

LETTERS

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Post-tubal-sterilization syndrome

Sir,

In our practice it has become apparent that many patients who have had a tubal ligation subsequently require hysterectomy some years later. Computer analysis shows that 131 (5.9%) of our 2210 female patients have had tubal ligation, 24 of whom (18.3%) later required hysterectomy and a further 11 of whom (8.4%) developed menorrhagia requiring dilatation and curettage.

Muldoon¹ showed similar findings in Dundee; of 410 patients who had a tubal ligation, 90 (22.0%) later developed menorrhagia, 49 of these (12.0%) required hysterectomy, while a further 21 (5.1%) required hysterectomy for other causes. Destefano's² findings suggested that the outcome depends on whether the woman had normal or abnormal cycles prior to sterilization, but confirmed an increased prevalence of menstrual irregularity among the post-tubal-sterilization groups some years later. Interestingly, Neil and colleagues³ also found that both menstrual blood loss and menstrual pain were higher in women who underwent laparoscopic sterilization (coagulation) than in women who had tubal ligation performed by the modified Pomeroy (partial salpingectomy) technique.

Contrary to the suggestion of Rubin and colleagues⁴ that the post-tubal-sterilization syndrome is a misnomer, I feel that our findings suggest that it is important to advise the patient that menorrhagia may result from tubal ligation, especially in those women with a previous history of menstrual problems.

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Employing a medical student to audit the practice

Sir,

Performance review, or the auditing of practice activities, should lead to higher quality care for patients by provoking behaviour change in the practice. Self-audit within a practice shows how different doctors are performing, while the practice results can be used to compare performance between practices. Audit is thus an educational experience for those partaking, but it is not yet an activity that receives payment and the collection and analysis of data is time consuming. It can be delegated to ancillary staff but their lack of basic medical understanding means training and close supervision are necessary for many of the most basic auditing tasks.

We decided to look at various aspects of our practice and a medical student was employed for six weeks in the summer of 1986 under the family practitioner committee ancillary staff reimbursement scheme. We thus had an intelligent mind working full time on the audit of our practice and as she was from outside the practice and had no preconceived ideas or standpoint her view of our work was unbiased.

The medical student gained experience in data collection analysis, learned about the concepts involved in performance review, and obtained insight into the nature and working of general practice. After her day's work she sat in on the surgeries, gaining clinical experience. She also earned money.

Employed for six weeks she was able to look at various aspects of our repeat prescribing, the process and outcome of our maternity patients, our diuretic and anticonvulsant prescribing, and our hypertension screening programme.

There was a direct clinical and financial benefit to the practice, in that her work identified incomplete immunization

courses and patients requiring coil checks. This led to the introduction of a coil check recall system. Over a year, with the increased item of service payments, she will more than pay for herself.

As a result of her work we made changes in our repeat prescribing system and decided to review all our epileptic patients. Many of our practice policies have been reinforced. We feel there was mutual benefit for student and practice in her employment and she has also been invited back next summer to assess whether we have improved.

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Continuing audit of preventive care using a computer

Sir,

The use of conventional methods to perform audit exercises is tedious and slow. Data collection — even with the help of an age-sex register — is an onerous and repetitive task. With the help of a practice computer electronic data may be recovered rapidly, manipulated and displayed or printed elegantly.

In this practice every patient has a concise computer record which contains, among other details, data on the preventive care appropriate to the age and sex of that patient. Each month a program is run which compares each record with programmed screening criteria. With some 3000 patients this takes about half an hour. The results are filed on disk and these can then be accessed, displayed or printed in seconds.

Apart from the doctor, several members of the practice team are involved in