9. Alexander AG, Harpur NCW, Luxton KD, Talbert AW. The problems of collecting the Korner minimum data set at a district psychiatric hospital. *Health Trends* 1985; **17:** 76-78.
10. Jachuck SJ, Price P, Bound CL. Evaluation of quality of contents of general practice records. *Br Med J* 1984; **289:** 26-28.
11. Mansfield BG. How bad are medical records? A review of the notes received by a practice. *J R Coll Gen Pract* 1986; **36:** 405-406.
12. Glanz A, Taylor C. Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers. *Br Med J* 1986; **293:** 427-430.
13. Bucknall CA, Morris GK, Mitchell JRA. Physicians attitudes to four common problems: hypertension, atrial fibrillation, transient ischaemic attacks and angina pectoris. *Br Med J* 1986; **293:** 739-742.
14. Fullard E, Fowler G, Gray M. Facilitating prevention in primary care. *Br Med J* 1984; **289:** 1585-1587.
15. Williams EI. The general practitioner and the disabled. *J R Coll Gen Pract* 1983; **33:** 296-299.
16. Nuffield Provincial Hospitals Trust. *Occasional paper 1. General practice: policies for a crisis? Some aspects of DHSS policies for the care of the elderly.* London: Nuffield Provincial Hospitals Trust, 1984: 38-45.
17. Williams EI. Anticipatory care for the elderly in general practice. In: Isaacs B (ed). *Recent advances in geriatric medicine.* Edinburgh: Churchill Livingstone, 1985: 255-265.
18. Freedman GR, Charlewood JE, Dodds PA. Screening the aged in general practice. *J R Coll Gen Pract* 1978; **28:** 421-425.
19. Williams EI, Bennett FM, Nixon JV, *et al.* Sociomedical study of patients over 75 in general practice. *Br Med J* 1972; **2:** 445-448.
20. Tulloch AJ, Moore V. A randomized controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **29:** 733-742.
21. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London: HMSO, 1986: 12-21.
22. Brown AM, Jachuck SJ, Walters FM, Van Zwanenberg TD. The future of general practice in Newcastle upon Tyne. *Lancet* 1986; **1:** 370-371.

Acknowledgements

We thank all the participating general practitioners, consultants and professors for their contribution. The project was partially supported by the Joint Care Funding and we gratefully acknowledge their support. We also thank Lynda Scott for her assistance in preparing the manuscript.

Address for correspondence

Dr S.J. Jachuck, The Medical Research Centre, 377 Stamfordham Road, Westerhope, Newcastle upon Tyne NE5 2LH.

Psychoactive drug use by doctors in the USA

Random samples of 500 practising physicians and 504 medical students in a New England state were surveyed during 1984–85; 70% of the physicians and 79% of the students responded. Fifty-nine per cent of the physicians and 78% of the students reported that they had used psychoactive drugs at some time in their lives. In both groups, recreational use most often involved marijuana and cocaine, and self-treatment most often involved tranquillizers and opiates. In the previous year, 25% of the physicians had treated themselves with a psychoactive drug, and 10% had used one recreationally. Although most of the use was experimental or infrequent, 10% of the physicians reported current regular drug use (once a month or more often) and 3% had histories of drug dependence. More physicians and medical students had used psychoactive drugs at some time than had comparable samples of pharmacists and pharmacy students. The results suggest a need for renewed professional education about the risks of drug misuse.

Source: McAuliffe WE, Rohman M, Santangelo S, *et al.* Psychoactive drug use among practicing physicians and medical students. *N Engl J Med* 1986; **315:** 805-810.

INFECTIOUS DISEASES UPDATE

Pertussis and *Mycoplasma pneumoniae* infections

Both these infections cause outbreaks at approximately three to four year intervals. We are currently coming to the end of a pertussis epidemic but mycoplasma is on the increase. The recent pertussis epidemic appears to have been slightly smaller than the last, probably owing to greater use of vaccine. We would expect few cases now until the next outbreak starts in around 1989. *Mycoplasma pneumoniae* typically causes fever, cough and a patchy pneumonia without the severe toxicity usually associated with pneumococcal or legionella infections. Erythema multiforme or a 'glandular fever' like illness are alternative presentations. More cases occur between epidemics than with pertussis. Most virus laboratories can now look for specific IgM on a single serum sample which confirms the diagnosis.

Meningococcal infection

Over the last 12 months there has been, throughout Britain, an increase in notifications and laboratory reports of meningococcal infection to approximately double the 'usual'. The last national epidemic (as opposed to local outbreaks) was in around 1975. The combination of an acute febrile illness with purpura (sometimes very scanty) should suggest the diagnosis. Parenteral penicillin given before transfer to hospital, if any delay is anticipated, can be lifesaving.

Searching for nasal carriage of meningococci among contacts or looking for the source of infection are of little practical value in preventing secondary cases since there is a high rate of carriage in the normal population. Giving rifampicin or minocycline to close contacts (for example, family and playgroup friends) as recommended in the *British national formulary* may be helpful.

HIV infection

General practitioners are increasingly requesting blood screening for patients concerned about human immunodeficiency virus (HIV) infection and for those who are in high risk groups. It is, however, important for general practitioners to be ready to respond to positive tests because of the implications for the patient and the need for counselling those infected so as to prevent further spread. Facilities vary from region to region and local community medicine specialists should know what clinics or specialist advice is available.

Rabies vaccination

A recent case of 'imported' rabies contracted following a dog bite in India is a reminder that a human diploid cell vaccine, largely free from side effects is now available. It is effective if used before or after exposure. Travellers may wish to be protected before departure especially if intending to be 'off the beaten track', although they should note that boosters plus hyperimmune rabies immunoglobulin should still ideally be received after a suspect bite. The vaccine is obtained from Merieux UK Ltd (telephone 02816 2566) and costs around £20 for a 1 ml dose. Three injections of 1 ml deep subcutaenously (at four week and 6–12 months intervals) is the standard recommended schedule. Intradermal injections of 0.1 ml can be used. They must be truly intradermal and their effectiveness is as yet less well documented.

Further information about these subjects can be obtained from the contributor: Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (telephone 041-946-7120).