of the patient's problem.

It is also a method which ultimately saves money by preventing unnecessary repeat requests for x-rays and other laboratory tests which would otherwise lie buried in the middle of the notes without the doctor or the patient being certain as to when or what was done.

As yet I have found no software that would be able to present this information on a screen or part of a screen and I hope to stimulate discussion by present computer users as to the value of this system.

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Primary Health Care in Industrialized Countries

Sir,

Dr Hannu Vuori asks in his letter (December *Journal,* p.827) which myth I am writing about and what exactly I am claiming.

I am claiming that it is completely misleading for a representative of the World Health Organization to suggest that primary care in Sweden is basically carried out through community health centres when, on his own admission, in 1981 55.8 per cent of all primary care visits took place in hospital outpatient departments. He makes no mention of private consultations carried out by private specialists and general practitioners, or of full time hospital doctors and industrial medical officers who also provide primary care: all these make up perhaps a further 10 per cent. Of course, I accept that official policy is for each community to have a health centre which should provide primary care: as Dr Vuori has stated, 734 centres out of the 775 planned by 1985 have already been built. But the fact remains that even now they do not, in reality, carry out the main burden of primary care.

Furthermore, particularly since the Alma Ata Conference of 1978, all pronouncements from the World Health Organization have rightly stressed the importance of the acceptability to the patient of any primary health care system and have made this issue one of the essentials of good primary health care.

What can be seen from Sweden is that most patients still prefer—for whatever reasons—to use hospital outpatient departments or private practice. There is a great deal of difference between theory and reality.

This is the myth that I think Dr Hannu Vuori is in danger of perpetuating. Without an honest assessment of what actually happens in any country, there can be no useful international cooperation or exchange of ideas and little chance of learning from each other's successes and failures. It is absolutely imperative that an independent body such as the World Health Organization should be able to disentangle what actually happens from what is intended to happen.

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Use of a Nebulizer for Acute Asthma

Sir,

I read with interest Dr Jenkinson's article (November *Journal,* p.725).

Some practitioners may wish to know which nebulizer to buy for their practices, and I recommend that each partner purchase his own footpump nebulizer costing £25 for his car,[1] and that the surgery has one electrically driven nebulizer costing about £100.

Details of the footpump nebulizer are available from Cameron-Price Medical Division, Birmingham Factory Centre, Kings Norton, Birmingham B30 3HL. The electric compressor nebulizer is available from porta-Neb, Medicaid Ltd, Pollard House, Lake Lane, Barnham, Chichester, Sussex.

In our practice all partners have their own footpump nebulizers for emergency management of asthma particularly at night or weekends in the home, and there is a Health Centre electric nebulizer for asthma attacks in the surgery.

Patients who wish to purchase their own nebulizers are advised first to buy a mini Peak Wright Flow Meter, costing £12. They are allowed to purchase a nebulizer later if it is really necessary.

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Reference

1. Masters NJ. An inexpensive nebulizer for asthmatic patients. *Practitioner* 1983; **227:** 1733–8.

Sir,

I was interested to read the paper by Dr D. Jenkinson (November *Journal,* p.725). This is an excellent short paper promoting the use of nebulizers in general practice, but Dr Jenkinson has omitted to mention when *not* to use a nebulizer. Among other contraindications is hypoxaemia, when present or suspected.

It has been shown that beta-adrenoreceptor agonists tend to reduce the partial pressure of oxygen in arterial blood (p_aO_2) by reversing pulmonary arteriolar constriction and restoring perfusion to underventilated alveoli. Thus, if these drugs are administered via a nebulizer to hypoxaemic asthmatics without preoxygenation, the p_aO_2 may fall to a dangerously low level.

If hypoxaemia is present or suspected, the patient should be given oxygen before a beta-adrenoreceptor agonist is administered via a nebulizer.

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Chlamydial Cervicitis

Sir,

In reply to Dr L. J. Southgate (February *Journal,* p.118) reliance on a high index of suspicion and immediate and proper empirical management is less likely to miss active cases of chlamydial cervicitis in general practice than testing for antibodies. This is because a serum IgG antibody level of 1/16 points to an infection at some time but not necessarily one that is current. More than one such test is needed in order to show a rising titre.

This was exemplified in my paper (November *Journal* p.721). Two of five women were both isolate and serum antibody positive. In one of these, the antibody level when *Chlamydia trachomatis* was isolated was only 1/2 reaching 1/64 after a week.

I understand from Dr G. L. Ridgway, Consultant Pathologist, Clinical Microbiology, University College Hospital London, who is an authority on this, that the test for chlamydial antibodies in cervical secretions is insensitive and unreliable. One problem is that it is uncertain to what extent the antibodies are local or from serum transudate. At present, the standard acceptible technique for the diagnosis of a transmissible chlamydial genital infection is by cell culture for inclusions.

Dr Southgate's comparison between the management of gonorrhoeal and chlamydial genital infection is fatuous, because the diagnosis of the former can be achieved by routine general practice procedure. In this context, empirical treatment should not be even envisaged.

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