LETTERS

Clinical and Population Medicine

Sir,

Few will question Professor Irwin's statement (October *Journal,* p. 593) that "the fundamental requirements of a sound university education are to make students think clearly and critically", or the importance he attaches to teaching "basic clinical skills" to medical undergraduates.

Given this stance, his belief that "there is an inherent conflict between the educational objectives of a clinical discipline . . . and those of a subject concerned with population medicine" is surprising. Of what does this conflict consist? Merely a conflict for curricular time; or a more significant conflict between those concerned with the medical care of individuals and those concerned with the care of populations?

"Basic clinical skills" include the "ability to think clearly and critically" about clinical problems. How is such thinking possible without a foundation of knowledge derived from the study of populations? The ability to take an appropriately selective history; to examine a patient relevantly; to investigate and prescribe judiciously; to predict accurately—all derive from observation of disease in populations. Similarly, every reliable assessment of a drug's efficacy uses epidemiological concepts and methods; and the pitfalls of generalizing from the individual clinician's experience are well recognized. The student who, in due course, is to become the doctor responsible for the clinical care of individual patients needs a sound grounding in these concepts and methods.

To postulate conflict, rather than complementarity, between the study of individuals and of populations is thus to destroy any possibility of teaching the student sound clinical method. The attempt to synthesize both disciplines is not the prerogative of a few "heroic professors" but the task of every medical undergraduate. Indeed general practice "provides an ideal opportunity to achieve properly defined educational objectives in clinical medicine" not least because it obliges the student to recognize the probabilistic character of all general practice—and to think about population characteristics from which relevant clinical probabilities are in part derived.

The justification for, and advantages of, general practice being accorded departmental status within a university—an issue which Professor Irwin juxtaposes to the issue of "conflict"—is of course an entirely separate matter.

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Residual Coding in ICHPPC

Sir,

Robertson and Simpson are to be congratulated on a thoughtful approach to what they perceive as a problem with ICHPPC (August *Journal,* pp. 495-498). It is difficult to ascertain why their data are at variance with the data collected during the International Field Trial (300 practices in nine countries) and with recent data (Lamberts, H. Analysis of Ommoord Health Center data—personal communication). There are several possible explanations. Merging of morbidity data collected using the RCGP classification with those from the ICHPPC could result in an increased assignment of codes to residual categories because the RCGP classification contains more diagnostic titles than does the ICHPPC. Computer-assisted coding using a synonym dictionary might be responsible for the variance, and of course both unusual patient population characteristics and physician coding practices are additional possibilities. The authors are encouraged to explore these possibilities by analyses of their data.

It is unclear why the authors reject optional hierarchy, which may be employed in at least two ways. The first is to select additional diagnostic titles from the ICD that are of particular interest to the investigator. A second method is to analyse residual categories for the frequent appearance of diagnostic titles which can then be added to the diagnostic list. It is unfortunate that the authors did not provide us with a detailed analysis of those residual categories that accounted for a large percentage within each section.

Lastly, the authors might re-examine the purposes for which ICHPPC was constructed. As a tool to retrieve charts of cohorts of patients with similar problems, it will function well if the problem to be studied is contained in the diagnostic list. As noted previously, diagnostic titles of interest to the investigator can be added, if they are not present in the classification. Comparisons of morbidity profiles between practices are, of course, more difficult, because of the variables of practice demography and coding habits of health care providers. These comparisons, however, will be facilitated by the next edition of ICHPPC entitled *ICHPPC-2-Defined,* in which specific inclusion criteria are given for most of the diagnostic titles. This volume will be published early in 1983 by the Oxford University Press.

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Sir,

It is unfortunate that in discussing ICHPPC (August *Journal,* p. 495) Robertson and Simpson confuse its use as a classification and as a nomenclature. A classification "must be confined to a limited number of categories which will encompass the entire range of morbid conditions" . . . "a specific disease entity should have a separate title in the classification only when its separation is warranted because of the frequency of its occurrence or its importance" . . . "it is this element of grouping in a statistical classification that distinguishes it from a nomenclature, a list or catalogue of approved names for conditions which must be extensive in order to accommodate all conditions". (Introduction to International Classification of Diseases). ICHPPC was designed as a classification rather than a nomenclature.

Although the authors quote Clark (1974) as stating that 10 per cent is usually considered the maximum acceptable size for residual codes, there is little or no evidence to substantiate this. To a large extent this depends on the degree of sensitivity and specificity that is required of data recorded using the classification. So far, these indices have not been examined in relation to ICHPPC, although I am currently analysing the 1981 field trial of the defined version of ICHPPC. In this trial, standard clinical vignettes were coded and it is possible to determine validity and reliability, sensitivity and specificity.

Use of ICHPPC as a nomenclature in order to retrieve medical records relating to specific conditions is very satisfactory if, as the authors indicate, 85.7 per cent of conditions can be retrieved without hand sorting. I cannot agree with their conclusion that "many of the problems forced into the residual category by the ICHPPC system were actually well-defined and highly prevalent diagnoses". In Table 2 they indicate that the maximum number of residuals in any class (other than class 16, which is by definition residual) was 952 or 1.1 per cent of all diagnoses. The maximum number of episodes of any individual problem recorded in a residual category must, therefore, have been well below 1 per cent of the total. This can hardly be called "highly prevalent".

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Is Peyronie's Disease Iatrogenic?

Sir,
We were interested to read Dr Owen's paper (August *Journal,* pp. 499–500) about the possible role of beta blockers in the pathogenesis of Peyronie's disease. Coupland (1977) also reported two cases, and seven of the 19 cases associated with beta-blocker therapy reported by Pryor and Khan (1979) had received practolol. We report four additional patients who developed Peyronie's disease in association with practolol treatment.

Case 1. A 44-year-old man was admitted to hospital for the investigation of angina pectoris in 1973. He was mildly hypertensive and whilst in hospital suffered a myocardial infarction. He recovered and was prescribed practolol 100 mg three times a day. After 14 months on this treatment he reported distortion of the penis on erection. He continued to take the drug and eventually indurated plaques appeared on the shaft of the penis. The practolol was stopped in May 1976.
Case 2. A 50-year-old man with hypertension was prescribed practolol 100 mg twice daily in August 1970. In January 1971 he noticed curvature and pain in the penis during erection. In April 1971 the treatment was changed to propranolol, but the penile deformity persisted and in April 1972 the diagnosis of Peyronie's disease was confirmed.
Case 3. A 46-year-old man was prescribed practolol 100 mg three times a day in February 1973 following a myocardial infarction. In April 1974 symptoms of Peyronie's disease appeared and progressed over the following year. Practolol was stopped in April 1975.
Case 4. A 65-year-old man developed angina pectoris and was prescribed practolol 100 mg three times day in January 1974. After three months the drug was withdrawn. In May 1975 penile symptoms developed and Peyronie's disease progressed rapidly during the following year.

Both patients described as cases 2 and 3 suffered from xerophthalmia.

Practolol has been accepted as the cause of fibrosing conditions in various parts of the body. The occurrence of Peyronie's disease in 11 people taking this drug seems a striking coincidence and strongly suggests that practolol was also involved in its pathogenesis.

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References

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Chlamydia Trachomatis in General Practice

Sir,
With reference to your report (September *Journal,* pp. 562, 563) we would like to emphasize that chlamydial cervicitis is often asymptomatic. The at-risk criteria as given should only be taken as a guide. There is no evidence for claiming that most cases of chlamydial infection could be identified by these risk factors. The risk factor given last on the list, i.e. recent change of sexual partner, is obviously the most important. Many of the others that are suggested would be irrelevant to most women, considered insulting by some and not likely to be disclosed by those most at risk.

We think it should be pointed out that the culture method for the detection of *Chlamydia trachomatis* is very difficult to use in a general practice context; mainly because the specimen needs to be stored in liquid nitrogen unless it can be transported to a specialist laboratory within 48 hours (at + 4°C). An alternative method is to look for antibody to *Chlamydia trachomatis* in cervical secretion (Treharne *et al.,* 1978) which is absorbed onto a small sponge. This can be stored at room temperature for up to a week, and sent to the laboratory by post if necessary.

We have already carried out a study among all 200 women who had vaginal examinations in a Health Centre over a nine-month period. We failed to get any positive cultures, but local IgG antibody was detected in four women, probably indicating current infection. As yet, this antibody method is not widely used, but we feel it offers a cheap, sensitive method which is easy to use either for screening purposes or as a diagnostic procedure.

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Reference

Treharne, J. D., Darougar, S., Simmons, P. D. & Thin, R. N. (1978). Rapid diagnosis of chlamydial infection of the cervix. *British Journal of Venereal Disease,* **54,** 403–408.

Patient Movement and the Accuracy of the Age/Sex Register

Sir,
Dr Robin Fraser's excellent article (October *Journal,* p. 615) says that no information is available on the most efficient way of removing age/sex register cards when patients leave a practice or die. He kindly referred to my article of 1975, but I did describe the mechanism for ensuring that these cards are removed when a patient leaves the practice in an earlier paper. This describes the system which has been in use in this practice for 13 years and has proved eminently successful.

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Reference

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