

My study, therefore, clearly demonstrates that the stethoscope is not a vector for MRSA in the community. This observation strongly suggests, but does not prove, that MRSA presents a problem in the UK that is confined to the hospital environment.

#### STUART SANDERS

General Practitioner  
22 Harmond House, 20 Harley Street,  
London W1G 9PH.  
E-mail: drsanders@msn.com

#### REFERENCES

1. Jevons, MP. 'Celbenin'-resistant staphylococci. *BMJ* 1961; **1**: 124–125.
2. Derbyshire D. Labour is to blame for superbugs, says Howard. *The Daily Telegraph*, 2 September 2004. <http://news.telegraph.co.uk/news/main.jhtml?xml=/news/2004/09/02/nmrsa02.xml> (accessed 6 Dec 2004).
3. Sanders S. The stethoscope and cross infection. *Br J Gen Pract* 2003; **53**: 971–972.
4. Smith MA, Mathewson JJ, Ulert IA, *et al*. Contaminated stethoscopes revisited. *Arch Intern Med* 1996; **156**(1): 82–84.

## C-reactive protein values in viral respiratory infections

We welcome the paper by Melbye *et al* on the course of C-reactive protein (CRP) response in upper respiratory tract infection.<sup>1</sup> It provides valuable insight, broken down by virus type. However, the design of the study may possibly limit the generalizability of its results.

From the title and the abstract we are tempted to believe that all episodes that were treated with an antibiotic, were excluded. However, it is not clear to us what the indication for antibiotic prescription was. In the methods section, we read that, 'subjects were excluded if a bacterial infection was suspected and antibiotics were prescribed'. The ambiguous word in this sentence seems to be 'and'. When patients were prescribed antibiotics, did the investigators verify that it was a bacterial infection or did they assume that the GP had thought this?

Without doubt, the authors are aware

of the fact that GPs frequently prescribe antibiotics for diseases of viral origin. The seriousness of the disease might well have played a role in the decision to prescribe antibiotics, indicating that those patients who were seriously ill were not included. Perceived patient preference is another reason. Further studies are needed that take a more comprehensive view on CRP in respiratory tract infections presented to general practice.

#### JOHANNES C VAN DER WOUDE

Senior Lecturer  
Department of General Practice, Erasmus  
Medical Centre, University Medical Center  
Rotterdam, Rotterdam, The Netherlands.  
E-mail: j.vanderwouden@erasmusmc.nl

#### MIRIAM MONTENY

#### MARJOLEIN Y BERGER

General Practitioner

#### REFERENCES

1. Melbye H, Hvidsten D, Holm A, *et al*. The course of C-reactive protein response in untreated upper respiratory tract infection. *Br J Gen Pract* 2004; **54**: 653–658.

## Author's response

We wanted to demonstrate the natural course of the C-reactive protein (CRP) response during viral respiratory infections, and none of the patients described in our study were treated with antibiotics.

Our material is, as van der Wouden *et al* comment on, not sufficiently representative of the upper respiratory tract infections we meet in general practice. The most severe viral infections may have been excluded, and we know from previous studies that CRP values above 100 mg/l may be found in influenza and adenovirus infections.<sup>1</sup> I agree with van der Wouden *et al* that more systematic research is needed in this field. However, some useful information may be obtained from our study.

The CRP response in viral respiratory infections has some typical features. The maximum CRP value is reached when the illness has lasted 2–4 days, and falls

rapidly over the following days. Values below 10 mg/l is the rule after 7–10 days in uncomplicated cases. These features have also been indicated by other studies.<sup>2,3</sup> This knowledge can be taken into consideration when results of the CRP test are interpreted in patients with acute cough or a flu-like illness.

#### HASSE MELBYE

Professor of General Practice  
University of Tromsø, Tromsø, Norway.  
E-mail: hasse.melbye@ism.uit.no

#### REFERENCES

1. Ruuskanen O, Putto A, Sarkkinen H, *et al*. C-reactive protein in respiratory virus infections. *J Pediatr* 1985; **107**(1): 97–100.
2. Whicher JT, Chambers RE, Higginson J, *et al*. Acute phase response of serum amyloid A protein and C reactive protein to the common cold and influenza. *J Clin Pathol* 1985; **38**(3): 312–316.
3. Melbye H, Straume B, Brox J. Laboratory tests for pneumonia in general practice: the diagnostic values depend on the duration of illness. *Scand J Prim Health Care* 1992; **10**(3): 234–240.

## Time to acknowledge the workings of the 80/20 principle?

Julian Tudor-Hart has devoted his life to demonstrating and exposing the inverse care law<sup>1–3</sup> and the rule of halves.<sup>4</sup> There is a part of me that shares his anger that such inequitable distributions exist and persist.

However, I wonder whether what Tudor-Hart has described in the medical context is actually another example of the Pareto principle of asymmetric rewards, popularly known as the 80/20 principle. We see multiple examples of this principle in action. For example:

- A university department that is doing well gets a better research assessment evaluation, and so more money with which to do better still.
- An author who has been published once is much more likely to be published again, even if new and better authors are emerging.
- Twenty per cent of patients will take up 80% of available appointments.
- A surgery with many settled and loyal