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**Note to authors of letters:** Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

## Workload in general practice

Sir,  
Drs Fry and Dillane presented statistical data for a 36-year period (September *Journal*, p.403) and discussed the trend in their practice which showed a reduction in home visits (91%) and surgery consultations (43%). These figures led them to question whether list sizes should be encouraged to decline or whether the numbers of general practitioners could be reduced.

When debating the optimum list size it is important to compare data from different practices. Table 1 compares the 1985 figures for our Edinburgh dockside practice with those of Fry and Dillane (personal communication). Our practice has a smaller list size and a larger number of doctors but has a home visiting rate which is nearly eight times greater and a greater consultation rate. While I am unable to comment on the trend over the years in our practice, I think the figures for 1985 are important as they demonstrate the considerable differences between practices.

Professor Jarman's editorial in the same issue (September *Journal*, p.395) focused on the inner cities and the problems which NHS services in the community must tackle. He pointed out that there has to be objective evidence in order to make allowances for the difficulties experienced working in these areas. Our practice data perhaps illustrate how the different work profiles of an inner city practice and a suburban practice mean each requires different resources.

When discussing the issue of list size per doctor it is necessary to consider other factors in addition to consultation and home visiting rates such as the social class composition of the practice, the geographical area and educational commitments. Drs Fry and Dillane rightly pointed out that their data only measured the quantity of work and not the quality.

PHILIP RUTLEDGE

The Exchange Building  
41 Constitution Street  
Leith  
Edinburgh EH6 7AU

**Table 1.** Comparative practice data for 1985.

	Edinburgh dockside practice	South-East London suburb
List size	5806	8650
Turnover	23%	6%
Doctors	4 plus trainee	2.5
Staff	2 full time, 3 part-time	2 full-time
Population social class	4 and 5	2, 3 and 4
Consultation rate	3.76	2.14
Home visiting rate	0.61	0.08

Sir,  
We were interested to read the article by Drs Fry and Dillane (September *Journal*, p.403). We agree that information on differing consultation patterns is scarce and much of it out of date. We have been collecting similar statistics since 1979 and would like to add our figures to the debate.

We are a four doctor practice with a regular training commitment practising on the edge of Hull. Many of our patients live in a large local authority housing estate and many of them are unemployed. Our practice numbers over the past five years have been relatively stable at approximately 8200 (Table 2). The mean total consultation rate has increased by 22% since 1979 with a 35% increase in visits, our mean consultation rate over this period is 3.3 which is considerably higher than that reported by Drs Fry and Dillane.

**Table 2.** Mean number of consultations per patient per year over the period 1979-85.

	List size	Surgery consultations	Visits	Total consultations
1979	8117	2.5	0.34	2.90
1980	8168	2.7	0.37	3.10
1981	8000	2.7	0.38	3.05
1982	8072	3.2	0.37	3.55
1983	8152	3.1	0.40	3.50
1984	8225	3.1	0.42	3.60
1985	8212	3.1	0.46	3.55

Our impression is that our workload is continuing to increase. As we search for our patients' problems using screening programmes we generate work, both in the screening and in the treatment of the diseases found. This partly explains our increasing consultation rate.

The increase in the visiting rate is much more a reflection of patient demand. The increase is not due to lack of appointments as patients can always be seen on the day of their choice. If this rate continues to rise then eventually visits will begin to make inroads into the time available for consultations. This will have implications on planning for the future.

Changes in the pattern of care of the elderly and mentally ill have also increased our requests for visits. Factors peculiar to our practice may be the level of unemployment and the social disadvantage of many of our patients.

We would argue that to improve the quality of care to our patients we must resist pressure to increase our list size.

W. PHILLIPS  
W.J.M. HOOD  
C.A. JARY  
JEAN COX

85 Hall Road  
Hull HU6 8QL

## Sensory Chvostek symptoms, apparently owing to dietary fibre

Sir,  
A man aged 68 years in good general health complained initially of an unpleasant feeling of warmth in his feet brought on by pressure on the legs, for example when they were crossed. After about two months this was replaced by tingling now attributable to pressure on the thighs caused by sitting, particularly in the evening when even slippers could not be tolerated because contact with them was uncomfortable. After another month or so, tingling with an occasional stab of burning pain affected the ulnar two fingers of each hand when the forearms were rested on a table or desk.

It was then recalled that the symptoms began after a generous helping of mixed bran and muesli was adopted for breakfast, a regimen likely to impair the absorption of calcium. This diet was stopped and treatment with calcium lactate started. The symptoms lessened after the first dose of calcium lactate and ceased after three days on three level teaspoonfuls three times daily, disappearing in the reverse order of their appearance. Calcium treatment was tailed off over two weeks and then replaced by a glass of milk each morning. There has been no recurrence in the following six months.

Nineteen years previously the patient had been given streptomycin for six months for tuberculosis. Recent studies have shown that treatment with aminoglycosides affects calcium balance<sup>1</sup> although it is not known how long their effect may persist. Since streptomycin can damage hearing permanently, its influence on calcium metabolism may also be lasting. Because bran is so widely consumed and treatment with aminoglycosides is not uncommon, it is likely that mild examples of calcium deficiency are occurring in the community and they will not be recognized unless the possibility is considered. The key to the detection of calcium deficiency in the present case was that the symptoms depended on pressure on the arm or leg.

J. MARKS

121 Heathwood Road  
Cardiff CF4 4BJ

### Reference

1. Wilkinson R, Lucas GL, Heath DA, *et al.* Hypomagnesaemic tetany associated with prolonged treatment with aminoglycosides. *Br Med J* 1986; **292**: 818-819.

## Anaphylactic shock reaction to measles vaccine

Sir,

Recently, two children I have vaccinated against measles have suffered anaphylactic reactions. I feel it may be helpful to document once more the importance of having adrenaline at hand during childhood immunizations.

*Case 1.* An 18-month old West Indian boy was brought to the clinic for routine measles immunization. He had no contraindications and was given 0.5 ml of measles vaccine (Rimevax, Smith, Kline and French) intramuscularly into the upper arm. Five minutes after the vaccine,

the mother noticed that the child had 'gone sleepy' and called for assistance. The child's pulse rate was 15 min<sup>-1</sup> and his respiratory rate 10 min<sup>-1</sup>. He was peripherally cyanosed, had periorbital oedema and widespread erythema. He was hypotonic and responded only to painful stimuli.

Adrenaline was given intramuscularly (0.1 ml of 1 in 1000). Within one minute his pulse and respiratory rate were improving, within 10 minutes the eyelids were less oedematous and the vital signs had stabilized. He was transferred to the local hospital where he was admitted and observed overnight. There were no further sequelae.

*Case 2.* Three weeks later a 16-month old Caucasian girl was brought to the clinic for measles immunization. There were no contraindications, and she was given 0.5 ml of Rimevax vaccine intramuscularly into the upper arm. Five minutes later the child started to cry and had widespread erythema. Her heart rate and respiratory rate were normal. In view of the likelihood of an atypical reaction arrangements were made for the child to be transferred to hospital.

During the journey, 10 minutes after the vaccine had been given, the child became cyanosed and the respiratory rate decreased to 10 min<sup>-1</sup>. Widespread wheezing was audible on auscultation.

Adrenaline was given intramuscularly (0.1 ml of 1 in 1000). She responded rapidly and within two minutes her vital signs had stabilized. She was discharged from hospital later that evening with no further sequelae.

Anaphylactic shock is a well recognized complication of measles vaccination. It occurs at a frequency of around nine per 170 000 vaccinations.<sup>1</sup> In view of this risk, wherever immunizations are performed, up-to-date adrenaline should be available, preferably in the same tray as the vaccines. The childhood dose list (Table 1) should be kept with the adrenaline; the stress of a child in unexpected shock rapidly reduces one's ability to calculate the dose per kilogram.

**Table 1.** Dose of adrenaline (1 in 1000 strength) to be administered intramuscularly by age of child.

Age of child (years)	Adrenaline dose (ml)
<1	0.05
1	0.1
2	0.2
3-4	0.3
5	0.4
6-10	0.5 (adult dose)

If possible the adrenaline should be given before the vital signs have deteriorated.

ANNE THURSTON

Child Health  
Elizabeth Blackwell House  
New Cross Hospital  
Avonley Road  
London SE14

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1. Pollock TM, Morris J. A seven year survey of disorders attributed to vaccination in North West Thames Region. *Lancet* 1983; **1**: 753-757.

## Visits to children: is admission always required?

Sir,

Now we have entered another winter, we are in the period when we may expect an increase in sudden infant deaths. General practitioners will be reminded of the 1985 Department of Health and Social Security study which found that many babies had significant symptoms prior to death.<sup>1</sup>

A paper by Valman<sup>2</sup> suggested that any doctor encountering a child aged under two years with these symptoms should admit the child to hospital. Over a six-month period I studied how many extra admissions would result if I followed Valman's advice.

In my teaching practice of 16 000 patients, I made 530 home visits in six months (February-July 1985): 58 (11%) of these visits were to children under two years old, 44 of whom were under one year old. There was only one child who required admission, an eight-month-old boy with intussusception. There was however, one cot death in my study period.

I propose that admitting every child with symptoms of minor illness would cause not only increased upheaval in the family but also an unmanageable increase in hospital workload.

JOHN S. DOWDEN

Teaching Centre  
North Tees General Hospital  
Stockton on Tees  
Cleveland TS19 8PE

### References

1. Department of Health and Social Security. *A multi-centre study of post neonatal mortality*. London: HMSO, 1985.
2. Valman B. Preventing infant deaths. *Br Med J* 1985; **290**: 339.