and colleagues demonstrated the relationship between oestrogens and thrombo-embolism, and since that time the avoidance of oestrogens has left a hiatus. Sometimes no drug is necessary because the engorgement can settle spontaneously, but when a drug is needed, simple measures based on purgation are often ineffective, and bromocriptine can cause problems.

We encourage breast feeding, but roughly half our patients either bottle feed from the start or change early to the bottle. In those needing a drug to aid suppression we have used pyridoxine since 1975 and have found it to be effective and safe. Pyridoxine is thought to act by enhancing the natural conversion of DOPA to dopamine, which inhibits prolactin, and its use was based upon the study by Foukas, who used large doses.

Now, owing to its use in pre-menstrual tension, pyridoxine is better known, but in 1975 the safety of large doses was uncertain, and after communication with Foukas and with the Committee of Safety of Medicines, we settled for a dose of 50 mg tds, which was lower than recommended by Foukas. Given as a five-day course, subsidence of discomfort has always been rapid, although complete cessation of lactation may take several days.

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Footpump Nebulizer

Sir,

There is now a commercial version of the footpump nebulizer I described in my earlier letter (January *Journal*, p.61). It is much more efficient than my Heath Robinson machine. It also avoids the risk of oil inhalation injury since there are no lubricants used in the piston. The cost of the complete unit is £15, and a white box for the device will be available at an extra £2.50.

This new nebulizer is available from: Cameron-Price (Medical Division) Ltd., 71 Melchett Road, Birmingham Factory Centre, Kings Norton, Birmingham, B30 3HL.

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Measles Vaccine

Sir,

In this area where I am working as a trainee there has been a recent outbreak of measles affecting patients of both local practices. There were 32 cases notified of indisputable measles, of which 15 had been vaccinated previously. The Schwarz strain live attenuated vaccine is used locally and has been given intramuscularly to at least 90 per cent of the 584 children born between 1972 and 1981 on the lists of the local doctors.

It was with alarm that this apparently high failure rate was noted. The current *Medicine* Series (Collier and Geddes, 1981) states that a single dose confers a high degree of protection in most recipients. It is recognized that vaccinated children may develop modified or atypical measles (Geddes and Woodward, 1981), and indeed one local child was catarrhal, with Koplik spots but no cutaneous exanthem; however, it was not easy explaining this failure of protection to worried mothers.

These figures show only about a 3 per cent failure for the vaccine in immunized children, while 30 per cent of those not immunized contracted measles. However, extrapolated nationally, they would represent a large number of children who may catch measles despite vaccination, unless our local experience is a chance observation. Scrutiny of the community health returns may show if this is so. Can other GPs send in their experience?

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GP Groups in South East Scotland

Sir,

On behalf of the South East Scotland Faculty I recently investigated activities groups in this region (excluding those specifically involving trainers or trainees). The number of groups was found out by enquiries to the GP subcommittee of the Regional Committee for Postgraduate Medical Education and from the Faculty's education com-

mittee. A questionnaire was then sent to all group leaders asking them for details.

Eleven groups were active in the region, five in Edinburgh, four in Fife, one in West Lothian and one in the Borders. Apart from self-descriptive titles such as "The Borders Discussion Group", there were groups on health education, for young principals, on talking to patients, audit, research and preparation for the MRCGP.

Numbers ranged from six to 20 and a total of 136 doctors were members. One third were women and 40 per cent were members of the College. Sixty-nine per cent attended regularly. Three quarters of the doctors were under 40. The number of meetings from October to March ranged from one to ten, with a total of 61 meetings and an average of 12 a month. Most took place in the home or workplace of one of the doctors. Only two groups met in hospitals. Three groups had invited guest speakers. Most groups were made up solely of principals, but in two or three of the groups, trainees were included. A wide range of topics was covered, including therapeutics, practice management, MEQ and MCQ papers, doctor/patient relationship, role playing, audio visual tapes, student teaching in the practice, the 'inappropriate request', investigating complaints, 'hang-ups', and specific diseases such as hypertension, diabetes and so on. Random case analysis was universally popular.

Although it would perhaps be wrong to describe this review as an audit, it gives us some understanding of what is going on in continuing education through small groups in the region, and it might prove useful as a comparison for future developments. Perhaps other regions may undertake a similar exercise, and compare their answers with mine.

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CONTINUING EDUCATION

The Bransholme GP Clinical Club

P. N. K. HEYLINGS and N. ALEXANDER, Holderness

This is a communication about postgraduate education in a health centre, where one British and 11 Asian doctors meet regularly each month. Two are members of the College. We feel as a group that more people should know about our activities, since they prove that standards set by the College in postgraduate education can be reached outside 'official' College groups through the inspiration of College members. Our group is called the Bransholme GP Clinical Club.

IT is becoming more and more clear that postgraduate education must satisfy the following criteria if doctors are to attend regularly:

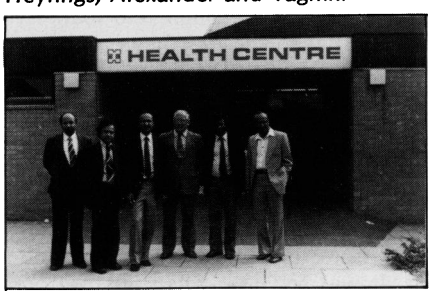
1. The GPs must be personally involved in individual meetings.
2. Meetings should be easy to get to.
3. The meetings must be time-saving—they must make use of time that cannot profitably be used otherwise.
4. The meetings should be sponsored by helpful drug firms who will provide refreshments, even though the subject of the meeting has nothing to do with their product.
5. Meetings should be held in suitable premises wherever possible. However, keen doctors will always manage to attend somehow, if they can just find the time.
6. Doctors must be willing to go ahead and set up meetings in health centres, sometimes without the co-operation of the Area Health Authority, who may be unsympathetic to GP postgraduate education if it conflicts with any of their committees' attitudes and decisions, or formal allocation of rooms.

We meet in our consulting rooms and the public area outside these rooms. There is no space in the Area Health Authority part of the building which can be made simultaneously available for lectures and food at a time convenient to the doctors. Our staff room is too small and is used by other staff at lunchtimes, when we meet.

We meet regularly every third Friday at lunch time for no more than one hour, sometimes less, including eating and having a chat with the pharmaceutical representative who is our host.

Attendance at meetings varies from four to 13. Since the meetings are Section 63 approved they are widely publicized throughout Humberside. One trainee has attended; two doctors who do not practise in the health centre attend regularly.

A chairman is elected at each meeting by common consent and is responsible for the minutes. For the first six months these were passed to the postgraduate dean, whose office supported our Section 63 application. The main cost to the postgraduate scheme is the £2 per head which is given to each patient to cover travelling expenses. Our practice manager looks after the attendance sheet and the money.



Six members of the Bransholme Clinical Club. From left to right: Drs Mahindora, Chowdhury, Ghosh, Heylings, Alexander and Yagnik.

Patients, who take part in the sessions by invitation, wait either in the main waiting room or in individual examination rooms.

We eat in the public area between the consulting rooms and hold the clinical meeting in several of the consulting suites and examination rooms, depending on the number of patients we see. Late-comers eat when and where they can. Quick sips of wine and mouthfuls of chicken are interspersed with tit-bits of clinical knowledge, but it is good fun.

Our constitution governs the conduct of the club:

1. Meetings are open to all GPs.
2. Meetings are for the joint exchange of clinical information between GPs, not experts, consultants or practice teams. Letters in patients' files (readily available) act as specialist opinion.
3. Cases are presented by consent, not by regulation or by turn.
4. The meetings are centred on the presentation of cases from the GPs own practice and mainly to other GPs working locally.
5. GPs are encouraged to demonstrate their methods of diagnosis and treatment.
6. Undiagnosed or untreated cases are presented. Doctors are encouraged to show how good they are at treatment, but have to face the inquisition of their colleagues after each case or set of cases.

In our first year we held 12 meetings at which 36 cases were presented. During