

LETTERS

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Sterile instruments for minor operations in general practice

Sir,
We believe there is increased interest among general practitioners in performing minor operations, possibly because of contractual changes. Sterile surgical instruments are required and practices may have bought, or be considering the purchase of, a portable steam sterilizer. Nothing less than genuine sterility is acceptable for instruments being used in a high risk situation, that is being introduced into any sterile body area, or in close contact with a break in the skin or mucous membrane. We therefore believe in these days of increasing public concern regarding the risk of iatrogenic infection by the human immunodeficiency virus and the hepatitis B virus, that it is important that general practitioners can demonstrate that adequate procedures have been followed.

We were concerned that purchasers of portable steam sterilizers might not appreciate the limitations of performance of these appliances, or the complexity of maintenance and record keeping which is mandatory to provide, not only good results, but also evidence of good practice generally, and in individual cases. We therefore sent a short questionnaire to the 208 general practitioners in the Fife health board area, to which 138 replied (66.3% response rate).

Of the 138 respondents 127 used sterile surgical instruments, and of these users, 106 (83.5%) had access to a portable steam sterilizer. Of these 106 respondents, 35 used a machine owned and maintained in a health centre by Fife health board and 71 users had a portable steam sterilizer owned and maintained by the practice. Of the remaining 21 respondents who used sterile instruments, 11 had an *ad hoc* arrangement to receive instruments from the central sterile supply department in their area and 10 applied methods which we regard as unsatisfactory: hot air, boiling water, a pressure cooker, or chemical disinfection.

Of the 71 respondents who owned a steam sterilizer 21 reported that they were insured against explosive accident, suggesting that 50 were not. Presumably all practices had employer liability insurance, but it is doubtful whether this would cover an explosive accident involving the steam sterilizer unless the instrument was mentioned in the policy, and had undergone regular inspection by an engineer from the insurance company.¹ None of those using a portable steam sterilizer appeared to keep an adequate logbook of regular performance checks, or to note the cycle number on the patient's record card for cross reference. Perhaps even more disturbing is the finding that 21 of the 106 users (19.8%) processed wrapped instruments, which directly contravenes recommendations.¹

The purchasing, commissioning, and use, including maintenance and accurate record keeping, of a portable steam sterilizer requires a considerable capital outlay, a thorough understanding of the principles involved, and considerable tenacity. We believe that general practitioners should be able to avoid this commitment by obtaining sterile packs from the central sterile supply department in their area, at a reasonable charge. Regrettably, this is easier to say than to arrange. We are currently pursuing the possibility of establishing a sterile tray service for general practitioners in our area.

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Reference

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Side effects of influenza vaccination

Sir,
We previously reported on the nature and frequency of side effects from the influenza vaccine among our patients in the 1990 influenza vaccination programme.¹ The questionnaire was repeated for the 1991 programme and a total of 150 questionnaires were sent out.

Of the 82 patients receiving the influenza vaccine who replied to the questionnaire (55% response rate), 55 (67%) reported no side effects. Seven patients indicated that symptoms lasted for less than 24 hours, four for between one and three days, and two patients indicated that symptoms lasted for more than three days. The remaining 14 patients reporting side effects did not indicate how long their symptoms lasted. The symptoms reported included pain and swelling at the injection site (27 patients), headache (six patients), feeling 'achy' (five patients) and vomiting (one patient). One patient reported a recurrence of his gout. No patients reported a high temperature. Patients were asked if they subsequently developed influenza despite having had the vaccination; 75.6% of patients reported that they did not.

In both 1990 and 1991 approximately two thirds of patients reported no side effects. Of those who did, the majority of side effects were short lived and shorter than the duration of clinical influenza. Once again local reaction at the site of injection was the main complaint. It would be interesting to know how many patients would report a local reaction following an injection of placebo. The recurrence of gout has been noticed by Young;² it would appear that there may be an association in certain patients.

Ashton comments that 'patients' previous experience with the vaccine is a noticeable hindrance to good uptake rate.³ There are at present little data on this problem.⁴ As general practitioners are giving this vaccine to so many people,

and have a pecuniary interest in doing so, it is important to show we are not doing harm. In view of the costs in terms of time and money involved, it is important to show that we are doing some good.

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Screening elderly people

Sir,

One of the reasons for considering screening elderly people to be worthwhile is that it may reveal previously undiagnosed problems in those screened. This may result in an increased uptake of medical services.^{1,2} However, as those patients aged over 75 years come to have their second annual check, it seems likely that the scope for identifying problems will be diminished.

Of the 175 patients over 75 years old in a single handed practice who had an annual check in the first year of the new contract, 154 patients were reviewed in the second year, 21 patients having died or moved away. Table 1 shows the problems identified during the course of the year through normal, patient-initiated consultations, and at the time of the second annual check.

It would appear that patients in this age group are quite capable of presenting to the doctor with conditions requiring a new diagnosis (21 patients) but a small number of new diagnoses were also made at the second annual check (seven patients). In four of these seven cases the diagnosis was hypertension. Measuring blood pressure is not a requirement of the annual check for elderly people, but in view of the recent research on the benefit of treating hypertension in elderly people this may be a worthwhile exercise.³

Of the 154 patients having a second annual check, either in the surgery or at home, 63 had problems requiring action. It is difficult to equate this with benefit

Table 1. Problems requiring action identified among the 154 patients aged over 75 years.

	No. of patients with problem:	
	Identified during normal consultations	Identified at the second annual check
New diagnoses	21	7
Deteriorating mobility	4	0
Deteriorating mental function	5	0
Needed to be moved to residential home as unable to cope	2	1
Increased medication required	6	9
Treatment no longer needed	0	4
Needed to be registered blind	1	0
Needed to be registered partially sighted	1	1
Referral for hearing aid needed	1	5
Vaccination required	0	12
Referral to optician needed	0	4
Ear needed to be syringed	0	9
Referral to ophthalmologist needed	0	4
Referral to social services needed	0	2
Letter to other agencies required	0	2
Referral for surgery needed	0	3
Total	41	63

to patients, but it seems that problems with vision and hearing are more likely to be identified at the annual check than to be presented by patients during normal surgeries. Conversely, it seems that deteriorating mobility and mental function are more likely to be presented to the doctor during normal consultations.

These results indicate that a change in emphasis could be beneficial for the second and subsequent annual checks for those aged over 75 years.

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Treating candidiasis in community child health clinics

Sir,

Colonization with candida is common in infancy, one study reporting 82% of infants aged four weeks being colonized.¹ It is therefore not surprising that many babies require treatment for candida infections.

I would like to report a study of the in-

cidence and treatment of candidiasis in two community child health clinics in South Sefton, Merseyside. Both study clinics were in areas of high socio-economic deprivation (underprivileged area scores of 15, 23 and 45 for the wards covered).

Three clinics were held each week, two with the same doctor and one without a doctor. Treatment was prescribed and dispensed by the doctor when she was available, according to an agreed district policy. If a doctor was not available, the child was referred by the health visitor to the general practitioner for treatment. For this study, any child with clinical candidiasis not receiving appropriate treatment at the time of attendance was included. Children already receiving treatment were not included. Cases were collected prospectively for 13 weeks between September and November 1991.

There were 912 attendances during the study period and 399 were seen by the doctor. A total of 83 cases of candidiasis were seen in 73 children. All except two of the children were under one year old. Of the 83 cases, 42 (51%) were cases of perineal candidiasis only, nine (11%) were of oral candidiasis only and 32 (39%) were of both. Thus, there were 41 occurrences of oral candida infection and 74 occurrences of perineal infection. One child also had a facial infection.

Parents recognized candida infection in 33 of the 115 occurrences (29%). They recognized 16 occurrences of oral candidiasis (39%) compared with 17 occurrences of perineal candidiasis (23%). Reasons parents gave for attending the clinics were as follows: weighing (32), candidiasis (20), child health surveillance (16),