Otalgia in general practice

Sir,

John Price is quite right in stating that otalgia in children is frequently misdiagnosed as acute suppurative otitis media (Letters, September *Journal,* p.418). I studied the epidemiology of otalgia in general practice in 1979. Over a six-month period it was evident that of 76 patients presenting with otalgia 46% had suppurative otitis media, 26% tubotympanic dysfunction, 24% referred pain (18 patients — 10 throat, three ear wax, three teeth, one cotton bud injury and one branchial cyst) and 4% otitis externa. I cannot support his tenet that otitis externa is the commonest cause of earache in children.

Primary otitis externa invariably causes itching and irritation, usually with a discharge. The irritation is described by patients as burning, itching and more commonly soreness. The symptoms are exacerbated by any movement of the pinna whether secondary to mastication, yawning or the examining doctor retracting the pinna. Pain is usually due to a furuncle of the external auditory canal or incipient herpes zoster (Ramsay Hunt syndrome). Extreme soreness is usually due to *Aspergillus niger* infection.

Secondary otitis externa is triggered by exposure of the meatal skin to an irritant and this commonly follows syringing of the ears. It may also follow spontaneous rupture of the drumhead in acute suppurative otitis media and hence is frequently encountered in general practice; it is this condition which produces a pulsatile light reflex on otoscopy.

In my experience, the tympanic membrane is usually normal in primary otitis externa, the most common variant. In diffuse otitis externa where fever, regional lymphadenopathy and systemic distress are present, the meatal skin and pinna are usually so oedematous that the tympanic membrane may not be comfortably visualized by otoscopy, and the disease may mimic acute mastoiditis.

To improve diagnostic accuracy an adequate history must be taken and a full examination of the patient's nose, mouth, throat, neck, scalp and both ears made. Routine ear, nose and throat examination is a *sine qua non* for appreciation of the rather subtle changes of the eardrum in disease.

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Diabetes and the general practitioner

Sir,

I applaud John Nabarro's call for general practitioners to meet the challenge of diabetic review (September *Journal,* p.389). In many cases it would appear appropriate for family doctors to offer surveillance but at present legislation discriminates against this ideal. I refer to the inappropriate anomaly whereby a patient attending a hospital clinic may obtain dip-sticks at little or no charge while a well motivated diabetic attending a general practice clinic has to obtain these materials at great expense. One hopes that the government will continue to take rational steps to improve the daily management of diabetic patients.

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Geriatrics and the MRCGP examination

Sir,

I was interested to read Keith Thompson's letter on geriatrics and the MRCGP examination (September *Journal,* p.418). I am one of several trainers in Lothian Region who are somewhat disappointed in the syllabus issued for training by the Scottish Council for Postgraduate Medical Education. There is only one direct mention of geriatrics, in phase 3 of psychogeriatrics, in what is otherwise quite a comprehensive syllabus. This indicates the general reluctance to include geriatrics when teaching trainees. It is difficult for trainees to become involved with older people during their trainee year because they are in the practice for a short time and this is probably why trainees do not include books on geriatrics in their reading list.[1]

Positive steps must be taken to emphasize the importance of geriatrics and psychogeriatrics. There might be a place for including a six month geriatric or psychogeriatric post as part of the training for general practice. Trainees who are not interested in geriatrics should not undertake general practice training.

The negative attitude to geriatrics is fostered by medical training where doctors are taught to think of medical cases as diagnostically interesting rather than as people. This negative attitude is reinforced in those who are not interested in geriatrics as they have to deal with geriatric crises at inconvenient times because they have not carried out sufficient screening or got to know their geriatric cases.

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Reference

1. Heyes J. Straight from the horse's mouth. *J R Coll Gen Pract* 1987; **37**: 316-317.

Attendance allowance

Sir,

I would like to clarify two points in the recent article about attendance allowance in the *1987 Members' reference book.*[1]

First, a claim should be made if attention or supervision is needed for six months or more following the qualifying period of six months, not three months as stated in the article.

Secondly, the recent ruling about married women looking after their relatives refers to invalid care allowance, not attendance allowance. A person can qualify for attendance allowance whether or not there is somebody there to look after him.

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Reference

1. Proctor A, Noone J, Adams J. Mobility and attendance allowance. In: The Royal College of General Practitioners. *Members' reference book 1987.* London: Sabrecrown Publishing, 1987.

Rehabilitation for coronary patients

Sir,

The Coronary Prevention Group is compiling a register of rehabilitation facilities for patients recovering from myocardial infarction and coronary artery bypass grafting. I would be most grateful if any general practitioners who provide such facilities could write to me and let me know if their programme includes: (1) advisory pamphlets, (2) counselling on risk factors, or (3) an exercise programme, and also whether there is a 'self-help' group which their patients join, with its name and address.

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