

and is therefore a useful additional efficacy measure for clinical trials.

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Ultrasound in the diagnosis of symptomatic breast disease

Sir,

We are fortunate in having an ultrasound service at our local cottage hospital, available on an open referral basis for antenatal examinations or general ultrasound. We have used this facility to explore the value of screening breast lumps which present in our local surgical out-patients department.

Ultrasound is a safe, convenient, non-invasive test which lessens the need for formal biopsy, thus decreasing costs and providing reassurance to the distraught patient. Using this test Smallwood and colleagues have found a greater accuracy in the diagnosis of breast lumps, particularly when breasts were dense or a featureless density had been recognized on mammography. As about 50% of women in the UK today will experience symptoms of benign breast disease during their reproductive years and as one in 14 of these will develop cancer of the breast at some stage, any test which increases the accuracy of diagnosis and diminishes the anxiety of the patient must be welcomed.

We have recently scanned 100 consecutive patients referred to our local surgical clinic for whom a clinical

diagnosis and possible course of action had been planned prior to the scan. A Siemens Sonoline S1 with a 5 MHz linear transducer and stand-off gel were used, the examination being performed in the supine position. On localization of the lesion a Polaroid picture was taken and an accurate measurement of the extent of the lesion made. The clinical diagnosis reinforced by the scan was then discussed with the patient by the clinician and a decision taken about necessary treatment — a possible biopsy, review at a future clinic or aspiration. If the latter was required, it was carried out immediately and the patient re-scanned to reassure her that all the fluid had been removed. Using such a combined approach, our biopsy rate has diminished as we have become more confident in the extra diagnostic evidence supplied by the use of ultrasound.

We also submit that fear, perhaps one of the most commonly observed symptoms in association with breast lumps, is more rapidly dispelled by this combined approach. Even a simple description of the ultrasound image enables patients to overcome some of their ignorance and when shown the characteristics of a cyst or a smooth-walled fibroidadenoma clinical reassurance is immediately enhanced.

Ultrasound scanning is of no help as a screening procedure and does require the presence of skilled staff at the clinic. However, we feel that with the implementation of the Forrest report and the inevitable increase in the pick-up rate of breast lumps, increased use of ultrasonography will benefit first our patients and secondly an ailing National Health Service.

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Reference

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Patients' duration on a practice list

Sir,

Little is known about the average length of time a patient is registered with his or her general practitioner. The 1990 report of the standing medical advisory committee¹ gives a figure of 12 years, quoted from a personal communication from Difford.

From annual audits I have calculated the registration length of patients registered with my practice at any time

during the period 1 January 1966 to 31 December 1989. Analysis by age cohort revealed the following results.

Of all the cohorts, the women patients aged between 25–29 years have been registered with the practice for the shortest length of time (mean 5.3 years, standard deviation (SD) 7.1 years). By comparison, male patients of the same cohort have been with the practice for a mean of 5.8 years (SD 6.5 years). The cohort with longest duration on the list is female patients aged between 55 and 59 years, being registered with the practice for a mean of 16.2 years (SD 6.4 years). The male cohort of that age group has been with the practice for 14.6 years (SD 7.2 years). The mean duration on the list is 9.6 years (SD 7.5 years) for all female patients and 9.9 years (SD 7.2 years) for male patients.

It would be helpful for computerized general practitioner records to show how long the patient has been on the list. No software is yet offered that does this, and yet it is often relevant to the decision-making process, as well as being of interest.

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Reference

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Assessment of elderly people in general practice

Sir,

The first of the two papers by Iliffe and colleagues (January *Journal* p.9, 13) draws attention to the advantages of proper assessment of elderly people, while the second suggests that this could be satisfactorily done on a mainly opportunistic basis.

The first paper reported that 65% of patients assessed had seen their general practitioner in the previous three months and of these 78% were seen at the surgery. It would be interesting to know what proportion of unmet need was discovered in the 65% group of patients 'seen' as opposed to the 35% 'not seen' by their general practitioners. However, unless the former group were assessed by their general practitioners for risk factors, then opportunistic screening had not taken place.

We were one of four practices in Devon recruited in 1976 for the King's Fund trial into care of the elderly in Devon using an annual at-risk register card, and are the