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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References

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.

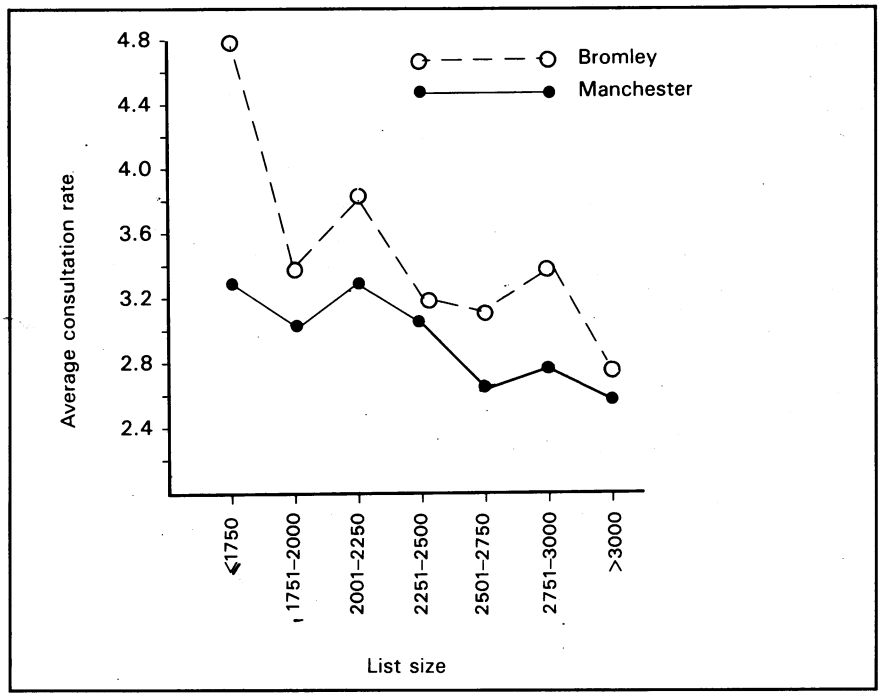

Figure 1. *Comparison of consultation rate by list size for the two studies.*

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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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