Premenstrual syndrome

Sir,

I agree with Nigel Oswald that 'the assessment of the different ways of relieving symptoms of premenstrual syndrome is especially difficult' (October *Journal* p.533). Unfortunately Katharina Dalton and R.I.D. Simpson (January 1985 *Journal,* p.41) wish to perpetuate the idea that premenstrual syndrome (PMS) is a progesterone deficiency disease. A study of mood and plasma progesterone concentration in 18 PMS patients and 10 controls showed that plasma progesterone levels were higher in the women with symptoms.[1] The conclusion was that 'progesterone deficiency is probably not the cause of premenstrual syndrome'.

A double-blind cross-over study of progesterone 200 or 400 mg suppositories and placebo in 35 patients with premenstrual syndrome[2] has shown no significant difference between progesterone and placebo in reducing symptoms. The case for progesterone therapy as specific therapy for PMS must remain unproven.

However the use of progesterone is sometimes justified by the clinical observation that it is often useful to disrupt the ovulatory cycle in order to improve symptoms which are related to the second half of the cycle. This may be achieved in various ways, for example prescribing oral progestogen which lowers progesterone levels,[3] depot progestogen, danazol, or the contraceptive pill. Satisfactory double-blind placebo controlled trials have demonstrated the effectiveness of mefanamic acid[4] and spironolactone[5] in controlling PMS symptoms.

In a condition which may show a 50 per cent improvement with a placebo it is important to use controlled studies as a guide to therapy. Making the diagnosis is in itself therapeutic. Use of a menstrual calendar to demonstrate the timing of symptoms in relation to the cycle, and the perception that the doctor understands her condition and has not 'merely labelled her as neurotic' is helpful to the patient.

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Referral to consultants

Sir,

In his discussion, Dr. Gillam (January *Journal,* p.15) favours measuring referrals per 1000 patient contacts rather than in terms of practice population. However, consultation rates can and do vary considerably.

The figures in Table 1 are taken from two papers both published in 1971, Dr J. Fry in the *Lancet* of 17 July and Dr D.C. Morrell in the *Journal,* volume 21. From the third column of Table 1 the reader would not realize that the second practice referred nearly four times as many patients to hospital as the first.

Table 1. Comparison of referral rates in two practices

	Dr Fry	Dr Morrell
Outpatient referral rate per 1000 list	31	119
Consultation rate per patient at risk	2.3	4.7
Outpatient referral rate per 1000 consultations	13.5	25.3

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Limited list, limited vision

Sir,

I was pleased to read your editorial on the Government's proposals to limit the range of drugs that can be prescribed by general practitioners (February *Journal,* p.60), and I agree with your comments which are clear and accurate. The proposals are ill-conceived and the motives behind them unclear. If the aim of the exercise is to save money then it would be more successful to look at generic prescribing as recommended in the Greenfield Report. I believe doctors are becoming increasingly cost-conscious and there are practices like mine which operate their own drug formulary.

As you say, the proposed list is an attack on patients because they will have to pay. However, my clinical freedom to prescribe is also being attacked because the majority of my patients would be unable to pay.

I have heard from doctors working outside the UK that they envy the doctor–patient relationship in this country which is not influenced by financial aspects from either party. If these proposals go through, the fundamental principles of the National Health Service, where everyone, rich or poor, is able to receive the advice and treatment their doctor recommends, will be abolished. This has nothing to do with saving money or effective prescribing but is arguably a much more important issue, and for this reason I think general practitioners should reject these proposals totally, without compromise.

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Opportunistic surveillance of child development

Sir,

Dr Houston and Professor Davis (February *Journal* pp.77-79) have neatly combined the Stott-Davis model of the consultation with the current concern to encourage paediatric surveillance within general practice, and have added to the increasing body of knowledge about child consultation patterns.

Their contention that opportunistic contacts with this age group can be sufficient basis for a surveillance programme is supported by the results of a survey I recently conducted of 30 practices associated with the Dundee University Department of General Practice.

In the 10 practices where a formal developmental screening programme was followed, all but two of the doctors questioned felt it was valuable. However in the 20 practices where the screening (which in this region covers all pre-school children) was done elsewhere, by clinical medical officers or health visitors, only six of the 20 doctors questioned felt that such formal screening was valuable.

The commonest reason given by those not in favour of screening was that significant problems and abnormalities were likely to be detected by them in the course of ordinary contacts for illness or immunization. The value of the latter as an opportunity for a brief developmental check was emphasized by several of my respondents.

I would agree wholeheartedly with the conclusion of this paper.

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