

Sir,

The points raised by Dr Levy illustrate that asthma is a difficult disease to study in epidemiological terms; first, because of wide variation in diagnostic criteria, and secondly, because the relationship between symptoms and pathophysiology is poorly defined, particularly in young children.

I agree that chronic cough should raise the suspicion of underlying bronchospasm, but in my retrospective study of case records it was not possible to identify such cases with any certainty. The study was therefore limited to a description of the outcome of wheeze (as a presenting symptom), rather than making more ambitious claims to elucidate the natural history of asthma (as a disease or diagnostic label).

Blair defined asthma as a minimum of three episodes of paroxysmal dyspnoea with wheezing; only one-third of the wheezy children in my study had presented as often as this. The less favourable outcome he describes probably relates to children with a more severe manifestation of the disease, but I accept that remission of symptoms at the age of seven years does not preclude the possibility of subsequent relapse.

My suggestion that wheezing in early childhood carries a generally favourable prognosis was not meant to imply that bronchodilator treatment should be withheld. Among those wheezy children whose parents responded to the questionnaire, 67 per cent had at some time received oral or inhaled β_2 -receptor sympathomimetic agents; 45 per cent of those with a single episode and 91 per cent of those with recurrent presentations. Such treatment did increase the recall of wheeze by the parents, but this may have been related to the common association with severity. Only nine per cent of wheezy children received a diagnosis of asthma, which usually implied regular treatment with additional antiasthma medication. Provided that bronchodilators are offered as symptomatic treatment from the start, it may be appropriate to reserve the label of asthma for children with recurrent wheeze, rather than to use a term with overtones of chronicity at the first or second presentation with wheeze.

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Patients' attitudes to chaperones

Sir,

In our practice women are never examined by a male doctor in the absence of a chaperone. If a female is requested to take

off any of her clothes the doctor invariably requests the receptionist or practice manager to enter the surgery. This applies not only to vaginal examinations, but also to examinations of the chest, breasts, abdomen and legs, which is in accordance with the advice of the Medical Defence Associations. I have never known any of my patients to object to being chaperoned.

Dr Jones (April *Journal*, pp. 192-193) noted that 63 women in his study definitely did not want a chaperone to be present. All but one of these women had, he states, had a vaginal examination previously. It is likely that the patient's reply is in fact an acceptance of their general practitioner's routine.

If Dr Jones wishes to repeat his study in our practice I shall be very pleased to help in any way he wishes.

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A national code for drugs used in general practice — an identified need?

Sir,

I wholeheartedly agree with Dr Carney's call for the adoption of a single unified system of classification of drugs to be used throughout general practice in this country (April *Journal*, p.198). I would dispute whether this needs to be a new British drug classification system.

I feel that there already exists a classification system that fulfils all the criteria for use, not just in general practice but throughout medicine. This is the Scandinavian Anatomical-Therapeutic-Chemical (ATC) Drug Classification System,^{1,2} which has already been used successfully in the Nordic countries for some years. The ATC classification is a hierarchical classification system, which divides drugs into anatomical and therapeutic subgroups, each chemical substance eventually having its own unique seven-digit alphanumeric code. The hierarchical nature of the classification means that coding can be done at the two-, three-, four- or five-digit level, depending on the specificity required. This gives the classification great flexibility and means that it could easily form the backbone of a computer program to monitor drug interactions. (This would be another important use for a drug classification system, in addition to the criteria mentioned in Dr Carney's paper.) The ATC classification system covers the whole pharmacological spectrum, and certainly includes all the drugs used in primary care. It is extremely well-documented (in English) and is also

available on magnetic tape for computer use. It is also the system recommended by the World Health Organization to be used in community-based drug utilization studies.

During the summer of 1984, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) Classification Committee met to finalize the format of a major new classification, which is due for publication in the immediate future. This is the International Classification of Primary Care Process. This classification covers all aspects of the process of care, and includes sections on:

1. Site and duration of service.
2. Diagnostic: clinical laboratory tests.
3. Diagnostic: imaging, including X-ray and ultrasound tests.
4. Diagnostic: procedures other than clinical laboratory tests and imaging.
5. Therapeutic: procedures.
6. Therapeutic: drug and pharmaceutical prescribing.
7. Clinical and administrative services.
8. Disposition (follow-up and referral).

As can be seen from the above listing, the classification contains a section on drugs and other medications. After careful consideration of many different drug classification systems, it was decided by WONCA, to adopt the ATC system as the international standard for primary care, as there seemed to be no better classification system anywhere in the world.

Since the ATC system so admirably fulfils the criteria for a drug classification system for British general practice, I can see nothing to be gained by the unilateral development of a British system, possibly based on the British National Formulary. Although an excellent publication, it was never designed as the basis for a classification system. Surely, in the computer age, there is no need to begin reinventing the wheel!

Details of the Nordic ATC classification are available by writing to the Secretary General, Nordic Council on Medicines, Box 607, S-751 25 Uppsala, Sweden.

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References

1. Nordic Council on Medicines. *Nordic statistics on medicines 1978-1980. Part II: Nordic drug index with classification and defined daily doses. Publication no 9.* Uppsala: NLN, 1982.
2. Nordic Council on Medicines. *Nordic statistics on medicines 1978-1980. Part III: Guidelines for ATC Classification. Publication no 10.* Uppsala: NLN, 1982.