In 1984, while a trainee in general practice, I surveyed the serum theophylline level of 20 patients. Only two had a serum theophylline concentration in the therapeutic range and, I suspected five patients of non-compliance. I attempted to increase the oral theophylline dose of the remaining 13 patients. Two were reluctant to increase their dose because of previous adverse effects with a higher dose and only four of the 11 patients who had their dose increased could tolerate it. Thus only six out of 15 patients in this survey could tolerate a therapeutic level of theophylline.

This survey clearly indicates that oral theophylline preparations are poorly tolerated in therapeutic dosage. I submit that general practitioners prescribe theophylline in subtherapeutic dosage because of the expectation that a considerable number of patients will be unable to tolerate a therapeutic dose.

D.W. BROWN

4 Hall Croft
High Street
Normanton
West Yorkshire WF6 2DN

Neonatal conjunctivitis

Sir,

Dr J.A. O'Brien (Letters, February *Journal,* p.82) makes some interesting suggestions in his report of a case of neonatal conjunctivitis. While most of his points are entirely accurate, I feel there are some areas where clarification is necessary in order to avoid misunderstanding.

First, Dr O'Brien quite correctly says that specimens for any microbiological investigation should if possible be taken prior to the initiation of antimicrobial therapy, in this instance citing the use of chloramphenicol eyedrops as the reason for failure to identify chlamydial infection. However, chloramphenicol is not the drug of choice for chlamydial ocular infections, even though a bacteriostatic effect may be demonstrated *in vitro*; indeed chlamydia can be the cause of a 'sticky eye' unresponsive to chloramphenicol eye applications.[1] In the neonate the treatment of choice is a topical tetracycline ointment, combined with systemic erythromycin therapy for at least two weeks. The latter addition serves several purposes — the oral therapy is easier for the patient to tolerate when up to six weeks of therapy may be necessary; ocular infection is not always eradicated by local treatment alone;[2] and perhaps of most importance is the prevention of respiratory tract colonization which may progress to chlamydial pneumonia.[3]

Secondly, I would like to comment on some of the diagnostic methods mentioned. Chlamydia culture remains the definitive method by which all others are judged — by necessity it is limited to centres that have facilities for tissue culture, and would not be available to the majority of general practitioners. Direct immunofluorescent techniques on the other hand are widely used by laboratories, and in skilled hands the incidence of false positive results is low. The ELISA test mentioned has promised to be an attractive alternative since the degree of skill needed compared with the immunofluorescent techniques is lower, but unfortunately a recent evaluation of the method concluded that it was unsuitable for routine diagnostic use at present.[4]

Finally, I should mention the process of specimen taking. As Dr O'Brien made clear, the diagnostic methods available are quite varied and it is important that the general practitioner liaise with his local laboratory prior to taking specimens so that the correct techniques are used, both in taking the specimen and transporting it to the laboratory. When examining for chlamydia, it is important to bear in mind that they are intracellular parasites, and in order to demonstrate them easily it is necessary to obtain cells for examination. In practice this usually means urethral scrapes in the male, endocervical specimens in the female, and for eye infections conjunctival scrapes (anaesthetizing the eye first if necessary).

I agree with Dr O'Brien that it is important for general practitioners to consider chlamydia infection in general practice. I would, however, request that general practitioners consult their local laboratory before embarking on extensive investigations, so that the appropriate specimens are taken and transported to the laboratory correctly.

A.D. GREEN

Royal Air Force Hospital
Wegberg
British Forces Post Office 40

References

1. Richmond SJ, Oriel JD. Recognition and management of genital chlamydial infection. *Br Med J* 1978; **2:** 480-483.
2. Ridgway GL, Oriel JD. Treatment of neonatal inclusion blenorrhoea. *N Engl J Med* 1977; **297:** 512.
3. Beem MO, Saxon EM. Respiratory tract colonisation and a distinctive pneumonia in infants infected with Chlamydia trachomatis. *N Engl J Med* 1977; **296:** 306-310.
4. Taylor-Robinson D, Thomas BJ, Osborn MF. Evaluation of enzyme immunoassay (Chlamydiazyme) for detecting Chlamydia trachomatis in genital tract specimens. *J Clin Pathol* 1987; **40:** 194-199.

Predisposing factors to infective disease

Sir,

Dr Bullimore concludes in his article on predisposing factors to upper respiratory tract infection (March *Journal,* p.107) that traditional theories of causation need revision. I would suggest that they do not.

The laudable search for causative organisms and thence 'magic bullets' has been centre stage in medical thinking for a century. Contagion accounts admirably for the illness process in many recognized infective syndromes leading to appropriate therapy. Many episodes of illness are now recognized to be the result of organisms within the system which remain inactive until, I presume, the balance between their further development and the bodily defences moves in their favour. Such organisms include Coxsackie B, herpes simplex, chickenpox, human papilloma virus and potentially many more.

A consideration of those factors widely accepted as effective prior to the availability of a definitive treatment for tuberculosis is instructive. Following transmission of the causative agent, the course of the illness very much depended upon the nature of the host's defences, varying from fulminant disease in the immune-impaired host to complete remission of the disease in the fit individual, provided this fitness was maintained. Which factors maintain 'fitness'? These are exemplified by the physical methods found in the sanitorium regimen. Advocating a balanced life-style with adequate nutrition, exercise, physical and emotional rest and sleep with avoidance of unhealthy habits is nothing new. However, these conditions rarely prevail in real life and not surprisingly ill health flourishes.

I contend that the current model of infective illness is too constrained. As for tuberculosis, models of chronic illness should encompass the spectrum of ill health. Our organism is constantly under attack and in most the balance swings towards disease with alarming regularity. I cannot prove that we do not always catch a cold or a sore throat or a spell of bronchitis yet I feel in many the disease process suggests recurrent intrinsic infection as in herpes or tuberculosis.

In our fight to target our magic bullets at offending pathogens we can easily overlook the traditional heath process which must be our constant ally.

S.P. ROTHERY

Health Centre
Stonesfield Street
Milnrow
Nr Rochdale
Lancashire

Health promotion

Sir,

As a general practitioner employed by a district health authority as a medical adviser in health education on a sessional basis, I was interested to receive the latest report from general practice.[1] With the increasing interest in prevention, health

education and promotion, I was surprised that the report makes no mention of the support, help and advice that is available from local district health education departments. A report[2] from the Department of Health and Social Security task force on health promotion in the National Health Service gives useful roles for the regions and the health districts in health promotion.

> 'The role of the district (1) To encourage, improve and promote the health of the people in the district. (2) Planning: in the context of national and regional policy to develop and set priorities in the light of analysis of local needs — to formulate plans, including qualified objectives, in the light of the above, to identify multi-disciplinary and/or multi-agency groups to implement those plans, to monitor and evaluate the effectiveness of such groups. (3) To encourage training for all those with a professional input to health promotion. (4) To ensure an adequate establishment of health education officers and other relevant staff. (5) To ensure relevant resources for health promotion.'

Surely the general practitioner should be in touch with, and support the local district health education/promotion departments, some of which may be linked with urban development programmes? Some have financial support from other agencies such as Manpower Services, particularly if the district is in a rural development area as defined by the Development Commission.

DEREK BROWNE

Merrival Lodge, Rhinefield Road,
Brockenhurst, Hants SO4 7SW

References

1. Royal College of General Practitioners. *The front line of the health service. Report from general practice 25*. London: RCGP, 1987.
2. Department of Health and Social Security. Health promotion in the NHS: a report on visits by a DHSS task force. *Health Trends* 1987; **19**: 27-29.

The objective structured clinical examination

Sir,

We read with interest the article by Walker and Walker on their experience of the objective structured clinical examination (OSCE) (March *Journal*, p.123). Their conclusions support our own impressions of the suitability of the examination[1] which we have used in the assessment of trainees in Grampian over the past two years. Given the current interest in this field, it is important that different forms of assessment are tested in different regions. Our own experience of it has convinced us of its value as an assessment procedure and as a learning experience for trainees.

We are concerned that their paper fails to highlight the main strength of the examination, namely the opportunity it presents to assess clinical competence. Given that the majority of trainees will have adequate clinical knowledge, it seems to us appropriate to assess their skills in the consultation. In our view, the OSCE is helpful in this process, particularly since it allows trainees to be assessed in a wide range of clinical settingss using real or simulated patients. The question stations give the opportunity of assessing decision making, for example by the interpretation of laboratory reports and diagnosis from clinical photographs. By using only multiple choice questions, this opportunity is diminished.

Readers may be interested to know of the course on assessment in medical education run by the Centre for Medical Education in Dundee. This course includes practical experience of the OSCE.

There is now a data bank of OSCE stations, and this includes several from general practice. Further details are available from Professor Ian Hart, OSCE Databank International, Department of Medicine, Ottawa Civic Hospital, University of Ottawa, Ottawa, Ontario, Canada K1Y 4E9.

WILLIAM REITH
MICHAEL W. TAYLOR

Grampian Health Board
Foresterhill Health Centre
Westburn Road, Aberdeen AB9 2AY

Reference

1. Reith W, Taylor MW. The objective structured clinical examination. *J Assoc Course Organisers* 1986; **2**: 34-40.

Sir,

We entirely agree with Drs Reith and Taylor that the main strength of the OSCE is the opportunity to assess clinical situations. We interpret this a little more widely. As well as assessing the consultation skills of trainees we also assess their response to items such as the laboratory reports and investigations that they may have requested for a patient. We would agree that another major advantage of the examination is that it is very flexible and can be used to assess any part of a general practitioner's work. In our paper we gave examples of a couple of simulated consultation stations which were used.

We have also built up a data bank of various other scenarios but space did not permit us to describe these in the *Journal*.

ROBERT WALKER
BARRIE WALKER

Postgraduate Centre
West Cumberland Hospital
Whitehaven, Cumbria CA28 8JG

Chiropody services for diabetics

Sir,

A working party has been set up by the British Diabetic Association and the Society of Chiropodists to survey the availability of chiropody services to diabetics under the National Health Service.

One reason for carrying out this survey is to ascertain what chiropody provision is available for diabetics and to identify where this provision may be lacking. Chiropody plays an essential part in the prevention of lower limb amputations by the detection and early treatment of foot ulceration and other foot problems in diabetics.

Evidence is invited from any interested party and should be sent to me at the British Diabetic Association.

SUSAN KNIBBS

British Diabetic Association
10 Queen Anne Street, London W1M 0BD

MRCGP examination

Sir,

I propose a new name for the College membership examination. The diploma in vocational training. I propose this for two reasons. The first is that the majority of candidates sitting the examination are vocational trainees who do not sit it because they want to join the College. They sit the examination for other reasons. The second is that the stated aims of the examination are 'the assessment of the knowledge and competence appropriate to the general practitioner on completion of vocational training'.[1] Thus MRCGP is now inappropriate as a reward for passing the College examination and DVT should replace the original letters.

T.W. NIMMO

Surgery, Union Road,
Camelon, Falkirk

Reference

1. Fry J, Hunt of Fawley, Pinsent RJFH (eds). *History of the Royal College of General Practitioners*. Lancaster: MTP Press, 1983: ch 10, p. 125.

Is your loo door really necessary?

Sir,

I have twice had difficulty in getting unconscious patients out of domestic lavatories. On neither occasion was the door locked. The first time, a man had fallen from the seat with his head in the hinge angle of the door. In the other case a lady had fallen jamming herself between the wall on one side and the cistern and lavatory pan on the other.

I suggest that on both these occasions life would have been easier had the doorway been closed by a curtain. This could be combined with a simple vacant/engaged sign on the doorpost or nearby wall. To provide auditory as well as visual privacy the vacant/engaged sign could be an illuminated electrical gadget wired up with a tape recorder to provide music at an appropriate level.

I.C. FULLER

Connor Lodge, Sedgefield,
Stockton-on-Tees