association of some jokes with groups or races and I am moved to wonder if, in some circumstances, the underlying insights possessed by these people may be more profound than the author has recognized. The wry humour of the Jews can be traced almost to the earliest days of the tribe with the arrival of the patriarch Isaac. His very name is derived from the Hebrew word for laughter. Abraham's wife Sarah had been barren until, in her old age, she conceived her child and Abraham recorded his fierce joy at the birth of his son by naming him in the likeness of mirth. Perhaps the underlying psychology of this story is an intuitive recognition of the value of laughter in human relationships — a recorded discovery in Semitic tribal folklore several thousand years prior to the advent of the Royal College of General Practitioners and Elliott-Binns' timely reminders on the subject.

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Variations in the night visiting rate

Sir,

We read with interest the paper by Dr Usherwood and colleagues on variations in the night visiting rate (August *Journal,* p.395). Going out at 03.00 hours on a cold and rainy night is an unpleasant experience; hence, we suspect, the repeated studies undertaken on night visiting.

Dr Usherwood's conclusion that variations in night visiting rates between the practices that he studied were due to doctor/patient factors is probably correct, and it would be churlish to criticize the various assumptions made in reaching that conclusion. Variations in the patients' and the doctors' perceived need for a night visit ultimately determine that event.

We conducted an analysis of night contacts (that is to say, telephone calls and/or night visits) over a 12-month period in our practice of approximately 16 000 patients, seven partners and two trainees, and several interesting points emerged.

1. As our practice offers obstetric care, the number of night contacts is higher than in other practices — this is not surprising.
2. The percentage of night contacts dealt with by telephone alone varied enormously between doctors — the lowest was 9% and the highest was 75%.
3. Doctors were asked whether they felt that the contact was justified (the doctors' perceived need?). One doctor considered that 92% of the contacts were justified (the highest) and another considered that 15% were justified (the lowest).
4. About 15% of the contacts were admitted to hospital, were requested to reattend surgery or were told that they would be visited again at home at some later stage. This may be an indication of the actual need in strictly medical terms.
5. The further the practitioner lived from the contact, the more likely it was that the contact would be dealt with by telephone alone.
6. The younger the practitioner, the fewer were the contacts that he considered to be justified.

In conclusion, we feel that to be meaningful, all night contacts (telephone calls and visits) must be studied. There are wide variations between doctors in visiting rates and for a variety of reasons (age, travelling time and so on). The patients' perceived need and the doctors' perceived need are often widely disparate and measurements, where possible, of actual need tend to suggest that many contacts do not need a visit in strictly medical terms.

Although not conclusive, our study seems to indicate that the considerable differences in doctors' attitudes and habits are probably more important than the patients' expectations. In studying night visits, it is therefore important that all telephone contacts should also be considered. In addition it is important that the role of the general practitioner in general practice obstetrics is clearly stated.

Finally, as in the paper by Dr Usherwood and colleagues where different practices on a shared rota system were studied, it is important that the individual practitioner's contribution to that rota is taken into account when considering differences between practices.

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Sir,

Dr Usherwood and colleagues conclude in their paper on night visiting rate variations between practices (August *Journal,* p.395), that some facet of the doctor–patient relationship may be the key. I would suggest that it is more likely to be some facet of the receptionist–patient relationship that matters most. While the individual practice's policy for appointments and visits may appear to reflect the wishes of the doctors concerned, the patient's first contact with the doctor is through a receptionist and the importance of her manner and approach to patients should not be underestimated.

My own impression is that the single most important factor is likely to be the flexibility of an appointment system which, of course, is largely governed by the receptionists.

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Sir,

I was interested to read the article by Dr Usherwood and colleagues (August *Journal,* p.395). Our study considered the apparent differences in visiting rate between two practices operating from the same health centre in London.[1] On be basis of analysis of individual doctors' responses to requests for night calls, we concluded that the difference in visiting rates is related to the difference in the doctor's attitude and response towards minor symptoms. Both practices in our study had a similar number of calls for serious symptoms but the practice which responded to apparently minor symptoms with a visit and which considered that minor symptoms were due to non-specific organic disease rather than to over-reaction or over-anxiety or unreasonable demands, had a higher rate of demand.

Although our conclusions were suggestive rather than definitive, we believe that they are part of the answer to Dr Usherwood's question.

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Reference

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Sir,

The article by Dr Usherwood and colleagues on the wide variation in night visiting rates (August *Journal,* p.395) concludes that further research into this subject would be fruitful. One of the aims of setting up a doctors cooperative, such as ours in Leeds, was to encourage such research. As all the clinical work is carried out by general practitioner principals covering each others' practices it is an ideal arrangement for studying comparative visiting rates and patient

morbidity as well as variations in drug treatment and patient management. Researchers are welcome.

General practitioner colleagues from different urban practices working with and for each other are motivated towards good patient education and management as well as satisfactory immediate treatment. Incidentally this working together, often for the first time, is an effective form of continuing medical education and peer review.

We hope that in the long term the philosophy of cooperative out-of-hours care will appeal to general practitioners in all urban areas. This may lead to more appropriate usage of out-of-hours services.

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Parvovirus infection causing arthralgia

Sir,

During an outbreak of parvovirus infection (slapped cheek disease, fifth disease, erythema infectiosum[1]) in Plymouth this summer, two adults with arthralgia caused clinical concern owing to uncertainty in immediate diagnosis and prognosis. Arthralgia is described as a complicating feature of parvovirus infection in adults but the clinical picture is not defined.[2,3]

A 35-year-old woman whose daughter had parvovirus infection, developed a rash (without red cheeks) six days after a 48-hour spell of high temperature, generalized aching, abdominal pain and diarrhoea. The rash lasted only three days and was followed by stiff and painful ankles, knees, elbows, wrists and fingers, with slight swelling of the joints. Ibuprofen (400 mg) was given thrice daily, and five days later she was substantially better and subsequently made a full recovery. There was no adenopathy. Rubella immunoglobulin (Ig)G antibody was present in an early serum sample (tenth day of illness from first presentation) indicating past infection, but rubella specific IgM was not detected, excluding recent infection. Parvovirus specific IgM was present (tenth day serum sample), consistent with recent parvovirus infection.

A 40-year-old woman developed slight redness of the cheeks and a rash after feeling off colour for one week. The right knee and the proximal inter-phalangeal joints of both middle fingers became stiff and painful at the same time. There was no adenopathy. Ibuprofen (400 mg) was given thrice daily, and three days later she experienced aching wrists, a transient carpal tunnel syndrome and pain in the knees and ankles when climbing stairs. However, all joint symptoms had disappeared after seven days. She continued to feel off colour, and both the rash and the redness of the cheeks waxed and waned for a further three weeks before complete recovery. Rubella specific IgM was not detected; latex fixation was negative; and parvovirus specific IgM was present.

In addition to the arthralgia, both patients exhibited a prodromal illness and a constitutional upset, contrary to the findings in children in whom the illness is most commonly seen.

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A case of piles?

Sir,

Mr X, a single 25-year-old hotel manager, came to my surgery one busy afternoon. He was a new patient. He appeared self confident and looked embarrassed as he said, 'my piles are at me doctor — they're sore about three weeks now and I've had some bleeding on and off as well . . . I can't understand why they are giving me so much trouble because I'm on a high-fibre diet. They are so bad I'm finding it hard to sit down sometimes.'

Expecting to see prolapsed haemorrhoids I was surprised when the initial inspection of his anal margin was unremarkable. Digital rectal examination was also normal. I explained to the patient that I was about to do proctoscopy when he said in a worried voice: 'Actually doctor, I've got two other problems'.

Thoughts of proctoscopy rapidly disappeared as he pointed to two lumps in the right groin which had been present for about three weeks. These were 1 × 2 cm rubbery non-tender nodes below the inguinal ligament. He had further smaller nodes above the left inguinal canal. None of the other lymph nodes were enlarged.

'This is my other problem' he said, removing his shirt. Over his trunk and upper arms was a diffuse maculopapuler ham-coloured rash. His face, palms and soles were spared and the rash was not itchy. It looked similar to pityriasis rosea except that there was no surface scale and there had been no herald patch. The rash had been present for five days.

Apart from the above three problems the patient was feeling well and had no history of malaise, influenza or headaches. On further examination I noted some pink macules over the glans penis and penile shaft. I could find no evidence of hair loss and inspection of the oral cavity revealed no abnormality.

He then remembered having a small painless mark on the corona of his glans penis about four months earlier — it had disappeared with no treatment. He had never noticed any ulceration or discharge from the penis. He had had several 'one-night stands' with different girls in the past eight months. To his knowledge none of these partners had had a venereal disease.

In view of the history and the presence of painless lymphadenopathy with generalized non-pruritic maculopapular rash I sent off a serological screen for syphilis. The results for both the non-specific and specific tests were strongly positive.

When I discussed this diagnosis of syphilis with the patient he was relieved to find that the disease was easily treatable and said he was happy he would 'not end up like Maupassant'! A week after he first presented the rash extended to his palms and feet and he attended a special clinic for contact tracing and treatment.

Lessons learnt from this case:

1. This consultation had an interesting evolution from piles to secondary syphilis and illustrated that the initial symptom in general practice is often not the main problem.

2. With increasing sexual promiscuity in society one must always consider homosexual contact as a source of sexually transmitted disease. Although this patient denied homosexual practice, in retrospect, it is possible that his anal symptoms might have been due to rectal trauma if he were a practising homosexual.

3. This patient was a strong reminder to me that not all papulosquamous rashes are psoriasis, pityriasis rosea or tinea versicolor and it is worthwhile bearing in mind the other manifestations of secondary syphilis in anyone presenting with such a rash — mucous membrane patches, condylomata lata, lymphadenopathy, systemic illness and patchy alopecia.

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