deplorable. If we no longer make home visits both patients and doctors should be pitied and doctors should, rightly, be blamed.

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Wheezy bronchitis

Sir,

In the editorial on asthma (February *Journal,* p.52) Dr Levy decries the use of the term wheezy bronchitis. 'Wheezy bronchitis' is a useful diagnosis and should not be disdained. Its very use indicates that the doctor considers that there is bronchospasm present and that asthma is a likely diagnosis although perhaps not certain at that stage. It almost certainly means that he has also prescribed a theophylline preparation or a beta-receptor agonist and it alerts his partners and reminds himself next time to be particularly watchful for the stigmata of asthma. In explaining the diagnosis to the patient I would always mention the possibility of an atopic origin without branding the child as a definite asthmatic.

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Original pack dispensing

Sir,

The editorial on prescribing (April *Journal,* pp.146-147) stated that changing to original pack dispensing might result in pharmacists becoming undervalued. This is a strange reason to attempt to undermine the development, particularly as the Pharmaceutical Society of Great Britain has joined with the Association of the British Pharmaceutical Industry in stating that original packs should be the normal method of dispensing.

I fail to see how a defence of 'traditional dispensing skills' can be taken seriously — the counting of tablets or measuring medicines from bulk containers, often to cater for requests for irregular quantities by the prescribing doctor, can hardly be in the best interests of patients. Dispensing using original packs should make the job much quicker, and allow the pharmacist more time to talk to patients, a role that the editor of the *Journal* is obviously keen to support.

The question of flexibility in dosage or length of a course of treatment has been much discussed — directives on how long a medication should be taken should surely primarily be made by the manufacturer. The Association of the British Pharmaceutical Industry circulated advice to all its members in February 1986. Chronic treatment packs should contain treatment for 28 days, while short-term treatment packs should contain the quantity required to meet the manufacturer's recommendations for a course of treatment. The chronic *pro re nata* treatment pack should not deviate from the principle for chronic packaging, containing multiples of 28 tablets or capsules. This avoids the breaking of bulk to meet prescriptions.

The College has been obsessed with discussions on quality in practice over recent years — the *Journal* should support our pharmacist colleagues by supporting original pack dispensing with its many advantages.

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Patients' attitudes to generic prescribing

Sir,

Generic prescribing is recommended by the College to the profession. A review of the literature reveals little information on patients' attitudes to this change.

A survey of 50 consecutive patients who had had one drug changed from a brand name product to a generic equivalent on repeat prescription was carried out by questionnaire in a suburban teaching practice in February 1985. For the purpose of the study a repeat prescription was defined as a drug which the patient had been taking regularly for more than three months.

The aims of the study were to assess: patients' awareness of the change to generic prescribing; patients' education as regards generic prescribing and its origins; and patients' attitudes to generic equivalents.

The results showed that only 39 of the patients (78%) were aware of any change in their prescription; of these, approximately two-thirds (24) became aware by observation and less than one-third (12) recalled receiving information from a professional person (doctor or pharmacist). Twenty-nine patients (58%) recalled receiving an explanation as to why there had been a change in their prescription. These results imply a poor level of patient education; the patient either did not remember or understand the information given, or was not given any information.

Only 12 patients (24%) received a generic equivalent preparation. Analysis of the drugs involved in the study showed that for 70% a generic equivalent preparation was available to the pharmacist. Three of the patients receiving a generic preparation felt that the medication was similar to the brand product and nine felt that it differed in its effectiveness — eight patients felt it was less effective and one felt it was more effective. Four patients expressed dissatisfaction with the generic equivalent.

The advantages and disadvantages of generic prescribing will continue to be a point for debate but as from April 1985 generic prescribing, in some therapeutic areas at least, is compulsory. Therefore, the impact of generic prescribing on patients and on general practice gains increasing relevance.

This small survey illustrates two unresolved points about generic prescribing. The first is that by prescribing drugs generically the doctor leaves the choice of actual preparation dispensed to the pharmacist. The second point is that a high proportion of patients receiving the generic equivalent drug doubt its effectiveness and are dissatisfied with the change from a proprietary preparation.

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Arthralgia from parvovirus infection

Sir,

I was interested to read the letter from Dr M.T. Everett (November *Journal,* p.540) about two adult females with arthralgia from parvovirus infection during an outbreak in children in Plymouth. I have recently seen a similar case, but in a male and unassociated with an outbreak of fifth disease.

A 37-year-old marketing director presented on Christmas Eve 1985 with a 24-hour history of joint pains. He felt tired and lethargic but had no fever and no rash. The pains were localized to his neck, back, wrists and knees; there was no joint swelling. He took ibuprofen (400 mg) three times daily with no benefit. The arthralgia later spread to his hips and the proximal interphalangeal joints of his

hands; the latter joints were stiff. He also developed a faint macular rash on his forearms for about 48 hours. The whole illness lasted for nine days.

The patient's wife had had a fleeting rash on her hands, forearms and the tops of her legs a fortnight previously, lasting about 24 hours only. However she had no malaise or joint symptoms. About a fortnight after my patient's illness, his 10-year-old daughter developed a rubelliform rash all over her body which lasted for 10 days. She also had no malaise or joint symptoms.

This man's past history consisted of a nasal allergy treated by desensitization injections, two episodes of neck pain eight years previously with evidence of mild cervical spondylosis on the X-rays and an episode of pain in both knees two years previously after unaccustomed jogging on roads. The knee symptoms had settled rapidly and the erythrocyte sedimentation rate at the time was 3 mm h^{-1} with a normal uric acid level. His family history consisted of a mother with widespread arthritis, the exact nature of which was not known. She had been severely affected from her mid-30s onwards and had had bilateral knee replacements.

The patient's full blood count was normal apart from an eosinophilia related to his nasal allergy. The erythrocyte sedimentation rate was 17 mm h^{-1} and both the infectious mononucleosis screening test and RA latex test were negative. Uric acid level and antistreptolysin 0 titre were normal. Paired sera showed no difference in rubella haemagglutination inhibition titres (both 1:32). However, a radioimmunoassay performed at the Virus Reference Laboratory, Colindale, showed that anti-human parvovirus immunoglobulin M fell from over 100 units to 66 units over a period of 10 days, indicating recent infection.

Contrary to Dr Everett's statement, the clinical picture of adult parvovirus infection has been described.[1-3] It is interesting that my case was in a man, as arthralgia is far more common in women. It seems that not all patients have joint symptoms which are so mild or which settle so quickly; occasionally patients may be so badly affected that they present at rheumatology clinics. In a group of 19 such women, although joint symptoms were improved within two weeks, all but two patients experienced symptoms which persisted for more than two months and in three cases for more than four years.[1] On rare occasions patients have arthritis which is severe enough to warrant hospital admission.[2]

It appears that my patient had joints which were vulnerable to this particular viral infection. However it seems unlikely that he is developing anything resembling his mother's arthritis.

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Patients' access to their records

Sir,

In a pilot study carried out in 1984 at a Birmingham practice a random sample of patients were asked their initial responses to reading their records.[1] The practice in which the study was undertaken is situated in an inner-city area of Birmingham and has 4000 patients of diverse cultural backgrounds.

A small number of patients are not given access to their records. Information that is potentially distressing is communicated personally by the doctor to the patient before the patient is given the record. A record is not shown to a patient if it contains information given by a third party on the understanding that it will not be shown to the patient, if the patient asks not to be handed the record, (perhaps because the patient's spouse insists on looking it), or when a patient is so disturbed that any information in the record is likely to be misinterpreted.

The practice uses FP5/FP6 envelopes for records and allows patients access to their complete record. Patients are given their record by the receptionist when they come to the surgery. They are invited to read their notes in the waiting room and can do so before seeing the practitioner or after the consultation.

Over a period of 10 days 100 patients aged 16 years and over were randomly selected in ordinary surgery sessions and were invited to complete a questionnaire. Only three patients did not do so.

Of the 97 patients who completed the questionnaire 85 said patients should have the right to see their records. Of the 60 patients who had read their records 51 said they could understand about half or more than half, 48 said it made understanding their problem easier, 37 said it helped them in making decisions, and 45 said it increased their satisfaction with treatment.

Conclusions cannot be drawn from this small pilot study. The results, however, show that a majority of patients in the sample welcomed the chance to read their records and did so when given the opportunity. Patients' access to their records is not simply to be viewed as an abstract issue of rights — members of the primary health care team involved in the study believe that allowing patients to share and read their records has therapeutic benefits.[2] The experience of the practice is that the advantages far outweigh any disadvantages and that difficulties can be overcome.

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Referrals from general practice to specialists in Denmark

Sir,

It is well known that there are unexplained differences in the rates at which general practitioners make referrals to other medical specialists.[1,2] One of the most importants aspects of primary care is the general practitioner's need for advice.

We investigated data from a study carried out by the Danish National Health Service in Ringkjobing County[3] on 17 586 referrals from 141 general practitioners to specialists in seven specialties — dermatology, internal medicine, general surgery, obstetrics–gynaecology, orthopaedics, ear–nose–throat and physiotherapy. In Denmark there is a permanent relationship between the patient and general practitioner and it is compulsory for a patient to be referred from general practice for consultation with a specialist. As an expression of the referral rate a referral index was estimated for every general practitioner. The referral index is the number of referrals to the specialists in the seven specialties per 1500 patients per year including children, standardized by age and sex to an average practice in Ringkjobing County. The