

citizens' advice in general practice since October 1992. Four practices, including our own, were selected, and a citizens' advice bureau worker has attended our surgery twice a week, available for consultation for approximately 11 hours each week. In our practice although initial interest was low, use of the service increased from six consultations (eight enquiries) in November 1992 to 46 consultations (111 enquiries) in April 1993. Anyone living within our practice boundary, even if not registered with us, may attend. Employment, family and personal issues, tax and debt enquiries tend to predominate. Audit shows that 20% of enquiries are repeat enquiries, indicating users are keen to bring further details to the citizens' advice bureau adviser, which is a strong demonstration of consumer satisfaction. We hope that the service will continue to be funded, because of its valuable contribution to the work of our primary health care team.

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Traveller Gypsies and childhood immunization

Sir,

The paper about immunization levels in Traveller Gypsy children recommended outreach services to caravan sites (*July Journal*, p.281). In the Newry and Mourne Unit of Management, Northern Ireland an onsite clinic was established in a local traveller community in 1989. This provides a weekly clinic run by health visitors and a monthly clinic run by a senior clinical medical officer. It is estimated that 20% of the children attending this clinic have medical/developmental problems which may affect their future potential.

Since the clinic was set up immunization uptake rates have improved considerably. In May 1992, the primary immunization uptake rates of traveller children were compared with children in the settled community. It was found that 100% of the 35 traveller children and 96% of the 28 560

children in the settled community had received their diphtheria/tetanus/polio immunization, 64% and 90%, respectively, had had their whooping cough immunization, and 100% and 95%, respectively, had had their measles/ mumps/rubella immunization.

These figures show that it is possible to increase the uptake of immunization in the traveller community by modifying services to take account of their special circumstances.

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Endometrial sampling

Sir,

Increasing numbers of women receive hormone replacement therapy from their general practitioner (Scottish Medicines Resource Centre, 1991). Irregular bleeding can occur with hormone replacement therapy and current advice on management of this is vague: 'If bleeding is obviously associated with poor compliance, antibiotic therapy or gastrointestinal upset no investigation is required. If more serious causes are suspected then an endometrial biopsy... is required.'² It is uncertain upon what basis such suspicions can be objectively founded. Endometrial sampling by the general practitioner would quickly resolve any uncertainty about endometrial cancer. A study was carried out in general practice to determine if endometrial sampling by the general practitioner was acceptable to the woman, the general practitioner, the gynaecologist and the pathologist.

The study involved three general practitioners based in three different surgeries. In two surgeries, the technique was already being used. One author (D G) was based in the third. Asymptomatic women receiving hormone replacement therapy were chosen as the study group; 33 women were invited for endometrial sampling. The samples were intended to be taken in the week prior to menstruation although this was not possible in every case. Two contiguous 10 minute appointments were booked for each patient and the practice nurse assisted in the second part of the double appointment. The details of the procedure have been reported elsewhere.¹ After sampling, each woman was given a questionnaire to complete.

Samples of the endometrium were obtained from 28 women. The procedure did not have to be abandoned because of reported pain in any woman, although in four women it proved impossible to negotiate the cervix. For one woman, no material was obtained in the sample, indicating that the uterus had no significant pathology. Histological findings were: secretory endometrium 22 women, proliferative endometrium three women, atrophic endometrium two women and endometrial hyperplasia one woman.

The 28 women from whom a sample was obtained stated that they would undergo the procedure again if it was thought necessary.

The procedure is already routinely used in the outpatient department at the local district hospital to investigate abnormal vaginal bleeding. The reservations which may be expressed concerning use of the device by general practitioners would centre around the competence of those performing the procedure. The general practitioners in this study were taught the technique by a gynaecologist. It was easy to learn and was less technically demanding than the insertion of an intrauterine contraceptive device.

The management of women with abnormal vaginal bleeding has traditionally been undertaken by the hospital consultant and has relied on examination under anaesthesia and dilatation and curettage. The introduction of endometrial sampling procedures provides an opportunity for the general practitioner to investigate these women.

Access to endometrial sampling can only contribute to the early diagnosis of endometrial abnormalities. The study identified one case of endometrial hyperplasia in a healthy, asymptomatic woman taking conjugated oestrogens, with progestogen. It has been claimed that combined hormone replacement therapy reverses endometrial hyperplasia.³

It would appear from the results of this study that appropriately trained general practitioners could offer endometrial sampling to women with postmenopausal bleeding or who are taking hormone replacement therapy and have irregular bleeding. To our knowledge this is the first study demonstrating the applicability of the technique in the general practice situation.

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Vaginal speculum examination

Sir,

For several years I have been using a technique to make passing a vaginal speculum easier for patient and doctor. I have yet to find another doctor or nurse who uses this technique. It may be of help and interest to readers.

When explaining to the woman what I am going to do, I tell her that I will ask her to squeeze 'down below' around the end of the speculum (suitably warmed and lubricated) as soon as I have introduced it gently into the entrance of the vagina. Immediately after the squeeze, the vaginal muscles relax and the speculum slips in easily. When the speculum meets any resistance, I ask again for a squeeze and as many more as needed to pass the speculum to the required position in the vagina. Almost all the women who have done this have been relieved and say how much easier this technique is compared with 'the usual discomfort'.

In an intrusive procedure like passing a vaginal speculum, any method to reduce unpleasantness and therefore enhance the doctor/nurse-patient relationship is useful.

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***Tinea capitis*: a novel mode of transmission**

Sir,

We have become aware of a new means of spread of *tinea capitis* among young and teenage boys.

A five-year-old boy presented with multiple areas of alopecia over the back of the head, within the shaved area of his hairstyle. Culture of plucked broken hairs from the affected area grew *Microsporum canis*, and the infection cleared following a six week course of oral griseofulvin.

We are seeing an increasing number of children with *tinea capitis* associated with the current trend for shaved hairstyles. It appears that the same razor may be used for many children (particularly, if the hair-styling is done by amateurs). Awareness

of the need for adequate disinfection of such razors is imperative, in order to prevent an epidemic of *tinea capitis* among the fashion conscious.

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Asthma and computer games

Sir,

There have been reports in the media of certain computer games triggering epileptic seizures and some games even carry a health warning to this effect. However, I report a case of a 10-year-old girl who developed an acute asthma attack while engaged in a computer battle game.

The girl suffered from mild asthma with infrequent episodes of wheeze on maintenance therapy of inhaled beclomethasone dipropionate 100 µg twice daily. She had been well for over 18 months with no clinically significant wheezing. On this occasion she had been staying at a friend's house for two days. She was playing on a computer game for 20 minutes when she had to stop because of acute breathlessness and wheezing. She was unable to speak and required her salbutamol inhaler. She was fully recovered after two hours but felt anxious about re-engaging in the computer game. There were no other factors to account for this exacerbation of her asthma.

The effects of intense concentration and excitement induced by sophisticated and challenging computer software is analogous to the fight or flight response. The triggering of an asthma attack may be an inevitable consequence in certain sensitive individuals who may be advised to take prophylactic bronchodilator therapy before playing certain computer games.

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Identifying asthmatic patients

Sir,

In the paper by Sue Ross and colleagues (June *Journal*, p.236) I note that at no time was the consent of the patients concerned sought before their names and addresses were passed on to a third party.

The general practitioners' consent is immaterial. The Pharmacy Practice Division in Edinburgh would appear to be in breach of its duty of confidentiality as well as its duty under the data protection act as the data was stored on computer.

The general practitioners concerned would also seem to be in breach of their duty of confidentiality by passing on information about clearly identified patients without their consent.

These views were confirmed by the Medical Protection Society when, as a member of an ethics committee, I was presented with a similar problem.

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Sir,

The letter written by Dr Scriven in response to our recent paper contains some inaccuracies, particularly with reference to the Pharmacy Practice Division of the Common Services Agency of the National Health Service in Scotland. The division has a strict code of confidentiality, to which it adheres rigorously. Prior to the release of any data, researchers must provide full details of any study they are undertaking. In our study, we used GP10 forms to identify possible asthmatic patients in two health board areas of Scotland. The Pharmacy Practice Division gave us access to prescription forms (GP10 forms) only when the general practitioner had given written permission for us to access their forms for the purpose of the study. The Pharmacy Practice Division database contains no patient information, although it does contain data identifying individual prescriptions. These data may be used for medical research, in accordance with the data protection act.

Once possible asthma patients had been identified, we wrote to each general practitioner in the study with the list of names and addresses, asking the general practitioners to verify that the patients had asthma, were within the desired age range and had not attended an outpatient clinic for asthma in the past 12 months. Once the general practitioner agreed that we could do so, we sent each patient a questionnaire about their asthma. Several general practitioners who thought it necessary contacted each patient before returning the verified list of names to us.

After the general practitioner had given consent for us to contact the patients, the patients could give their own consent (or not) to the study by replying to the questionnaire. When contacting patients, we clearly explained how we had obtained