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Distance learning package for eye disease

Sir,

One in 14 people consults a doctor with an eye problem each year, two thirds of these consultations being in general practice, accounting for 1.5% of all general practice consultations.^{1,2} There is evidence that the general practice management of eye problems could be improved.³⁻⁵

Our aim was to develop a distance learning package related to eye disease for general practitioners and to evaluate its effectiveness. The package, consisting of videotape material to demonstrate clinical method and physical signs, and an accompanying book concentrating on facts, knowledge and reference material, was developed following an audit of eye problems in 13 general practices. General practitioners and an ophthalmologist developed a consensus of desired knowledge and management patterns for general practitioners. After piloting, the final package was offered to all general practitioners in Wales, outcome measures being knowledge change for each topic covered and a change in theoretical patient management.

A total of 270 Welsh general practitioners (15.6%) enrolled for the distance learning package, of whom 203 (75.2%) completed the course. There was a marked increase in knowledge: mean mark of 54.4% among 270 respondents answering questions before the course compared with a mean mark of 85.5% among 203 respondents afterwards (paired *t*-test, $P < 0.01$). Knowledge increased for all six clinical topics: glaucoma, squint, visual problems, wet/dry eyes, acute red eye and ophthalmoscopy. Mean percentage of participants answering questions correctly on glaucoma and squint are shown in Table 1, as examples. There was a significant improvement in theoretical patient management decisions, the mean mark among respondents rising from 66.2% to 78.6% (paired *t*-test, $P < 0.01$). These results were sustained at two months.

The package seems to have been successful because it was related to real need, and because it was available in a format which suited the learner. This conflicts

with Rosenthal's statement that general practitioners will need to be kept up to date with the technological advances in ophthalmology, this education being the responsibility of ophthalmologists.⁵ The study has shown that knowledge and skills need to be wider than this, encompassing common and important problems and should respond to the identified needs of general practitioners.

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Exercise on prescription

Sir,

Everyone agrees that exercise is good for people. It reduces the risk of stroke,¹ coronary heart disease² and osteoporosis³ and is beneficial in many other conditions. Advice from general practitioners can influence exercise habits,⁴ but doubts have been expressed about schemes that prescribe exercise.⁵ There are several schemes operating around the United Kingdom such as the Oasis leisure centre project in Hailsham and Pals (practice activity and leisure scheme) in Kirklees. Most exercise sessions take place in leisure centres; such sessions are usually enthusiastically welcomed by the leisure centres because they bring people in at times when business is normally slack. For many people, however, the mention of a leisure centre brings visions of slim bodies and crowded changing rooms, which may put off the very people such schemes are hoping to reach. In addition, transport is often a problem, especially in rural areas where it may be many miles to the nearest leisure centre.

In the summer of 1994 an exercise scheme was started in South Mofton. It has proved to be popular, was easy to set

Table 1. Proportion of respondents answering questions on glaucoma and squint correctly before and after the distance learning course.

Topic	Mean % of GPs answering each question correctly	
	Before course (n = 270)	After course (n = 203)
<i>Glaucoma questions</i>		
A	52.2	85.2
B	68.5	89.2**
C	78.1	90.1**
D	62.2	93.1**
<i>Squint questions</i>		
A	33.3	91.6**
B	75.9	93.1**
C	27.8	62.1**
D	50.7	94.1**

Paired *t*-test: ** $P < 0.01$.

up, and could be reproduced anywhere. Patients are recruited from three practices and the exercise sessions take place in the gymnasium of the local community college. Patients pay the cost of one prescription, which entitles them to 10 exercise sessions. Sessions are run on weekday evenings by a trained fitness adviser, who is advised by the referring general practitioner of the indication for exercise, and given any relevant medical information. No age limit is set on participation, and conditions referred range from patients with coronary heart disease and obesity to patients with anxiety and depression.

Two courses have now been completed and a third is oversubscribed. The drop-out rate so far is five out of 75 patients referred. Post-course questionnaires have shown high levels of satisfaction. For example, respondents highlighted areas in which the scheme had helped: weight loss, having been helped socially, stress relief, better awareness of body shape, improved strength, and reports that the course had been educational. Most encouraging is that a group of patients who have completed the course continue to meet for exercise, having hired the gymnasium and the fitness adviser themselves.

This scheme has aroused considerable interest in the community, and has been reported in the local media. We commend it to others.

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Diagnostic delay in appendicitis

Sir,

Perforation of the appendix is common in young children, the main contributing factor being diagnostic delay owing to non-specificity of symptoms or signs.¹ A retrospective study was undertaken to determine how often general practitioners contribute to delayed diagnosis in young children with acute appendicitis, and the consequences of such delay.

The hospital records of all 100 cases of clinically suspected appendicitis in preschool children (aged five years or less) in the greater Belfast area from 1985 to 1992 were reviewed. Acute appendicitis was confirmed histologically in 81 children. Fifty eight patients were assessed by a general practitioner; appendicitis was suspected in 39 children at the first consultation and these children were referred for surgical opinion, the diagnosis being confirmed in 36 (92%). Of the 19 children not referred initially for a surgical opinion, five were reviewed by the general practitioner within 24 hours then sent for surgical opinion and appendicitis being correctly diagnosed in four. Five of the cases not referred initially were admitted to the regional infectious diseases unit with suspected gastroenteritis, of whom two had simple appendicitis and three had appendiceal perforation. All of the remaining nine children were 'self-referred' to hospital; three had appendicitis and one had appendiceal perforation.

Appendiceal perforation was found in 35 of the 100 cases. The greatest contributing factor was considered to be diagnostic delay as this was the only significant difference found between the groups with and without appendiceal perforation. The mean duration from onset of symptoms to surgery in the group with appendiceal perforation was 77 hours compared with 45 hours in the group of 46 children without appendiceal perforation (chi square = 4.3, 1 degree of freedom $P < 0.05$). In 19 cases where delay was attributable to the general practitioner, symptoms or signs were non-specific: diarrhoea (10 cases), dysuria (four), respiratory infection (two), constipation (two) and tonsillitis (one). In this group, four (21%) had perforated appendicitis compared with 49% of the 39 children referred following the initial consultation.

The population of greater Belfast is served by 314 general practitioner principals (Eastern Health and Social Services Board statistical data, 1990). Thus a general practitioner would expect to encounter a case of preschool appendicitis once in 27 years.

General practitioners do not contribute unnecessarily to the high rate of appendiceal perforation in young children and, indeed, given the low incidence of the condition in this age group, diagnostic accuracy was high. However, it should be noted that nine children were 'self-referred' to hospital after being assessed by a general practitioner and it seems that the traditional dictum of early reassessment of cases of abdominal pain in this age group not referred to hospital was not observed. We would reinforce the wisdom of the principle of reassessment.

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Urban community hospitals

Sir,

Acute medical admissions to hospital are increasing (by 13% per year in Exeter, unpublished data). Surveys suggest that up to 16% of these admissions do not require the additional resources available in a district general hospital.^{1,2} One proposed solution is to use community hospitals for this group of patients. The presence of a rural community hospital has been linked with decreased admissions to an acute hospital,³ but this may reflect the type of general practitioner who practises in such an area. Indeed, an experimental urban community hospital had little success in attracting general practitioners to use it.^{4,5} Therefore, before an urban community hospital is established in an area which has never before had such a hospital it is important to determine general practitioners' opinions.

All general practitioners practising in Exeter were surveyed to assess their views about an urban community hospital and to examine whether it was a realistic solution to relieving pressure on district general hospital beds. Questions were asked about interest in a community hospital and categories of patients suitable for the hospital.

In June 1994, 76 questionnaires were sent of which 72 were returned (95%). Of general practitioners, 49% were very or moderately interested in having a community hospital, 17% were neutral, and 35%