professionals working in primary care.

If we really wish to pay more than lip service to the functional integration of members of the primary care team, this is the direction in which our thoughts should be moving today.

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PARALDEHYDE AND STATUS EPILEPTICUS

Sir,

"Does any general practitioner really use paraldehyde these days?", asks P. J. Hoyte in his recent book review (January *Journal*, p. 59).

This is not the first time that I have seen the use of paraldehyde in general practice disparaged recently, and I for one am immensely reassured by the glass syringe and the non-expired ampoules of paraldehyde I keep in my bag—even though seldom used.

Are we really to suppose that intravenous diazepam ('Valium') can always be injected into the veins of a fitting child or an obese woman, particularly in general practice, where good illumination and a strong helper may not be available, and when the disadvantages of a short-acting drug may become all too apparent in the ambulance?

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SIGMOIDOSCOPY IN GENERAL PRACTICE

Sir,

Last year (April *Journal*) I was taken to task for recommending the use of a sigmoidoscope as a diagnostic instrument in general practice. I therefore thought it might be useful to review the patients who were sigmoidoscoped in this practice in 1976, and then readers can draw their own conclusions.

The practice comprises five partners of whom four use the sigmoidoscope. The total practice population is about 12,500. In 1976 41 sigmoidoscopies were performed; 23 of these were done before requesting a barium enema because the local x-ray department will not accept people for barium enema until they have been sigmoidoscoped. It is not surprising, therefore, that in 29 cases the examination was negative.

There were 12 positive findings consisting of five cases of non-specific proctitis (which included some follow-up examinations) and two cases of patchy erythematous changes, which were possibly due to early proctitis. Haemorrhoids were confirmed as a cause of rectal bleeding in three cases, and there was a case each of a rectal polyp and a villous adenoma.

Twenty-three cases were referred for barium enema, of which 13 were found to be normal and ten were abnormal; there were seven cases of diverticular disease and one case of carcinoma of the sigmoid colon. One case showed x-ray evidence of proctitis and in another a filling defect was diagnosed and referred but later found to be normal.

About half way through the year we acquired some biopsy forceps and a biopsy was taken in ten cases. Five were reported as normal and three confirmed the presence of proctitis. One polyp and one villous adenoma were reported.

It will, of course, be argued that 41 sigmoidoscopies among four partners does not give each doctor enough practice to enable him to give a reliable opinion, but in our experience this is not the case. Once the technique of doing the examination has been mastered, the likelihood of any significant pathology being overlooked is very small.

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Reference

Evans, J. W. (1976). *Journal of the Royal College of General Practitioners*, **26**, 261.

CONTRACEPTIVE RECORD CARD

Sir,

I would agree with Dr Froggatt (February *Journal*, p. 107) that the use of a planned contraceptive record card aids the collection of significant positive and negative data, and provides an *aide-mémoire* to ensure that important points of history are not omitted. I have been using a prototype card for the past 18 months which was printed for us by a drug firm (Wyeth Laboratories) and am aware of at least three derivatives of this which are available on request from this and other firms supplying contraceptive pills.

However, with space at a premium, I feel that Dr Froggatt's card could be modified to give greater prominence to the most relevant information and provide more space for comment. I doubt whether such full details of obstetric history (taking up a third of a side) are relevant; I have found that more space needs to be devoted to contraceptive history, which can often be complicated, for example by reasons for failure to continue previous methods. No specific space is provided to note the presence or absence of history of pelvic inflammatory disease, which deserves consideration in assessing suitability for an IUCD. It also appears that details of personal and family history are combined under one heading; it would be easier if these were separated.

I hope that the College will be able to produce a standard record card for contraceptive services. The information contained in the medical record envelopes of patients who have previously been provided with an oral contraceptive often amounts to no more than a blood pressure reading. Any aid to improving this situation would surely be welcome.

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Sir,

In the February issue (p. 107-109) I was most interested to see an article on contraceptive records in general practice.

The author did ask for constructive criticism and I note that there is no space on the card to enter the fact that a claim has been submitted for either contraceptive services or a cervical smear. I think it should therefore be redesigned with this in mind.

I am of the opinion that good practice should benefit the doctor as well as the patient, and I feel that without good record-keeping money is likely to be lost by default.

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DOCTOR/PATIENT RELATIONSHIP

Sir:

I presume that your correspondent, Dr D. M. Smith, in his letter in the January *Journal* (p. 58) means to be taken seriously, and he cannot therefore object to a systematic rebuttal of his arguments. They are in any case but a series of *non sequiturs*.

With great respect, his apologia is a prime example of woolly thinking combined with a hopelessly impractical approach to common problems. Such attitudes bid fair to be some of the main