Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Examinations

I have just read Neville Goodman's critique of current trends in examinations (March *Journal*),[1] and have been reminded of the unhelpful attitude of the teachers who saw me through my first months as a clinical medical student. Having recently become a member of the College, the difficulties candidates face in MCQ papers are all too clear in my mind, and I find myself angered by his opinion because I feel that he is missing the point.

He asks if anyone claims not to understand his statement about the weather. I understand how I interpret it. Because I am usually a cautious sort of chap, I would probably take an umbrella with me from 8 am onwards, in case the rain comes earlier than expected; after all, 'before lunchtime' might mean 9 am. When I'm out, though, I may bump into a friend of mine. He is only out to get a paper and saw that the rain wouldn't start until about 12.30, so he would definitely take an umbrella to lunch but for now he's happy in his shirt sleeves. The worst that could happen is that he'd get a bit damp.

The difference between my friend and I is not that I am a 'better' pedestrian than he (or vice versa) but that we come to different conclusions when faced with the same indication of risk. This can be extrapolated to the example the author gives regarding pulmonary embolism. My friend and I both know that haemoptysis *can* occur in pulmonary embolism, just as we knew it could have rained at 9 am. When a patient comes with haemoptysis (with or without other symptoms that may alter the immediate plan) I may choose to refer for a V/Q scan while my friend takes some other course of action. In that situation, it makes no difference how common a symptom is in a given condition. As long as we have both considered the diagnosis, we have served our patient well.

What, then, does this tell us about examinations? It depends what the examination is setting out to achieve. If the examiners will pass those who have learned the frequencies of all symptoms in all illnesses, then it is a perfectly reasonable question to ask about 'common' symptoms. If, however, the examiners want to discover those who will consider the diagnosis, the term 'recognised feature' becomes appropriate. The argument that there is then no distinction between this and 'Chest pain is a recognised feature of pulmonary embolism' says more about the MCQ as an examination tool than about the candidate sitting the exam.

The example of his question dealing with fluid therapy after burns brings back unpleasant memories of sitting in exam halls, nervous and afraid of failure, trying to second-guess what the examiner is thinking. The problem in answering the question correctly is not one of rigid thinking on the candidate's part. It is that a question like this induces immediate dysphoria, because, knowing the 'rule of 9s', I would expect this to be a mark in my favour. The way it has been asked, however, given that I do not know the examiner, makes it no more likely I will get the answer right than if I were to guess it. In MRCGP, I would be left dissatisfied with what felt like a stolen mark. In other (negatively marked) exams, I would almost certainly have left it blank — more a test of my confidence than my knowledge.

As examinations and revalidation are to become more and more part of our everyday lives, it would be disastrous if poor planning led to mistakes of this kind. Examiners must have clear ideas of what they are trying to assess and then build the question carefully. This has to mean that a normal human being, thinking the way normal human beings do, answers the question to give the examiner a true idea as to whether the standard has been achieved.

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Which method of communication do general practitioners prefer to use?

The advent of e-mail, and the opportunities for professional communication by the Internet and an NHS intranet, can be viewed as an opportunity to save time or as an additional strain on busy practitioners.[1] We report brief findings of a survey to explore which method GPs prefer for different professional scenarios. We used a predetermined random numbers sequence to select GPs from the UK General Medical Register (GMR) and allocated 20 to each of four groups: postal questionnaire, fax questionnaire, telephone survey, and e-mail questionnaire. GPs were asked to state their preferred medium for receiving information about an individual patient discharge summary, important drug information, e.g. pill safety, and an advert for a postgraduate course. There were so few e-mail addresses listed in the GMR that a group of GPs known to have e-mail addresses (members of the General Practitioners in Asthma Group) were selected with 20 chosen at random to form an e-mail questionnaire group. No attempt was made to chase up late or non-responders.[2]

Ten out of the 20 (50%) in the letter group responded within a six-week period, 12 out of 20 (60%) in the telephone group, 13 out of 20 (65%) in the fax group (four of the faxed questionnaires were sent back by post), and two out of 20 (10%) in the e-mail group. Letter responses were complete within one week, and one fax response was returned within one hour, but the remainder took up to three weeks to be returned. Telephone responses were either immediate or during the next day if participants opted for the researcher to telephone at a convenient time.[3] E-mail responses were returned within days.

For Patient Discharge Summaries, 29

(78.4%) of 37 responders preferred letter, none telephone notification, nine (24.3%) fax, and one (2.7%) e-mail. For Important Drug Information, 14 (37.8%) of 37 responders preferred letter, none telephone notification, 26 (70.3%) fax, and none e-mail. For an advert for a postgraduate course, 35 (94.6%) of 37 responders preferred letter, none telephone notification, one (2.7%) fax, and one (2.7%) e-mail. In keeping with other work, response rates were low — GPs are showing 'communication fatigue'.[4]

Not all GPs have faxes, which creates a problem for disseminating urgent messages, e.g. meningitis alerts or drug safety information. E-mail is not yet widespread and not yet trusted by GPs; these concerns need to be addressed in time for the introduction of the NHS Intranet. Letter remains the popular choice for patient discharge information, perhaps because it can be filed.

Several responders stated they would use e-mail given a choice. E-mail users encountered difficulty with receiving and sending e-mail, which could be attributed to technical reasons or to unfamiliarity with the medium. The opportunities and pitfalls of e-mail communication need to be addressed.[5,6] The experience of selected GPs who routinely use e-mail for professional purposes may prove valuable in assisting the NHS move from paper to electronic communication.

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(Un)deserving male impotence

The National Health Service (NHS) Executive regulations on sildenafil and its use in the treatment of impotence[1-4] are due for review. It is therefore timely to highlight that there is still confusion and uncertainty surrounding their introduction, particularly the premise on which the recommendations appear to be based; namely, deserving and undeserving forms of erectile dysfunction (ED).[5] The alternative is to continue with a recipe for bad medical practice and potential medicolegal entanglements.

Patients who do not have the medical conditions for which impotence treatment is provided on the NHS[3] must pay for drug treatment on private prescription. There is little clinical justification for such 'medicalisation'; vascular diseases, the most common organic factor in ED, are excluded, and many would dispute whether poliomyelitis, Parkinson's disease, or single-gene neurological disease actually cause ED.

Health Service Circular 148[3] included an exemption category for patients who were receiving other NHS therapy for ED prior to 14 September 1998. Do we still conclude that excluded patients will need to pay for expensive long-term treatment simply because they were on long hospital waiting lists or had unsupportive doctors? Will GPs still be expected to arbitrate on any gaps in therapy and rule on who is disqualified? In financial terms, this list made it advantageous to be diagnosed diabetic, or opt for prostatectomy rather than medical treatment, or choose inappropriate NHS psychosexual therapy, or request a surgical implant.

Specialists should not have to ask at the beginning of a consultation whether the patient can afford to pay. However, if they don't ask, time will be wasted and the patient's hopes may be built up, only to be later deflated. If patients are paying for ED treatment, how do clinicians deal with the dilemma that some medical therapies, such as sildenafil, may be half the price of injection therapy and intra-urethral therapy?

There are other unsatisfactory elements for GPs in the current recommendations, including the judgement of whether patients 'need' sex more than once a week. In addition, the concept of 'severe distress' secondary to impotence[4] does not appear in published literature, nor does the observation that ED treatment may be less expensive than antidepressant therapy.

Finally, the hospital review process remains unclear. What happens when the patient responds well to ED therapy and there is no more severe distress? Do we stop therapy until severe distress returns or continue hospital-based review and medication of contented men for life? Let us hope the review process introduces a modicum of common sense.

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Patient-held cancer records

The important study by Drury *et al* (February *Journal*)[1] is a disappointment to those of us engaged in giving patient-held records to patients with cancer. Their properly conducted randomised controlled trial shows that for patients receiving radiotherapy a patient-held record confers no significant benefit or harm, as measured by several measures of patient health and satisfaction. Before we abandon the patient-held record in cancer patients we should therefore consider three points.

First, the authors themselves make the point that their patients were relatively well. Specifically, outcomes were not measured in those who died nor in those considered too ill to be sent a questionnaire. They may thereby have excluded from their study the very patients most likely to benefit, since the terminal stage may well prove to be the time when the record is most useful.

Secondly, the outcomes measured were all patient-centred. One function of a patient-held record is to facilitate commu-

nication between clinicians. Had the clinicians been asked about their communications with each other, positive outcomes might have been observed. An uncontrolled study from Ayrshire and Arran[2] found that 95% of clinicians thought the record was useful.

Thirdly, not all patient-held records are the same. The authors used an A4-sized wallet containing communication/diary sheets and pages for appointments, medication, and addresses and telephone numbers. This does not sound as likely to empower the patient as the National Cancer Alliance Personal Information File,[3] which has aids to assist the patient to talk to professionals, nor as easy to carry around as the Sussex Patient-Held Record, which we use and is smaller than A5 size.

It is too early, therefore, to abandon the patient-held record in cancer, although the study from Oxford puts the onus on those of us who do use it to demonstrate its value.

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Withdrawal syndrome after long-term treatment with tramadol

Tramadol hydrochloride is a synthetic opioid analgesic with a selective activity at the μ receptors. In addition to its activity on opioid receptors, it also inhibits noradrenaline and serotonin reuptake, which contributes to its analgesic effect.[1] As an analgesic, it is effective in the treatment of moderate-to-severe acute or chronic pain; it is currently used in postoperative and gynaecologic pain as well as pain of other origins, including cancer.[2]

Severe side-effects have been described for tramadol.[3] We present the first case of a withdrawal syndrome presumably associated with this drug as reported to the Spanish Pharmacovigilance System.

A 60-year-old women, weighing 70 kg, started a treatment of tramadol 150 mg t.b.d after a painful shoulder. She kept this regime for seven months. Following treatment discontinuation, she developed an increase in her libido, insomnia, panic attacks, pallor, and abdominal discomfort. She experienced no relief with tranquillisers. Her symptoms disappeared when she restarted the treatment (her own decision). Afterwards, the dose was progressively reduced to complete discontinuation after three weeks, with no further symptoms being observed.

The causal relationship between tramadol intake and withdrawal syndrome was suspected in view of the temporal sequence of drug administration and manifestations, the existence of symptoms characteristic of opiate withdrawal, and their disappearance following the treatment restarting.

Tramadol was introduced to the Spanish market in 1992. Between then and 1998, its consumption increased from 2.1 to 570.6 daily defined doses per 1 000 000 inhabitants per day.[4] At the moment, this drug, together with dihydrocodeine and dextropropoxyphene, is the only opioid not requiring a special prescription form and, probably owing to this fact, the opioid with the highest sale figures. The consumption data are similar to those of other European countries.[5] We have conducted a literature search from 1988 onwards (Medline, Iowa Drug Information System) and, as far as we know, very few cases of withdrawal syndrome following tramadol discontinuation have been reported.[6,7] The non-restricted sale of the drug, its dramatic widespread use, and the possibility of potential abuse stress the importance of the case described. In addition, it is likely that not every person using tramadol is aware of its opioid nature.

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The leap forward

Your editorial, 'Waiting for the Great Leap Forward' (March *Journal*),[1] encompasses such a host of the past, present, and future that I find it hard to control my opinionated and argumentative response.

After years of believing that editors were filling their waste paper baskets with our irrelevant letters, I now take it that what we read in your correspondence columns are an average cross-section of opinions. Their seriousness I took for granted as being the aura of academia, so that anything not conforming to a John Knox Presbyterian work ethic was considered taboo. Now your editorial destroys this myth by moving the stereotype on to the authors themselves. In the rebirth of the *Journal* into a delightfully professional presentation, the one thing you have been unable to change are your contributors; so the final measure of perceived success comes down to quality of content.

The *BMJ* correspondence columns used to mirror your description 'GPs in the UK — a wonderfully disparate lot'. Where are these views now? Certainly not in our journal, where the pall of unrelenting endeavour gives the impression of a conformity to convince others of our worth. Decades ago we battled with this attitude — are we not grown up enough now to relax and allow our scientific journal a little more elbow room?

'There's nothing there for the ordinary GP' not only rings out in Princes Gate but also out here with the rank and file. You highlight the language of science as making some articles impenetrable and this is where your realistic leader fills me with hope. The paper by Sheikh and Hurwitz (March *Journal*)[2] is so very typical, where the reader at once finds something of real interest, only to find a mass of statistics destroying enjoyment and masking the message. Good research and satisfying the academic establishment, while still stimulating a wide readership, is a challenge that to date has eluded us. If the *Journal* online clears away the 'data sludge' — your words — then I believe the future can satisfy all our needs. Add an online bulletin board for views and opinions and the way ahead really does look inviting; but for many of us only if we can rediscover those 'opinionated, talented, argumentative, conciliatory, and bloody-minded' absentee colleagues who must be out there somewhere.

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Stopping antihypertensive drugs in general practice

I wish to comment on the withdrawal of antihypertensive drugs study conducted by Aylett *et al* (December *Journal*).[1] As the authors have stated, mild to moderate hypertension is a risk factor almost entirely managed in general practice. It is therefore important that research be carried out in this population with a pragmatic approach that gives both generalisable results and can, more importantly, be sold to the GPs themselves.

I have concern, however, about the 22% success rate. While this is comparable to most studies of this type conducted, I think that it may overstate the actual rate in this particular study.[2] The numerator is overstated because successful withdrawal of medication should not include subjects who have returned to hypertension but remain untreated. This is not a clinical success. The denominator should also be 224 not 196, as loss to follow-up should not have excluded these subjects. There is a real concern about drug withdrawal, with or without loss to follow-up, as an exposure to medicolegal risk if a cardiovascular event should occur.

While this study is unlikely to have the power to demonstrate differences in cardiovascular event rates between the groups, it would have been useful to provide comparative data for the 499 who did not enter the study or between those who returned to medication and those who did not.

Without a statistical test, it is difficult to comment about predictors. However, with the provision of baseline characteristics of the study population and where an effect was suggested by gender, male and female baseline characteristics would have allowed us to judge if the groups were comparable or if the effect could have been explained by a confounder such as age. Even though this study has failed to demonstrate it, many studies have found polypharmacy versus monotherapy to be a predictor of lower success of maintenance of normotension.[3-7]

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In response to the article by Aylett *et al* (December *Journal*),[1] we would recommend that more research is carried out on the Omron device that has been recommended for use in primary care. Previously, O'Brien *et al*[2] demonstrated that the Omron device was accurate within a secondary care research setting. The paper by Aylett *et al* makes the assumption

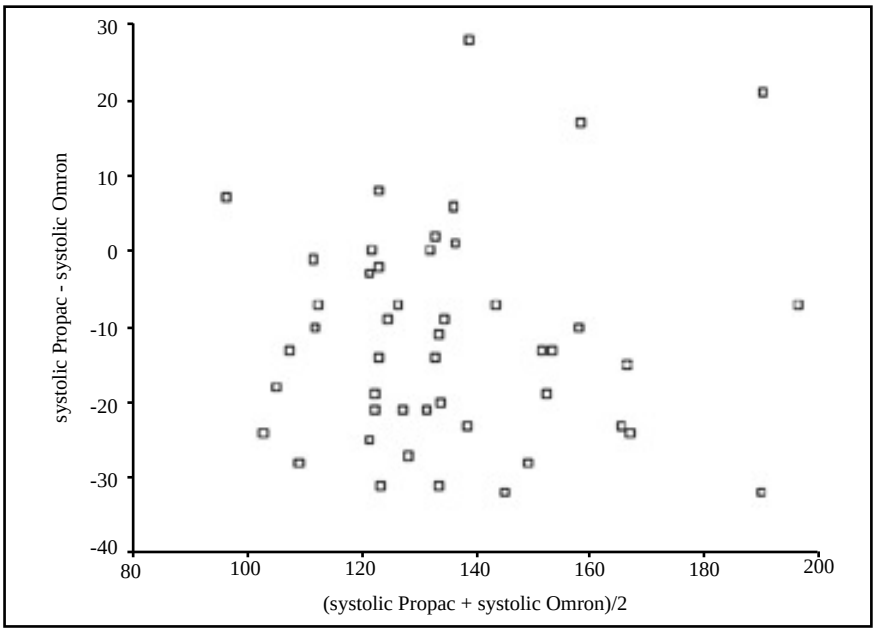

Figure 1. Limits of agreement = 39.5 to –16.5, i.e. mean difference between devices (11.5) ±(2 standard deviations) (-28.0).

that we can rely on the measurements recorded by patients themselves and stored in the Omron device's memory. Our experience within a pilot telemedicine project[3] showed that patients found the application of the Omron device at home difficult and that they often took multiple readings until one that fitted their expectation was achieved. The 'Y-tube' comparison can only act as a validation of the accuracy of the device rather than a validation of the use of the device in its entirety in the field.

In a recent telemedicine pilot,[4] a study nurse compared the Omron blood pressure device with another blood pressure monitoring device. In this study, the Omron's blood pressure recording was being compared with that produced by a Propaq Encore Monitor Model 202EL (Protocol Systems Inc, Oregon, USA) device used commonly in intensive trauma units and other hospital settings. In this small pilot, we failed to show agreement between the devices and the limits of agreement[5] were outside those recommended by the British Hypertension Society.[6] Like O'Brien, we found that the Omron device over-read systolic blood pressure, as indicated by limits of agreement (Figure 1).

In a separate study,[7] we found that the Omron device was less accurate than an alternative automatic blood pressure measuring device, with its limits of agreement again being outside those recommended by the British Hypertension Society.

While we feel that self-measurement of blood pressure in the presence of white coat hypertension may be of enormous value, GPs should be cautious when rushing out to buy automatic devices. Before automatic devices are routinely adopted there needs to be further evaluation of the devices, particularly when they are self-applied by the elderly at home.

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Table 1. Background details of patients (n = 135) by counselling and usual general practitioner group. Figures are numbers (percentages) of patients.

	Counselling group	Routine general practice group
Accommodation	(n = 69)	(n = 66)
Rented accommodation	25 (36)	29 (44)
Owner/occupier	34 (49)	24 (36)
Other	10 (15)	13 (20)
Number in household	(n = 65)	(n = 59)
1 adult, no children	12 (19)	15 (25)
2 adults, no children	14 (22)	15 (25)
1 adult with child or children	12 (19)	9 (15)
2 adults with child or children	18 (28)	10 (17)
Other	9 (14)	10 (17)
Number of bedrooms	(n = 70)	(n = 66)
1 bedroom	7 (10)	13 (20)
2 bedrooms	25 (36)	16 (24)
3 or more bedrooms	38 (54)	37 (56)
Social security benefit	(n = 25)	(n = 29)
Income support	12 (52)	11 (38)
Income support plus rent or housing benefit	2 (9)	12 (41)
Disability, invalidity or sickness benefit	3 (13)	3 (10)
Other	6 (26)	3 (10)
Number of weeks on benefit	(n = 23)	(n = 28)
Less than 3 months	9 (39)	5 (18)
Between 3 and 12 months	6 (26)	9 (32)
More than 1 year	8 (35)	14 (50)

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Correction

In the April issue of the *Journal* we published an incorrect version of Table 1 in the paper by Karin Friedli, Michael B King and Margaret Lloyd, entitled 'The economics of employing a counsellor in general practice: analysis of data from a randomised controlled trial' (*Br J Gen Pract* 2000; **50:** 276-283). We apologise to the authors for the error and for any confusion this may have caused, and reproduce below the correct version of the table in full.