Orthopaedic medicine

Sir,

I would like to draw your attention to an area of medicine seldom used and rarely taught, a knowledge of which I have found extremely useful in my year as a trainee general practitioner.

My training practice is in a rural area and has two partners and just over 3000 patients. There is an average spread of age groups and the area is relatively affluent with little unemployment and a large farming community.

A one-week course in the rudiments of orthopaedic medicine was enough to give me the confidence to use basic manipulative techniques on my general practice patients with generally good results and grateful patients. Encouraged, I learnt further techniques of injection and manipulation in the treatment of 'mechanical' musculoskeletal disorders and started a six month trial treating these problems at a clinic held one afternoon a week.

Over the six month period I treated 125 separate lesions in 108 patients with acute or chronic neck, back, shoulder or tendon/ligament disorders (Table 1). At the end of the period I sent a questionnaire to every patient asking whether treatment had been helpful or not, whether they would recommend the same treatment to someone else with the same condition, and how useful they felt a clinic of this type was.

Table 1. Lesions treated at clinic.

Lesion	Number treated	Number helped by treatment	Estimated annual incidence (per 1000 patients)[a]
Acute neck	19	17	13
Acute back	33	30	22
Chronic neck	11	11	7
Chronic back	15	11	10
Capsulitis of shoulder	12	9	8
Subacromial bursitis and supraspinatus tendinitis	14	11	9
Tennis elbow	9	6	6
Monoarticular flare ups of rheumatoid/ osteoarthritis	4	4	3
Tenosynovitis	3	3	2
Carpal tunnel	5	4	3
Total	125	106	83

[a]Figures may be an underestimate as some patients were seen by other doctors and did not attend the clinic.

Of the 108 questionnaires sent out 89% were returned. Ninety per cent of patients said they had found the treatment helpful and 95% said they would advise someone else with the same problem to have the same treatment. This sort of clinic was felt to be 'very useful' by 85% of patients; only 3% felt it was 'not useful' and 12% felt it was 'quite useful'.

The treatment helped a high proportion of different types of problems (Table 1) although many patients had not been helped by previous treatment with non-steroidal anti-inflammatory drugs. Many of the patients who had previously been treated by osteopaths and chiropractors would prefer to be treated by their general practitioner but only if he or she had more to offer than drugs.

Not all general practitioners will be interested in using orthopaedic medicine but I would suggest that even those who do not want to inject or manipulate mechanical lesions would benefit from learning a little more about these common disorders. The techniques of orthopaedic medicine are simple, safe, effective, easy to learn[1] and cheap. More emphasis should be placed on treating these disorders in general practice. After all about 15% of people consulting their doctor do so with a 'rheumatic' or musculoskeletal problem.[2]

I strongly encourage general practitioners and trainees to seek extra training in this area of medicine and can vouch personally for those courses run by the Society of Orthopaedic Medicine.

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References

1. Grayson MF. Manipulation in back disorders. *Br Med J* 1986; **293:** 1481-1482.
2. Fry J. *Common diseases.* London: MTP Press, 1979.

The age–sex register in general practice

Sir,

The age–sex register is an important tool in general practice research for selecting the sample group for study. However, for this purpose the register needs to be continually updated and even the best register is likely to have some degree of inaccuracy.

For example, Sheldon and colleagues[1] found an error in the address of 10% of patients from 10 practices (range 5–20%). They recommended that practices interested in research should allow patients every opportunity to correct the details contained on their medical record envelope. Fraser and colleagues[2] found that addresses in the age–sex register were incorrect for 8.2% of patients surveyed from five practices. They suggested that an accurate age–sex register is necessary for screening, research and administrative purposes in general practice.

My trainee project involved the selection of 180 pre-school children from a practice age–sex register. The families of 13 of these children (7%) had changed address. The new address had been recorded on the child's medical record envelope but not in the age–sex register in nine cases (5%) and in the remaining four (2%) the new address had been recorded on the medical record envelope of the parents but not in the age–sex register or on the child's record. As a result of this letters were posted to the wrong address, so reducing the potential response rate of the study.

My project confirms that an up to date age–sex register is necessary for research in general practice. Furthermore if the age–sex register is to be used for screening or research it is important that it is up to date for children as well as for adults.

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References

1. Sheldon MG, Rector AL, Barnes PA. The accuracy of age–sex registers in general practice. *J R Coll Gen Pract* 1984; **34:** 269-271.
2. Fraser RC, Clayton DG. The accuracy of age–sex registers, practice medical records and family practitioner committee registers. *J R Coll Gen Pract* 1981: **31:** 410-419.

The College has produced an information folder on age–sex registers available from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU, price £3.00 for members including postage (£4.00 for non-members).

Disclosure of medical information

Sir,

The time has come for general practitioners to call a halt to the disclosure of medical information to non-medical agencies, especially insurance companies and future employers. Our patients have no option but to consent to disclosure as to do otherwise would preclude them from their job or life assurance.

It is often said that one of the strengths of the National Health Service and general practice in particular is the lifelong patient records held. However, we are already seeing the reluctance of patients to allow their general practitioners to be

told the results of tests for the human immunodeficiency virus and this reluctance might extend to other negative findings at commercial health checks. I cannot be alone in having been asked by patients not to record certain facts in their notes or their spouse's notes or to delete records of previous events, usually terminations of pregnancy.

If commercial organizations wish to obtain medical information they should arrange for independent medical interviews with examination and investigation as they see fit. We should not risk the breakdown of doctor–patient relationships for the sake of a cheque for £11.

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Azapropazone in the treatment of gout

Sir,

I read with interest the article by Fraser and colleagues (September *Journal*, p.409) on the use of azapropazone in the treatment of gout. The suggestion that monotherapy is effective in both treatment of the acute attack and as a long term agent for lowering the serum urate level will, no doubt, tempt many doctors to use this simplified regimen as first line therapy in the future.

However, I would like to sound a caveat from the authors' own results. First, 11 of the original azapropazone group were withdrawn from the study because of adverse gastrointestinal reactions — a dropout rate of 24% — despite exclusion of patients with a past history of peptic ulcer disease. One third of these were after day 28 and one patient developed a potentially fatal perforated peptic ulcer on day 85.

Secondly, there is no significant difference between the azapropazone and allopurinol treatment groups in the attack rates for gout from day 85 onwards suggesting that the observed reduced number of attacks is solely a feature of the uricosuric property of azapropazone as compared with indomethacin.

It would seem sensible, therefore, to maintain allopurinol as first line prophylaxis of gout as it is a well tolerated effective agent, with little risk of producing a fatal side effect.

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Sir,

There are several problems in interpreting the trial by Fraser and colleagues (September *Journal*, p.409) purporting to compare azapropazone with indomethacin plus allopurinol in the management of acute gout.

Allopurinol precipitates gout so a non-steroidal anti-inflammatory drug is always used for a few weeks when treatment is started. In this trial indomethacin was withdrawn when allopurinol was started so it is not surprising that there were more attacks in the group treated with indomethacin followed by allopurinol. This point is acknowledged in the text but the summary contains the misleading statement 'Fewer breakthrough attacks of gout occurred in the azapropazone group..' It would perhaps have been more in accord with current clinical practice to have continued the indomethacin when allopurinol was started, as the title of the paper suggests.

Azapropazone was said to be 'superior' to indomethacin with regard to lowering serum urate. Again this statement is misleading since lowering the serum urate is of no importance in treating acute gout. The authors themselves showed no significant difference between indomethacin and azapropazone in the first month of treatment despite much lower serum urate in the azapropazone group.

Many general practitioners would not start urate lowering treatment after a single attack of gout because the patient may not suffer another attack for months or years. When long term prophylaxis is considered necessary a non-steroidal anti-inflammatory drug is more likely to cause adverse effects than allopurinol. In this study two patients taking allopurinol were withdrawn from the trial because of unwanted effects compared with 10 taking indomethacin and 12 taking azapropazone.

This study has not demonstrated any advantage of azapropazone over other non-steroidal anti-inflammatory drugs in treating acute gout and it would not seem to be a drug of choice for prophylaxis. Was the trial sponsored by the makers of azapropazone? If so this should have been clearly acknowledged.

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Practice nurses

Sir,

We read with interest the article by Greenfield and colleagues on practice nurses (August *Journal*, p.341) but were concerned that practice nurses in the sample were undertaking tasks for which they may not have received the appropriate training.

The paper states that 21% of the sample of 300 nurses were trained midwives and 8% had a family planning certificate, but 36% were giving family planning advice, 71% were performing cervical smears and 60% speculum examination of vagina and cervix. These skills are taught on the English National Board (ENB) course 900/901–family planning nursing.

In addition, 11% of the sample were performing bimanual examination of uterus and adnexae, 18% intrauterine device removal and 62% examination of breasts. These skills are not covered by the ENB course 900/901, and are usually only performed by those nurses who have undertaken an advanced course in family planning and have the appropriate indemnity insurance cover.

Our concerns are for:

— The professional accountability of nurses who may be practising outside the UKCC Code of Professional Conduct. We would draw particular attention to numbers 1–4 of the code (2nd edition).

— The personal accountability and legal implications for the nurse concerned.

— The patients who may receive information, advice and screening from inadequately trained nurses.

— The general practitioners whose professional reputation is reflected by the standards of their practice personnel.

Family planning is a recognized specialism in nursing with its own programme of preparation and refreshment. It is essential for nurses involved in these tasks to hold the current ENB course 900/901 Certificate of Competence in Family Planning Nursing. Indeed, the steering group who reported on the training needs of practice nurses endorsed this view.

In view of the practice nurses' desire to be less task-centred it is of interest that the revised course curriculum places considerable emphasis on the development of counselling skills and health promotion in relation to fertility and sexuality. The course is open to registered nurses, midwives and health visitors. Details of training centres can be obtained from ENB, Victory House, 107 Tottenham Court Road, London W1P 0HA.

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