present a major challenge to health and personal social services over the next decade'.[3]

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Treating puberty gynaecomastia

Sir,

My attention was drawn to a report by Hooper[1] of two cases of puberty gynaecomastia being successfully treated by short courses of tamoxifen. Jeffreys[2] was the first to treat painful gynaecomastia with tamoxifen and ever since his report I have been using tamoxifen to treat gynaecomastia. Initially it was used to treat cases that were truly idiopathic; more recently those associated with puberty and adolescence were also treated. Fourteen patients (six adolescents and eight at the age of puberty) with breast masses varying from 2.5 cm to 6.0 cm were treated with tamoxifen over a mean period of 2.4 months (range one to four months). Complete regression was seen in 12 of the 14 patients (86%). There were two recurrences; one soon after stopping treatment and the other 22 months later. The former was treated by surgical excision of the recurrent mass, and the latter by a second course of tamoxifen, which resulted in complete regression. No further recurrence was observed, following the second course of tamoxifen, over a follow up period of 18 months. None of these patients experienced any side effects due to tamoxifen.

I do feel that a short course of tamoxifen can save these young patients from the embarrassment and distress caused by their physical appearance. It is certainly better than the traditional treatment of doing nothing and hoping that the lesion will disappear with time.

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Unexpected problems raised in prevention clinics

Sir,

In the clinics run by the Hackney district to help patients decrease their risk of coronary heart disease and stroke, it has become apparent that issues not directly related to coronary prevention are often raised. Sometimes they are the patient's primary concern; at other times they only emerge in the course of a consultation on life-style and health.

The heart disease prevention clinics are held once or twice a week in the Hackney Healthmobile, a converted caravan used for prevention and health education services in busy high street or residential locations. All attenders complete a questionnaire covering demographic data, medical history and life-style risk factors, and have their height, weight and blood pressure measured. They then discuss the questionnaire in private, and are advised on reducing their coronary risk. Consultations are conducted by a health visitor, a nurse, or a dietician with experience in health education (all female).

From 26 November 1985 to 10 June 1986 records were kept of all problems which attenders raised which were unrelated to coronary prevention. During this period 692 people were seen, and 68 (9.8%) raised such problems. There were no significant differences in age or sex between those raising problems and all attenders.

The type of problems presented were analysed using broad categories from the RCGP classification of problems in primary care.[1] As might be expected, the largest group (34) consisted of psychiatric illness. Problems of substance abuse (7), bereavement (4), depression (4) and concern about a relative's illness (11) were particularly noteworthy. The number of women's health issues raised (11) may relate to the female staff of the clinics; since the Healthmobile is used for well-women services at other times, it may also reflect confusion over the clinic's role. Of the 19 physical ailments raised, 10 were those often held to have a partly or wholly psychological cause — for example, low back pain or ulcerative colitis — or which may have been somaticized anxiety or depression — such as tiredness, chest pain, dizziness and tingling in the fingers. Two patients wanted general information on a health issue unrelated to an illness. There was, however, only one social problem — an elderly lady who wanted a telephone.

Although the numbers in this study are small, there are important lessons for those running open access prevention and screening services in general practice, community health or any other setting, who may see clear divisions between mental and physical health, between coronary prevention and well-woman work. But patients do not compartmentalize health in this way; consciously or unconsciously, the need to discuss problems other than coronary heart disease leads them to attend the clinic. Perhaps certain features of the service made them prefer it to other options. The availability of women staff may have influenced some women without easy access to a woman general practitioner. The anonymity may have appealed in some cases, as they could unburden themselves to a stranger whom they will never need to see again, rather than to their general practitioner who knows them only too well. There is evidence that some patients find it easier to talk to a nurse on some issues than to a doctor and many patients say that they do not want to 'bother the doctor' with problems which they see as trivial, embarrassing, or on the fringes of medical concern. It may be that encouraging someone to look dispassionately at their life-style in relation to coronary artery disease opens a Pandora's box and allows other 'hidden agendas' to surface.

Whatever the reason, these observations have implications for those planning and working in health education services. Staff need to be equipped with the skills to deal with additional problems raised. In addition to knowledge about the primary area of their work they need consultation skills, practical information about a wide variety of other services, and the judgement to know when to refer patients back to the general practitioner. It is not sufficient to teach someone a health promotion 'patter' and send them out into the field.

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