LETTERS

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.

Sexual abuse of children

Sir,

There is currently a great deal of concern about sexual abuse of children. One aspect of interest is the extent to which professional workers involved in the care of children have themselves been sexually abused. Professor Finkel has looked at this area in considerable detail in Canada.[1,2] He issued a questionnaire to a large number of professional audiences at workshops on sexual abuse and the results are shown in Table 1.

Table 1. Results of a questionnaire survey of professional and semi-professional audiences in Canada.

	Females	Males
Number of subjects responding	1022	360
Number (%) who had been sexually abused	570 (*55.8*)	95 (*26.3*)
Number (%) who had been overtly abused (grades 3 and 4)	253 (*24.8*)	46 (*12.8*)
Number (%) who kept overt abuse secret	112 (*44.3*)	27 (*58.7*)

I used Profesor Finkel's questionnaire as part of my presentation at the Spring Meeting of the College in Edinburgh. I invited each member of the audience to complete their questionnaire anonymously and place it in a ballot box. The respondents were asked whether before the age of 16 years they had ever been molested in any way by someone at least three years older. If the answer was 'no' they responded with 0; for exposure, voyeurism or harrassment they responded with 1; for casual, 'accidental' contact, rubbing or feeling 2; for sex play including oral kissing without penetration of an orifice 3; and for attempted or actual oral, genital or rectal penetration of any kind 4. They were also asked to specify whether they had told somebody within seven days or later or whether the information was still secret; to give selected details of the perpetrator; and to rate the abuse on a pain/pleasure scale.

Of approximately 300 general practitioners at the Spring Meeting 82 responded (27%). There were 53 male respondents and 10 reported some such experience during childhood and for five of them it was overt abuse (grade 3 or 4). Among the 23 female respondents 10 had had such an experience and four had experienced overt abuse. Six respondents had not indicated their gender and of these two had experienced overt abuse. Of the respondents reporting overt sexual abuse four of the five men, all of the four women and one of the two doctors with no gender indicated had kept the information secret up to the time of the survey. In all the instances of overt abuse, except one, the perpetrator was a family member or an adult well known to the child (teachers in two cases). For the whole group the age range at which abuse started was 3–14 years but for the majority was 8–12 years. On the pain/pleasure scale abuse was usually rated as unpleasant or painful, but one female respondent indicated enjoying grade 3 abuse at the age of 11 years.

The figures from both Canada and the UK indicate that a significant number of health professionals have experienced sexual abuse in childhood. These childhood experiences may have had serious consequences for some professional workers[3] affecting both their personal and professional lives.

It is important that organizers of training programmes on sexual abuse of children should be aware of the probability that some of the participants will have a personal history of such abuse. It is possible that these participants may not be consciously aware of their own childhood experiences and the training programme may bring the memory of the experience to the surface.[4]

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2. Finkel KC. Sexual abuse of children: an update. *Can Med Assoc J* 1987; **136:** 245-252.
3. Doyle C. Management sensitivity — an issue in child sexual abuse training. *Child Abuse Review* 1987; **1:** 8-9.
4. Spring J. *Cry hard and swim.* London: Virago Press, 1987.

Opiate administration in acute myocardial infarction

Sir,

The majority of patients suffering a myocardial infarction at home will call their general practitioner. The main role of the practitioner is to administer a strong opiate analgesic to relieve the patient's pain and anxiety. As a clinician who administers opiates to such patients, both in the accident and emergency department and at their homes, I feel that the need for caution with regard to dosage should be emphasized.

Research has shown that 5 mg of diamorphine given intravenously will relieve pain in most patients with few side effects.[1] This dosage was recently recommended to practitioners in an article in *Update.*[2]

Earlier this year our department surveyed 93 general practitioners in the Chester area. They were asked which analgesic and what dosage they would give to a patient with a suspected myocardial infarction. Seventy-seven doctors replied. Diamorphine and a morphine/cyclizine mixture were the most commonly used agents. The intravenous route of administration was favoured.

Fifty-four practitioners (70%) stated that they would give 10 mg or more of opiate as an initial dosage.

The side-effects which cause most concern are hypotension and respiratory depression. It is logical to assume that hypoperfusion and/or hypoxia could have serious consequences for a myocardium which is already damaged. There is no doubt that patients in hospital receive doses of intravenous opiates which occasionally produce deterioration. Resuscitation facilities, however, are more readily available.

I routinely give 5 mg of diamorphine to most patients. In the elderly or in those who are already hypotensive I would recommend an initial bolus of 2.5 mg diamorphine. Diluting the drug in water (10 ml) makes the administration of small doses easier. The placement of an intravenous plastic cannula or steel 'butterfly' allows administration of an incremental dose if necessary, as well as providing access for other drugs should complications develop.

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1. Scott ME, Orr R. Effects of diamorphine, methadone, morphine and pentazocine in patients with suspected acute myocardial infarction. *Lancet* 1969; **1**: 1065-1067.
2. Hampton JR. Management of myocardial infarction. *Update* 1987; 34: 661-665.

Patterns of work in general practice

Sir,

Dr Wilkin suggests (July *Journal,* p.322) that we did not properly relate our findings on patterns of work in general practice in Bromley (June *Journal,* p.264) to other studies or fully discuss their implications. We did in fact compare our results with those of the other major non-selective survey of general practice patterns of work, that of Wilkin and Metcalfe in Manchester,[1] but two graphs which directly compared our findings were cut at the editorial stage, owing to pressure of space in the *Journal.* Dr Wilkin, however, seems to have seen those graphs — probably as one of the paper's referees — as he correctly refers to the striking similarity between the two studies in terms of the relationship between list size and consultation rate, noting specifically that consultation rate falls with list sizes of between 1751 and 2000 patients. However, the data provided on one of our omitted graphs (Figure 1) do not suggest that this decline is continued for list sizes below 1750. We therefore felt unable to conclude that lower list size necessarily reduced consultation rate.

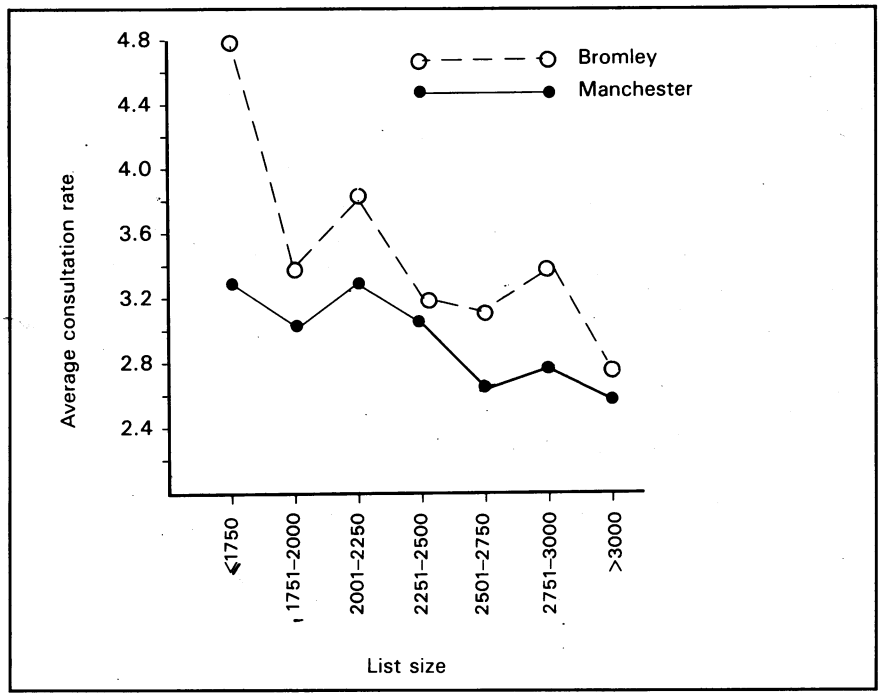

Figure 1. *Comparison of consultation rate by list size for the two studies.*

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Reference

1. Wilkin D, Metcalfe DHM. List size and patient contact in general medical practice. *Br Med J* 1984; **289**: 1501-1550.

Chlamydia trachomatis infections

Sir,

The paper by Longhurst and colleagues describing a simple method for the detection of *Chlamydia trachomatis* infections in general practice (June *Journal,* p.255) raises exciting possibilities for the control of the current epidemic.

However, I am worried by the paragraph on treatment. First, there was no mention of the infected women being told to avoid sexual intercourse until they and their partners had been treated and cured. Secondly, asking them to 'ask their sexual contacts to seek medical advice' is surely inadequate. Expert advice is needed, as each contact must either be firmly reassured if uninfected or treated and asked to tell his other sexual contact(s) to attend. There is little point in treating individuals for chlamydial infection; each patient forms part of a chain which must be pursued as far as possible to avoid the risk of reinfection. Even if the doctor is convinced that the chain is now broken, there is an obligation to warn other contacts that they may be at risk.

Male partners should attend a sexually transmitted disease clinic, having not passed urine for at least four hours, so that a urethral smear may be performed and Gram-stained for pus cells. This is cheap, and gives an immediate indication not only of chlamydial non-specific urethritis but also of non-chlamydial cases and gonorrhoea.

If a low-cost, low-technology screening system is required then maybe the future lies in screening men, both those with symptoms and those attending well-men clinics. Whichever sex is looked at initially, the future of the management of sexually transmitted diseases will depend on scrupulous contact tracing and the avoidance of intercourse by those still infected.

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