

family health services authority, jointly with the South East London Commissioning Agency, are now commissioning accident and emergency services for 1992-93 which include the King's College Hospital model of accident and emergency primary care. A number of other districts are considering similar plans.

Primary care in accident and emergency departments is no longer the bugbear of old. It is becoming a legitimate part of a more integrated health service. The potential for developing accident and emergency primary care is considerable, and general practitioners should be playing a leading role.

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Meningococcal infections and the general practitioner

DURING the last decade 1238 deaths in England, Wales and Scotland have been attributed to meningococcal infections.¹⁻³ Since younger age groups are particularly afflicted,⁴ this represents an unwelcome loss of young life, and is accompanied by a burden of morbidity related to the disease itself, its complications and its sequelae.

From the perspective of an individual general practitioner, however, symptomatic infection with meningococci is uncommon. Bearing in mind that the delay between suspicion of a diagnosis of meningococcal infection and treatment affect morbidity and mortality, it has legitimately been described as a diagnosis not to be missed and doctors of first contact are expected to have a knowledge of this condition out of proportion with their experience.⁵ Clinical presentation is varied, particularly with respect to cutaneous manifestations, if present. In reality, therefore, diagnosis is not always straightforward; retrospective studies of the accuracy of the clinical diagnosis given by general practitioners before their patients were admitted to hospital tend to confirm this.^{6,7} Thus, diagnostic vigilance needs to be maintained, and awareness should be heightened during winter and spring,⁸ during the course of a known local outbreak of meningococcal infection, and during outbreaks of respiratory viral infections, including influenza A,⁹ and mycoplasma infections.¹⁰

In the absence of contraindications, and in spite of reports

of emerging resistance,^{11,12} benzylpenicillin remains the drug of first choice for the treatment of meningococcal infections.¹³ Evidence for the benefit of early treatment has recently been reviewed.¹⁴ It seems to be generally accepted that a life saved by early, ideally intravenous, injection of an antibiotic outweighs the occasional failure to demonstrate pathogens in the cerebrospinal fluid.¹⁵ Shortly after general practitioners received a letter from the chief medical officer in 1988 recommending early treatment of meningococcal infections, a postal survey of general practitioners revealed that only 49% of respondents carried parenteral penicillin in their emergency bags.¹⁶ Participation bias may have concealed an even more disappointing result.

Communication is a key element of almost any infection control strategy. Notification rates for meningococcal meningitis in England and Wales have varied from 50%¹⁷ to 67%.¹⁸ In an ideal world, all suspected cases of meningococcal infection should be notified promptly, by telephone, to the responsible consultant in public health medicine or consultant in communicable disease control. The rapid identification of relevant contacts and appropriate administration of chemoprophylaxis (usually rifampicin) can then be coordinated with a view to preventing further cases, if possible. In the interests of good practice and compliance, contacts should be forewarned of the potential side effects of the chosen chemoprophylactic

agent. However, even when administered in optimal circumstances, chemoprophylaxis may fail, so the patient's family needs to be made aware of the prolonged risk of meningococcal infection among close contacts of affected patients.¹⁹

In addition to chemoprophylaxis, if meningococcal infections are due to serogroup A or C strains of meningococci, immunizing contacts may be considered for children or teenagers in schools where more than one case has occurred and in households of cases. The use of the vaccine in this context should be based on specialist advice.²⁰ Travellers to areas of the world where group A infections are prevalent should also be offered immunization.²¹ Unfortunately, there is no licensed vaccine against group B organisms even though group B infections currently predominate in England, Wales and Scotland.^{22,23}

Figures for the outcome of clinical disease in Scotland during the period 1972-82 revealed an overall mortality in cases of meningitis of 7.5% and in cases of meningococcal septicaemia of 20.6%.²⁴ Disability in survivors was relatively infrequent, although a pooled estimate of three other studies indicated a prevalence of hearing loss following meningococcal infection of 8.7%.²⁵ In general, affected families are likely to look to the primary health care team for support; the Meningitis Trust represents an additional resource in this respect.

In summary, general practitioners need to maintain a high index of suspicion for diagnosing meningococcal infections and they should carry parenteral penicillin at all times with a view to administering it as early as possible in a suspected case, prior to urgent hospital admission. Prompt notification of suspected cases is also of paramount importance.

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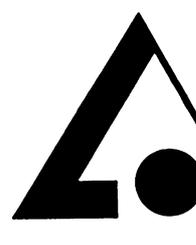
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FACTS

The FACTS Centre in north London is providing a range of services for people affected by HIV.

The Centre has a medical out-patients clinic and works closely with GPs involved in the care of patients with HIV.

FACTS also offers advice, support, training and education to GPs working in the field.

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