EPIDEMIC OBSERVATION UNIT

Sir,

The records kept by general practitioners in this, country contain a vast amount of extremely important information about the aetiology and natural history of disease. However, because each doctor usually sees only relatively few cases of any particular disease no total pattern can be seen from any one individual. The Epidemic Observation Unit is organising a network of practices which will provide useful data on the incidence of both infective and some non infective conditions. The morbidity patterns which appear will be correlated with several environmental influences, the importance of geological, geographical, climatic, and sociological factors will be assessed.

Each sentinel practice will be asked to keep a weekly record of 21 clearly defined common infective diseases, and to record on a monthly basis 21 non infective conditions. The table shows the diseases to be recorded. The number of diseases or syndromes which could be recorded profitably is almost infinite, but it was felt that at first simplicity should be the keynote of this project. To that effect a simple recording method has been devised and it is believed that the time required for recording is minimal. Generally, participating doctors will not be required to provide environmental data.

The information gathered will be used in several studies, the incidence of some infective conditions like measles, rubella and mumps will be used to check on the effectiveness of immunisation procedures, and correlations will be made between certain respiratory diseases and weather variables. A study of the non infective conditions will provide basic epidemic data and prevalence rates for many important diseases and when these are correlated with environmental factors. It is hoped that areas will be delineated which will be fruitful for more detailed prospective investigation into various causes of disease.

It is important to realise that often these morbidity studies can only come from general practice. Doctors engaged in teaching may find this research project a valuable way of illustrating to trainees basic practice research and data recording.

It is envisaged that this recording network should eventually be extended to our colleagues abroad, in this way comparable data from overseas may be used to check various environmental factors in any suggested disease aetiology. If your readers would like to find out more about this project they should write to me at the College.

PAUL R. GROB,
Honorary Secretary,
Epidemic Observation Unit.

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TABLE

DISEASES TO BE RECORDED WEEKLY

(Numbers refer to the College classification)

Disease	
5	Acute gastroenteritis
6	Scarlet fever
8	Whooping cough
11	Measles
12	Rubella
13	Chicken pox
14	Herpes Zoster
15	Mumps
16	Infective hepatitis
17	Infective mononucleosis *
183	Otitis media, acute
240	Common cold
242	Sore throat including tonsillitis
243	Sinusitis
242	Sore throat including tonsillitis
244	Laryngitis and tracheitis
245	Epidemic influenza
246	Pneumonia and pneumonitis
247	Acute bronchitis
251	Pleurisy
86	Acute asthmatic (a) infective episodes: (b) non infective
22	Scabies
*	Additional information required

DISEASES TO BE RECORDED MONTHLY

Disease	
156	Multiple sclerosis
181	Retrobulbar neuritis
9	Meningitis/encephalitis
211	Myocardial infarction (acute)
213	Carditis
155	Acute cerebrovascular accidents
67	Acute leukaemia
91	Acute onset diabetes
88	Thyrotoxicosis
89	Myxoedema
277	Gastric ulcer
278	Duodenal ulcer
282	Acute appendicitis
66	Hodgkins disease
405	Rheumatoid arthritis
350	Spontaneous abortion
431	Birth: CNS abnormalities *
AS	Attempted suicide *
S	Suicide *
464	Cot death *
3/4	Venereal disease *
*	Additional information required.

REHABILITATION

Sir,

As National Organiser of Rehabilitation Engineering Movement Advisory Panels (REMAP) I was very pleased that during a public meeting in Torquay on 24 April it was decided to create a Panel to cover the area of Exeter and Torbay.