ment over this period during which 9839 new patients were seen. Two epileptic patients were excluded as they were inadequately documented.

The following information was recorded. Fifteen patients had a tonic-clonic fit and one patient had a partial fit (simple right-sided motor). The age range of the patients was 14–74 years. Twelve patients had had one or more convulsions in the past year, nine of whom had had one or more in the previous month. Six patients were receiving a single drug for epilepsy, eight patients were receiving more than one drug and two patients were not receiving any medication. The convulsion occurred at home for eight patients, at their work place for two patients and in a public place for six patients. Fourteen patients arrived at the accident and emergency department in an ambulance, one in a taxi (on the driver's initiative) and one in a private car. The transport was organized by a relative in seven cases, a friend in four, a passer-by in three, the police in one and a general practitioner in one. Eleven patients were discharged after a period of rest of two hours or less with no treatment. Two patients were treated for injury and discharged (suture of lacerations), two patients were admitted (neither were in status epilepticus) and one patient was treated with the anticonvulsant drugs which he had recently omitted to take.

None of the epileptics carried a British Epilepsy Association Card. One patient wore a bracelet identifying him as an epileptic.

When a patient suffers a convulsion in a public place it is understandable for the emergency services to be contacted as there may be no one capable of supervising the patient and nowhere for him to recover. However, this was not the case for the majority of patients in this study.

Unnecessary admission to hospital accident departments is a waste of resources. Furthermore, far from doing the patient a service, the patients' realization that their convulsion resulted in their being taken to hospital serves only to heighten their self-awareness of their epilepsy. This may be partially responsible for the increased rate of suicide among epileptics which is four times that of the general population.[1]

However, a proportion of convulsions are a result of poor patient compliance with their treatment[2,3] and precipitate hospitalization may serve to reinforce compliance with prescribed medication. Where poor compliance is suspected we recommend that a blood sample for anticonvulsant drug levels is taken in the accident department.[4] The result of this test can then be considered during the necessary follow-up outpatient review.

The family and workmates of patients with epilepsy could be instructed in how to manage convulsions, with the knowledge that for known epileptics in the majority of cases only simple first aid is required. Useful guidelines for the layman are contained in pamphlets which are available from the National Society for Epilepsy and the British Epilepsy Association. In the event of a known epileptic having a convulsion the following criteria to call an ambulance should be applied by layment:

1. Unduly prolonged fit with slow recovery of more than 15 minutes.
2. Injury (especially head injury).
3. Inhalation of vomit.
4. Series of fits or the first fit in a patient in whom a fit usually presages a series.
5. Unusual precipitating factor or unusual circumstances for a fit, for example hypoglycaemia.
6. Difficulty with breathing after a fit.

Doctors are in a good position to help remove some of the fear and stigma of epilepsy by publicizing the appropriate management of epileptic convulsions. Unnecessary hospitalization of epileptic patients could then be avoided.

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References

1. Anonymous. Suicide and epilepsy. *Br Med J* 1980; **281**: 530.
2. Reynolds EJ. Drug treatment of epilepsy. *Lancet* 1978; **2**: 721-724.
3. Gibberd FB, Dunne JF, Handley AJ, Hazleman BL. Supervision of epileptic patients taking phenytoin. *Br Med J* 1970; **1**: 147-149.
4. Sellar L, Potter B, Robertson C. Anticonvulsant levels in epileptic patients presenting to an accident and emergency department. *British Journal of Accident and Emergency Medicine* 1983; **1**: 12.

Benzodiazepines as a major danger in overdosage in drug abusers

Sir,

There is pronounced regional variation in prescribing for drug abusers despite the recent DHSS guidelines for good clinical practice.[1] For this reason there are marked differences in black market trade in prescribed drugs and therefore in the experience of drug users in different centres. The prevalence of HTLV III infection also varies, presumably reflecting a high level of needle sharing in those areas of high seropositivity.[2] In regions of high seropositivity to the HTLV III virus[3] we support the provision of clean equipment as advocated recently.[4] However, we wish to draw attention to the dangers of introducing an unfamiliar drug into the illicit market in a well-meaning attempt to prevent the spread of HTLV III virus. In our own area there has been little or no prescribing of methadone and heavy reliance has been placed on non-opiate drugs as a substitution therapy or a withdrawal agent for heroin users. This is clearly reflected in the behaviour of the local black market where benzodiazepines are readily available and heavily used and abused.

Two recent cases have increased our awareness of the potential dangers of this situation. Both patients were heavy heroin abusers and both had antibodies to the HTLV III virus. In an attempt to stabilize their self-confessed chaotic opiate abuse, both were prescribed methadone as recommended by the DHSS.[1] Both continued to take prescribed diazepam but were warned that they should reduce the dose considerably if taking oral methadone (although they had previously taken illicit heroin in addition to diazepam). Both were admitted to hospital in the early hours of the morning, *in extremis,* two days after commencing therapy. One was seen by the doctor on call and given naloxone (0.4 mg intravenously) prior to admission and he survived. The other died of respiratory failure shortly after admission to the accident and emergency department of the hospital.

Although the dangers of opiate overdosage are well known and the potentiation with other drugs has been previously described, it is important that the prescribing doctor is aware of the experience of the drug users in his area and the substances available on the black market. Both of the patients described here had taken over 100 mg of diazepam and 80 mg of methadone on the day prior to admission.

The dangers of introducing a powerful opiate which is new to the local illicit market is considerable. The precise risks of large doses of opiates in combination with benzodiazepines in patients compromised by HTLV III infection is unknown.

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References

1. Medical Working Group on Drug Dependence. *Guidelines of good clinical practice in the treatment of drug misuse.* London: DHSS, 1984.
2. Marmor M, Des Jarlais DC, Friedman SR, *et al.* The epidemic of acquired immunodeficiency syndrome (AIDS) and suggestions for its control in drug abusers. *J Subst Abuse Treat* 1984; **1:** 237-247.
3. Peutherer JF, Edmond E, Simmonds P, *et al.* HTLV-III antibody in Edinburgh drug addicts. *Lancet* 1985; **2:** 1129-1130.
4. Mulleady G, Green J. Syringe sharing among London drug abusers. *Lancet* 1985; **2:** 1425.

AIDS — preventing a pandemic

Sir,

Acquired immune deficiency syndrome (AIDS) is a disease complex caused by a recently discovered pathogen, human T-cell lymphotrophic virus type III (HTLV III).[1-3] It is believed that this virus has been transmitted to humans from a primate reservoir and is spreading with no natural defences to combat it.[4] HTLV III is closely related to a group of retroviruses that cause fatal illnesses in sheep, horses and goats; the plasma and blood of affected animals remain infective for life and mortality rates reach 100%.[4]

The first cases of AIDS were reported in sexually-active male homosexuals in New York and this has led to it being branded by the popular press as the 'gay plague' and labelled by professionals and lay public alike as a sexually transmitted disease confined to the deviant sectors of society. This misconception is both naive and dangerous — AIDS is a blood-borne disease similar to hepatitis B in its epidemiology and mode of transmission and is confined at present almost exclusively to male homosexuals, intravenous drug users and people who came into medical contact with contaminated blood and blood products. Homosexuals are particularly at risk owing to the trauma caused by anal intercourse, giving an increased risk of blood innoculation — 50% of male homosexuals acqure antibodies to hepatitis B within two years of becoming sexually active.[5] In the UK screening for HTLV III positive serology has revealed a prevalence of 17% in male homosexuals at risk and of 1.5% in intravenous drug addicts.[6]

It has been shown that 1 x 10^{-7}ml of plasma infected with hepatitis virus will transmit the disease.[5] If hepatitis B is a true model for the transmission properties of the AIDS virus, AIDS would appear to be readily transmissible on multi-use non-sterile medical needles and similar instruments (for example, acupuncture needles, tattooists needles), by electrolysis in beauty salons, ear piercing and by non-sexual contact between cuts, sores and abrasions of carriers and healthy people. In 1967 Ringertz and Zetterberg reported an increased risk of transmission of hepatitis B in cross country runners — events were conducted through forests where runners sustained minor cuts and abrasions to their exposed arms and legs.[7] The authors concluded that hepatitis B was being transmitted by direct contact from one wound to another, either by multiple wounds caused by a single twig or by communal bathing in stagnant pools.

At present it is fashionable for men to wear ear-rings, the practice of tattooing is common and the lower socioeconomic classes and intravenous drug abusers often live in crowded unhygienic environments. These are the circumstances that favour the transmission of blood-borne diseases to the general population. Once established these diseases can spread rapidly unless preventive measures are taken. Government policy must therefore call for a ban on multi-use electrolysis, acupuncture and tattooing needles and tighter controls on the practice of ear piercing before it is too late.

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References

1. Barre-Sinoussi F, Chermann JC, Rey F, *et al.* Isolation of a T lymphotrophic retrovirus from a patient at risk for AIDS. *Science* 1983; **220:** 868-871.
2. Vilmer E, Barre-Sinoussi F, Rouzioux C, *et al.* Isolation of new lymphotrophic retrovirus from two siblings with haemophilia B, one with AIDS. *Lancet* 1984; **1:** 753-757.
3. Gallo RC, Salahuddin SZ, Popovik M, *et al.* Frequent detection and isolation of cytopathic retroviruses (HTLV III) from patients with AIDS and at risk for AIDS. *Science* 1984; **224:** 500-503.
4. Seale J. AIDS virus infection: prognosis and transmission. *J R Soc Med* 1985; **78:** 613-615.
5. Seale J. How to turn a disease into VD. *New Scientist* 1985; 38-41.
6. Cheingsong-Popou R, Weiss RA, Dagleish A, *et al.* Prevalence of antibody to human T lymphotrophic virus type III in AIDS and AIDS risk patients in Britain. *Lancet* 1984; **2:** 477-480.
7. Ringertz O, Zetterberg B. Serum hepatitis among Swedish track finders. *N Engl J Med* 1967; **276:** 540-546.

Quality in general practice

Sir,

As doctors, much of our time is spent in simplifying matters which seem complicated, and throwing light where they are obscure. *Policy statement 2. Quality in general practice* fails to do this at several points.

Quality assessment. This term is now associated with attempts to measure outcome — what in other fields of work would be called quality control — and has alienated some doctors within the College as well as many more outside. To these doctors, measuring the unmeasureable seems like arrogance or idiocy. More than 30 years ago Peterson[1] concluded that the variables defied measurement and that improvement is more likely to accrue from consideration of the nature of the future doctor. The College has acknowledged this in the *What sort of doctor?* report but the statement does not make this difference clear. A change of jargon to, say, 'performance improvement' might at least have helped.

Professional development. If a doctor has been licensed and vocationally trained, he should be fit to practise. If he is not, either the undergraduate training or the vocational training is at fault and needs revision. The universities are responsible for the former, and the JCPTGP for the latter.

It is an impertinence, and is seen as such, for the College to assume a responsibility for which it has no statutory authority. And its judgement in claiming such responsibility is doubted by doctors who know the unmeasureable outcome of their efforts to be more important than their ability to pass examinations, however intelligently planned.

The College's responsibility is to help the doctor (as by the *What sort of doctor?* friendly peer review) whose training has been deficient. At least, having originated the idea, it has the authority for that.

Practice teamwork and management. Shared ideas and experience in this area have been on offer for a long time now. They should not be imposed, at least until the desirable differences between practices have been explored. Practices serve both communities and individuals, and in neither are any two alike. We have paid scant heed since Lees and Cooper[2] drew this to our attention more than 20 years ago.

Accountability, incentives and resources. Paragraph 53 on data and technology (from the previous section) should be linked to paragraph 58 in this section. Systematic operational data at all levels should be gathered, in the view of most doctors, 'to say what resources are needed to run family practitioner services'. If these resources are supplied in terms of time and tools, encouragement through *What sort of doctor?* patterns may make good the defective training.

There is much commonsense in the policy statement, but most of it has been seen as such already. One wonders, therefore, if more time for reflection would have been valuable and perhaps resulted in a more mature philosophy. The flavour of the statement is of frustration