A family planning consultation may be the optimum time to determine the immune status. None of the 237 patients studied had attended specifically to get their rubella immunity checked.

Although awareness of the dangers of rubella infection are high, almost a quarter of patients in the 14–20 year age group did not know if they had been immunized or not. We feel that a history of rubella infection or vaccination should be recorded as part of the basic medical data base on any female patient in the childbearing years.

BART RAMSAY
JOHN KEENAN

38 Wilson Road
Mount Merrion
Co. Dublin
Republic of Ireland

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Topical Fucidin

Sir,

In view of the persistent recommendation from some quarters that topical sodium fusidate (Fucidin, Leo) shall enjoy wider use, we wish to report a case of relevance.

A 63-year-old diabetic woman with chronic renal failure presented to her general practitioner with excoriated lesions of both shins and the back of her neck as a result of uraemic pruritus. Topical Fucidin was prescribed and used on the affected areas. Ten days later the patient presented to the hospital with dehydration, persistence of the excoriated areas with surrounding erythema on the legs and a pustule on the neck. Swabs were taken from the inflamed sites and the pustule. Blood cultures which were taken at the same time grew no organism and she remained apyrexial.

Staphylococcus aureus of the same phage type (95) was isolated from all swabs taken from the different wounds and it was found to be resistant to fusidic acid (minimum inhibitory concentration 4 gl^{-1}) but sensitive to penicillin. Attempts to demonstrate plasmid mediated resistance to fusidic acid using the technique of Lacey and colleagues[1] were unsuccessful, hence, we presume that this was chromosomally coded.

Fusidic acid was first introduced around 1961 when clinical *S. aureus* isolates were almost universally sensitive to the drug. However, resistance could have been demonstrated *in vitro* in approximately $1/10^8$ colonies even at that early time. This resistance arose by chromosomal mutation and acted by altering the effect of the drug on the cell ribosome. Chromosomally mediated resistant strains have been shown to grow more slowly than sensitive ones[2] and colonies may revert to fusidic acid sensitivity if the selective pressure is withdrawn. Plasmid mediated *S. aureus* resistance, which has been particularly demonstrated in association with dermatology units does not seem to confer slow growth or disadvantage on the bacterium and it has been shown to remain pathogenic and infective.[3]

It has been suggested that resistant strains of the type found on this lady's lesions are much less pathogenic and ecologically at a disadvantage compared with coexisting fusidic acid sensitive strains. This case demonstrates that these bacteria can remain the sole causative agent in pathogenic lesions and can remain infective. Fusidic acid resistant *S. aureus* were recently found to be carried by less than 1% of general practice patients who had received topical fusidic acid and this has been used to alleviate the fears that its use may build up resistance in the community. We would use this case to show that the resistant organisms so selected by the use of topical fusidic acid can remain pathogenic and infective.

STEPHEN DEALLER
Department of Microbiology
ANDREW K. FRASER
Department of Renal Medicine

St James's University Hospital
Leeds 9

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Data Protection Act

Sir,

I am glad to see that you have published a summary guide to the Data Protection Act for general practitioners (December *Journal,* pp. 591-593). I wish to encourage all general practitioners who hold computerized data to do the following when registering as data users:

1. To register research and statistical analysis as one purpose for which data are held.

2. To register research workers as individuals to whom data may be disclosed.

Needless to say, the inclusion of these registration particulars will not commit general practitioners to collaboration with research workers such as myself but it will make it possible for them to collaborate should they wish to do so.

MARTIN VESSEY

University Department of Community Medicine and General Practice
Gibson Laboratories Building
Radcliffe Infirmary
Oxford OX2 6HE

How do doctors react to being videotaped?

Sir,

As a newly appointed course organizer I was keen to explore the most useful and least stressful way of looking at the consultation. My own experience as a trainee had led me to believe that viewing role-played consultations (using other trainees as patients) was better than not seeing oneself at all, but often unrealistic. An article in *Trainee*[1] drew my attention to how unpleasant one trainee had found this experience, and stimulated me to assess the acceptability to trainees of something to which they are increasingly being subjected — videotaping and viewing their consultations, either real or role-played.

Davis and colleagues showed that although more than half of a group of 41 students, trainees and experienced doctors were apprehensive before being filmed with a patient in a surgery, only seven remained apprehensive afterwards.[2] I wanted to see if this degree of acceptability was true in other centres.

By means of a postal questionnaire I compared the reactions of groups of general practitioner trainees in the Oxford region and West of Scotland who had undergone simulated consultations with role-played patients. In addition to this, those in the Oxford group had all been videotaped with real patients in their own surgery and their reactions to this ex-