AIDS, HIV and general practice

Sir,

I welcomed the editorial on AIDS, HIV and general practice (July *Journal,* p.289). The point that the rarity of the acquired immune deficiency syndrome (AIDS) creates a false sense of security is most important. The incidence graph of AIDS is initially quite flat, very slowly increasing over two or three years before suddenly turning towards the vertical. In the early stages of its epidemiology AIDS is all too easily ignored, especially since varied patterns of transmission of the disease in different communities can encourage us towards ostrich-like behaviour.

For the past 30 months I have been working in Amsterdam and much can be learnt from the Dutch experience. When I first went to the Netherlands, in January 1985, AIDS was a novelty, something that occurred among the homosexual populations of the urban USA and was unlikely to bother us in Dutch primary care. Within a few months I was able to find a general practitioner, with a practice of some 2000 patients, to speak at a continuing medical education meeting on his experience of three cases of the syndrome with one death. When I last spoke to that doctor in February of this year he was a very depressed man who had experience of 11 young men with AIDS, of whom seven had died. In the last month I have seen seven cases.

In Amsterdam the incidence graph has reached its turning point; it is only a matter of time before the same thing happens in the UK. General practice has an enormous role to play but I am increasingly concerned at our apparent lack of preparedness.

The only way we can tackle the epidemic is through education. We must not be inhibited in this by lack of knowledge — there is nothing like teaching a subject as a means of learning. Of course we need diagnostic skills, which are difficult to learn while the disease is still a rarity, but more particularly we need to gain and disseminate knowledge and understanding of the disease to both colleagues and patients. A later role for the general practitioner will be the support and counselling of those waiting to die from AIDS. Here again we need to modify pejorative attitudes and use skills gained from other fields of palliative care so characteristic of good general practice.

As a matter of urgency I feel that we should be organizing discussion meetings by general practitioners for general practitioners in order to prepare ourselves for a situation similar to that in Amsterdam. We should also be seeking every opportunity to provide health education about AIDS, in the surgery and in our patients' homes. We should be offering to speak at practices, schools, clubs and women's institutes. The lives of young people can be saved if they are given the knowledge that leads them to hesitate or use protection.

When shall we begin?

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Geriatrics and the MRCGP examination

Sir,

Dr Janet Heyes is to be congratulated on the reading list for the MRCGP examination compiled from a questionnaire sent to successful candidates (July *Journal,* p.316) and on her succinct advice to candidates.

However, I was dismayed that the reading list contained no book or journal specifically on the care of the elderly in general practice. Geriatrics and gerontology are growing subjects, affecting a section of the population destined to expand in coming years. It is commonly believed that patients aged over 65 years occupy 40% of a general practitioner's time and it is therefore a paralogism that *Geriatric Medicine* is not included in the top 10 journals.

On a number of occasions I have drawn attention to the paucity of questions on geriatrics in the MRCGP exam, and noted as an examiner how badly the first one to be included, as late as 1980, was answered. Indeed, the only mention of geriatrics in the May 1987 papers was in the modified essay question when the crisis of a 78-year-old lady interrupts a surgery consultation. It is this kind of clinical intervention that makes the care of the elderly unpopular.

That books on gynaecology should be included in the reading list is understandable, but the reasons for the inclusion of two books on obstetrics are difficult to sustain. Even those with the DRCOG will rarely undertake intrapartum care.

No doubt, many of you may disagree with my views. Before you do, let me ask you a simple question. If you get it right, I will accept that I may be wrong. A 75-year-old woman is rendered immobile by a swollen inflamed knee. You withdraw fluid which is reported as containing polymorphs, and calcium pyrophosphate dihydrate crystals. Your diagnosis is pseudogout. Name four important conditions which can be associated with pseudogout.

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Otitis media or externa?

Sir,

Studies in recent years into the problems of managing earache in children all appear to assume that earache must only be caused by otitis media, and there is much confusion over the pathology. Paul Thomas in his letter (March *Journal,* p.132) does 'accept that little is clear in the mire of otitis media..' while Roger Jones and John Bain in their reply (March *Journal,* p.132) speak of 'the remaining questions about the natural history and optimum therapy of otitis media in children'.

However, after 42 years experience of otological examinations, including acute clinical work in a hospital ear, nose and throat department, aviation medicine and general practice with a large paediatric component, there is no doubt in my mind that in general practice, the commonest cause of earache in children is inflammation of the lining of the external auditory canal and not that of the middle ear. But to determine this requires careful and critical examination.

The external canal is contained within the ear lobe (the concha), the bony canal and the external surface of the tympanum. It is these parts which are inflamed and all symptoms and signs relate to them. They are tender to touch, painful when gently pulled for examination with an otoscope and often itch. The canal is often lined with discharge which can be seen to pulsate in the light reflex. In middle ear pathology, signs are often assumed; certainly the external canal is not tender to touch. Even the tympanic membrane is different. In myringitis (or tympanitis) of otitis externa, vessels can be seen coursing from the upper bony canal over the handle of the malleus, and round the periphery of the tympanum (circumtympanic). In myringitis of otitis media, the internal surface may be a dull red colour except in effusion when no inflammed vessels are visible; discharge from the middle ear is associated with perforation of the tympanum, and usually with relief from pain.

These clinical details were given in my paper published in the *Journal*[1] in 1976 which was written to express my confusion