LETTERS

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A case of neonatal conjunctivitis caused by chlamydia?

Sir,

A 23-year-old woman phoned the surgery one evening, commenting on a television programme about chlamydia that her friend had seen. She requested a test for chlamydia as her baby, now some 17 months old, had had conjunctivitis at the age of two weeks. To put her mind at rest I obtained the appropriate swab from the pathology laboratory and at a later date took a cervical swab. To our mutual surprise it was positive. Was the neonate's conjunctivitis chlamydial? Unfortunately, this question can never be answered satisfactorily as the child had been treated with chloramphenicol eye drops before cultures were taken.

The mother, a primigravida with no significant previous gynaecological history, was 21 years old and unmarried when her daughter was delivered normally, following an episiotomy, in hospital. At 32 weeks pregnant the mother had had a slight pinkish vaginal discharge for four days, with slight abdominal pain and at 38 weeks there had been a somewhat excessive vaginal discharge but a high vaginal swab taken at the time was negative though there was no specific test for chlamydia.

Five days after the birth both mother and baby seemed well and were allowed home, two days later the baby developed a sticky eye. This failed to clear within two days with saline bathing by which time there was a definite purulent conjunctivitis. Treatment with sulphacetamide sodium eye drops 10% was started, and again there was no good response over several days and treatment with chloramphenicol eye drops was started. Initially there seemed to be a good response but the condition apparently recurred despite continued treatment. The child was then seen at the local opthamology outpatient department. On examination it was found that the right eye was quiet but there was oedema of the left lid and congestion of the conjunctiva and conjuncitival discharge. The baby was admitted to the local eye hospital where swabs were taken for chlamydia and bacteria. *Staphylococcus albus* only was isolated. While awaiting the culture results the child was prescribed gentamicin eye drops and penicillin eye drops for both eyes, she made an uneventful recovery and was discharged after four days. A bacterial swab taken at the outpatient department five days later grew nothing.

The most frequent cause of neonatal conjunctivitis is chlamydia. Many such infants are seen after leaving hospital by a member of the primary health care team when the conjunctivitis first develops. As with all infections the appropriate swabs, in this case for chlamydia and bacteria, should be taken before treatment is started. There are now several sensitive tests for chlamydia which could be used routinely for all cases of neonatal conjunctivitis, though a more appropriate test would be a cervical swab from the mother when 36–37 weeks pregnant. If this proved positive, treatment with oral erythromycin prior to delivery would cure the mother's chlamydial infection, preventing any sequelae including conjunctivitis in the neonate. However, because of the resources required, screening all pregnant women may be impracticable but all pregnant women at high risk should be screened, for example unmarried women and those who have complained of a vaginal discharge, especially a bloodstained vaginal discharge before or during their pregnancy.

There are two main diagnostic methods currently used for the detection of chlamydia in clinical specimens. First, the isolation of the organism and visualization — the viable elementary body form of chlamydia present in clinical specimens infects tissue culture cells and the resultant inclusions are detected by staining techniques, for example, Giesma, iodine or immunofluorescence.[1] Secondly, direct demonstration of chlamydia in clinical specimens using a fluorescein labelled monoclonal antibody, for example the Imagen chlamydia test (Ciba). The ELISA chlamydia test (Abbott) is an alternative diagnostic test for a genus specific chlamydia antigen and provides an enzyme amplification system to enhance the test signal. False positives occur using these immunological tests.

Chlamydia trachomatis has been recognized as a frequent cause of sexually transmitted urethritis[1,2] and has been implicated in a variety of clinical conditions. It is now important for general practitioners to think of the possibility of chlamydial infections and to be aware of the diagnostic tests which are available.

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Rubella vaccination — what happens in practice

Sir,

Rubella infection in the first trimester of pregnancy is still responsible for avoidable congenital abnormalities and terminations of pregnancy. The Department of Health and Social Security recommends that all girls aged 10–14 years and all seronegative women of reproductive age who are not pregnant should be offered vaccination and informed of their immune status.

The general practitioner's role in rubella vaccination is unclear. In order to determine the views of the general practitioners in the Brent and Harrow Family Practitioner Committee area, we circulated a questionnaire to them.

A response rate of 84% was obtained after three mailings. Of the respondents,

51% stated that they routinely invited all girls aged 10–14 years on their practice list to attend for vaccination, while 63% stated that they opportunistically checked the girls' rubella vaccination status when they attended surgery.

Of the respondents, 97% offered a family planning service to their patients. However, 30% of these general practitioners did not appear to ask women attending for family planning advice about their rubella vaccination status, thus missing a golden opportunity to identify women at risk. Furthermore, only half of the respondents had a policy of checking rubella antibodies in women who have not been vaccinated.

In Brent and Harrow and many other areas, general practitioners are not routinely informed of the rubella vaccination of their patients either by the school medical service or by local authority family planning clinics. We believe that such notification would assist general practitioners in identifying their female patients at risk for rubella infection. We should therefore like to recommend that any other agency carrying out rubella vaccination should be responsible for informing both the patient and her doctor of her rubella status so that the general practitioner can keep definitive records of this important information.

We also suggest that the current family planning payment claim form (FP1001) should include a box stating that the rubella status of the patient has been assessed and that this should be ticked in order to claim payment.

We have circulated the results of our survey to the general practitioners in Brent and Harrow and plan to carry out a repeat survey after one year. The results will be analysed to determine whether there has been any change in policy regarding rubella vaccination by the general practitioners concerned.

We should like to thank all those general practitioners in Brent and Harrow who completed the questionnaire and the North West London Faculty of the Royal College of General Practitioners who funded the study. We are grateful to Dr C.I. Dellaportas for his assistance with analysis of the data.

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Weight reduction in the management of hypertension

Sir,

Croft and colleagues have shown the importance of weight reduction in the management of hypertension (October *Journal*, p.445). In the clinics of the Kupat Holim Sick Fund in Israel hypertension follow-up clinics are run by practice nurses. Hypertensive patients are seen monthly and all aspects of their treatment are reviewed, including their weight. In a retrospective study of nine of these clinics in the Netanya area it was demonstrated that over 50% of the patients lost over 3 kg and maintained that weight reduction for the three years of the study (Table 1).[1] The nurses work in consultation with the doctor but without the assistance of a dietician and they use protocol type diet sheets as well as weighing the patients monthly.

Table 1. Percentage of patients losing weight (initial n = 132, 2% drop-out after three years).

	Weight reduction (kg)		
	3–5.9	6+	Total
After one year	*31.7*	*14.4*	*46.1*
After two years	*39.4*	*18.9*	*58.3*
After three years	*36.4*	*18.2*	*54.6*

Reisen and colleagues found that each kilogram of weight loss was associated with an approximate drop in diastolic and systolic blood pressure of 3 mmHg.[2] Thus the weight losses achieved in the Netanya study were of an order of magnitude which could make drug treatment unnecessary.

We attribute the success of weight reduction at our hypertension clinics to the persistence of the nurses and doctors and to the community based approach employed, all primary care activities being carried out in the same clinic.

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Can general practitioners teach other general practitioners?

Sir,

Although many postgraduate lectures to general practitioners are given by 'experts', attendance at these lectures has not been shown to alter the way people work.[1] A topic review presented by another general practitioner who has a special interest in the subject will have more relevance to general practice,[1] and can also provide an opportunity for peer review.[2]

One of us (I.F.) presented a lunchtime postgraduate education lecture entitled 'Terminal care in general practice'. We wanted to ascertain whether the key points of the lecture had been appropriately targeted to the audience's practical problems. Of 30 attenders, the 19 general practitioners who had signed the attendance register legibly were contacted by telephone less than one week after the lecture. An independent researcher (R.B.) discussed a short standard questionnaire with them about the lecture, to ascertain whether they had found the lecture useful and if they were currently practising the key points.

Eighteen general practitioners answered questions: the majority (16) had found the lecture useful (13) or very useful (3); one 'did not learn much' and one found it 'no use'.

Knowledge of drug use varied widely (Table 2). All attenders appeared confident in prescribing morphine sulphate tablets Continus (Napp), but one-third were unaware of the use of morphine to control dyspnoea from lung secondaries and only two general practitioners were aware that haloperidol was an antiemetic that could be prescribed 12-hourly. The use of laxatives to prevent constipation, or even bowel obstruction in patients with bowel tumours, was a new concept to one-third of general practitioners. Half of the doctors knew that dexamethasone in high doses could reduce raised intracranial pressure from secondaries, but did not use it in practice. The role of the domiciliary physiotherapist for intermittent limb-sleeve compression (Flowtron) therapy was unknown to 14 general practitioners.

The lecture was deemed 'useful' by the majority of the attenders and had introduced new concepts to those present. The general practitioner who thought the lecture to be of 'no use' went on to state he had learned three specific new concepts; the general practitioner who felt the lecturer had not taught him much new information, learned two new concepts from it.