

The elderly as underconsulters

Sir,

I was interested to read in Ford and Taylor's paper (*May Journal*, p.244-247) that the relationship between illness perceived and illness reported to the doctor remains largely constant even into old age. They also mention Hannay's findings that medical symptoms are more likely to be ignored by 30-65-year-old patients than by those over 65 years old. However, the perception of a discomfort as an illness or a symptom as a 'medical symptom' implies that the patient is already considering the possibility that the discomfort is within the ambit of medical intervention. What is perceived as an ailment or medical symptom as opposed to a normal discomfort of living by a particular person depends on the expectations of that person. The older person may expect to be deaf, and not complain about the wax in his ears. The younger person under stress may expect to have headaches and not avail themselves of relaxation techniques.

It may be that the reason why women, particularly in the 20-44 year age group have so many more ailments or 'medical' symptoms relates to the medicalization of physiological functions such as fertility, pregnancy, control of periods and the menopause. This may alter their perception of when physiological changes become ailments.

Universal screening of the elderly is declared to be costly and ineffective. However in a recent survey of patients over 70 years of age in my practice,¹ 38% were found to have unidentified needs. Most of these needs were not related to medical problems definable as illnesses.

What Ford and Taylor's survey appears to demonstrate is that, having defined a problem or change as an illness, or a symptom as a medical symptom, there appears to be about a one in three chance of this problem being presented at a consultation by a patient of any age. The definition of illness, however, depends on the patient's expectations, and these may alter dramatically at different ages. Furthermore, many of the problems of the elderly are not related to illnesses. They are more related to whether they can open a tin of food, or get to the toilet easily, or have enough money to heat their houses. If as a primary health care team we hope to look after the physical, psychological and social needs of our patients, we should be screening for these

Table 1. The yearly results of 721 students screened for rubella immunization.

Year	No. of students screened	Non-immune		Positive history of immunization	Positive history of immunization but found non-immune
		No.	(%)	No.	(%)
1976	140	23	(16.4)	8	(5.7)
1977	131	25	(19.0)	6	(4.5)
1978	51	5	(9.8)	20	(39.2)
1979	89	3	(3.4)	46	(51.7)
1980	86	11	(12.8)	52	(60.5)
1981	96	4	(4.2)	57	(59.3)
1982	49	3	(6.1)	^a	^a
1983	45	4	(8.9)	27	(60.0)
1984	34	1	(2.9)	23	(67.6)
Totals	721	79	—	239 ^b	—

^a Figures not available; ^b figures for eight years.

problems. It is very unlikely that they will be volunteered in a consultation.

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Reference

- Harrison S, Martin E, Rous S, Wilson S. Assessing the needs of the elderly using unsolicited visits by health visitors. *J R Soc Med* 1985; in press.

Rubella immunity screening

Since 1976 rubella immunity screening has been offered to women students about to leave S. Martin's College of Education. Sessions have been arranged with the help of Dr W.R. Falconer, our local Senior Clinical Medical Officer. A record has been kept of the laboratory findings and of the declared history of rubella immunization; 721 students have now been tested. The year by year results are shown in Table 1.

The number of students screened has declined since 1981 because College doctors are no longer required to examine potential teachers as they leave College. Screening was originally offered at this final medical examination. Voluntary attendance for a blood test has proved harder to achieve. In spite of this the percentage of non-immune students shows a progressive reduction in keeping with the marked percentage increase in immunized students. The year of change is 1978 and this fits in chronologically with the commencement of immunization of schoolgirls in 1968-70.

A small number of non-immune students from the group declaring

themselves to be immunized has appeared throughout.

The survey suggests that the number of women at risk to contract rubella when in the child-bearing years is much smaller now than in 1976. However, a risk remains even for those who have been immunized and there is clearly a need for continuing screening of young adult women.

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Agoraphobia study

Sir,

I wonder whether anyone in your readership might be able to help. I am nearing the end of a questionnaire survey of dietary and environmental factors in a group of 240 chronic agoraphobic patients and a matched sample of 100 healthy normal patients (of which I have collected data on 80). As one of the factors on which the controls are to be matched to the agoraphobic patients is approximate geographical distribution (in order to control for regional variations in diet), and as my hypotheses must not bias the selection of individual subjects, I have been recruiting my controls with the help of a number of general practitioners from all over the country. However, with 20 controls still to be found, I have run out of general practitioners and need to find some more who would be willing to recruit five very healthy women in the age range 35-55 years from their practices to take part. Participation is voluntary and involves filling in a long but innocuous and anonymous self-report questionnaire. The study has the approval of the Maudsley Hospital Ethical Committee. I would send large stamped addressed envelopes for the return of the question-

naires and the help of the general practitioner would be gratefully acknowledged when the study is up for publication.

If anyone can help, I should be grateful to hear from him or her.

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Editor's note: More could be made of our correspondence columns for research purposes. The significance of clinical observations in one practice may be impossible to test because of small numbers. Doctors in other practices may be interested in cooperating in a research project. Write to us with your ideas for such projects.

Providing sterilized instrument packs for general practice

Sir,

Recent publications, such as the General Medical Services discussion document of November 1983, have underlined the cost effectiveness of general practice, and in particular the provision by general practitioners of a simple surgical service.

Problems can arise in providing sterilized instruments within the surgery setting and increasingly there is pressure to monitor the quality of the effectiveness of sterilization, both to reduce the risk of infection and to maintain an acceptable quality of care both within hospital and outside. It therefore seems that if general practice is to continue to provide a surgical service then it will be necessary to provide instrument packs sterilized to a suitable standard. Presently, hospital sterilizing and disinfecting units provide such a service for hospital inpatient and outpatient departments and for certain community clinics. It is practicable to extend such a service to the general practitioner.

For some six weeks in the latter part of 1984, South Bedfordshire Health District liaised with a large general practice some 12 miles away in Leighton Buzzard and on a pilot basis provided the necessary pre-packed kits for such procedures as minor

operations, insertion of intra-uterine contraceptive devices, simple suturing, removal of toe-nails and dressings.

The study required considerable cooperation between the hospital sterilizing and disinfecting unit, the community services transport and the general practitioners and it is good to know that such liaison was both practicable and effective.

During this period, 55 packs were used by the practice and the breakdown of use is indicated in Table 2. The use of the local hospital services for suturings and minor operations was monitored for one week of the six-week trial period. During this time there were no minor operations and no suturings performed in either of the hospitals which cater for patients in this practice.

Thus, if it is assumed that the total catchment of the two hospitals is 480 000 people and that on average 80 minor operations are performed weekly, that is, some 4000 annually, and the cost of a minor operation is £20-£25, then the total cost of the minor operations service alone is £80 000-£100 000 annually. A practice of this size would generate perhaps 100 minor operations annually with a cost of at least £2000. In addition, performing suturings within the practice as opposed to sending patients to hospital would provide further savings. Thus it is argued that with the hospital sterilization service a practice could look after 80% of its minor operation and suturing load when in terms of the health service some £1600 a year would be saved for the outlay of £800 or less.

It is argued that the development of the hospital sterilizing and disinfecting service in this way is essential. Inevitably there would be extra costs falling on a district from the purchase of new instruments, the increased use of disposable materials and the use of the appropriate transport service. However, there is evidence that the system can work and by so doing improve patient care, doctor satisfaction and cost effectiveness.

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Table 2. Breakdown of use of the 55 sterilized instrument packs which were used by the practice.

Sterilized instrument pack	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Total
Basic dressing pack	8	5	11	9	2	3	38
IUCD pack	3	0	3	1	1	1	9
Suture pack	1	0	0	1	2	0	4
Toe-nail tray	0	1	0	0	0	0	1
Minor operation pack	0	0	1	0	0	2	3

Hyperthermia following a sauna bath

Sir,

The sauna bath is popularly recommended as an aid to health and fitness and saunas are becoming increasingly available at sports complexes and so-called health clubs in Britain. What is less widely available is knowledge of the potential health hazards associated with saunas, particularly to those who are unfit or suffering physical illness. I recently attended a case where sauna bathing converted a minor upper respiratory illness into potentially disastrous hyperthermia, drawing attention to the need for caution in the use of the Finnish sauna.

One evening in winter a visit was requested at approximately 20.30 hours to a 32-year-old man who was attending a three-week course at a local residential college. He was reported as shaking uncontrollably and complaining of severe limb pains. On attending him, the following history was obtained. He had been feeling unwell for a week with a headache, sore throat, rhinitis and general aching. The previous evening he had tried the comfort of the college sauna, despite the notices not to use the facility when unwell. He felt some relief from the sauna and he used it again on the evening of the visit, after which he had a cold shower and walked the 800 yards in the cold night air to his room. Within minutes he began to shake uncontrollably, to complain of myalgic pain particularly in the legs and to feel very cold. By the time I attended, his symptoms had been present for almost half an hour and were beginning to abate, although the feeling of incipient cramp in his legs was still prominent. There were no additional symptoms and in particular none referable to the urinary tract.

On examination he was rational and fully conscious but had generalized tremor and was very restless. His skin was pale and dry, pulse 122 per minute, in sinus rhythm, blood pressure 120/76 mm Hg, oral temperature 39.5°C. His throat was moderately inflamed and there was some tenderness over the right frontal and left maxillary sinuses. Examination of the chest revealed no evidence of chest infection and heart sounds were normal with no murmurs.

During the process of history and examination his skin colour changed from pallid to intensely flushed and his subjective feelings of cold changed to feelings of excessive warmth. His tremor subsided completely during the next half hour.

It was clear that his tremor was due to a rigor induced by his high temperature. After a sufficient period of time to ensure