

LETTERS

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Malaria and its prevention in British residents visiting west Africa

Sir,

British travellers to west Africa are at considerable risk of contracting malaria, principally *Plasmodium falciparum* malaria, in both rural and urban areas. Recent reports¹⁻⁷ have indicated that resistance to chloroquine is now present in various countries in west Africa and it can be expected that chloroquine resistant *P. falciparum* will increase in prevalence in these countries, and spread to other areas of west Africa.

On 23 October 1987 a family of four British residents returned from a seven week holiday in Ghana. The 39-year-old father has resided in the UK for 13 years while his 29-year-old Caucasian wife and children aged six and three years have always lived here. The parents took 300 mg of chloroquine sulphate weekly and 200 mg of proguanil daily throughout their stay, without omission. The children received similar doses of chloroquine together with 100 mg of proguanil daily, also without omission. The parents became ill within two days of their return and microscopy confirmed all four had *P. falciparum* infections. None were hospitalized because their symptoms were relatively mild and parasitaemia low. All the members of the family responded to standard therapy (adult dose 600 mg quinine sulphate three times daily for five days, followed by three tablets of pyrimethamine (Fansidar, Roche) without recrudescence.

The prophylactic cover used by the parents was suboptimal while subpatent infections were revealed in the children who had received adequate protection. Furthermore, parasite isolates were not tested, so resistance to chloroquine is by no means substantiated. A reduction in efficacy is, however, tentatively suggested. This is reflected in data collated by the Malaria Reference Laboratory. The proportion of travellers to Ghana reported to

have taken combined prophylaxis of chloroquine and proguanil but who acquired *P. falciparum* infections rose from 2% to 14% of those for whom details of chemoprophylaxis were known between 1985 and 1987. The absence of information about drug use in the denominator population limits interpretation, but nevertheless, this combined regimen has been recommended to travellers visiting west Africa since 1985 (Ross Institute, unpublished report).

Visits to Ghana have doubled from 6587 to 11 246 per year over the last 10 years and over 32 000 visits were made to Nigeria in 1986 alone.⁸ Over the same period, cases of *P. falciparum* malaria in travellers returning from Ghana and Nigeria have risen threefold.

Physicians need to be aware that travellers visiting west Africa will be exposed to drug resistant parasites. Emigrant families residing in Britain cannot be considered to be semi-immune,⁹ and require adequate chemoprophylaxis for visits abroad. No regimen can be 100% effective. The misconception exists that the dosage of chloroquine base and chloroquine sulphate/phosphate are identical but 100 mg of chloroquine base is approximately equivalent to 136 mg of chloroquine sulphate and to 161 mg of chloroquine phosphate. All adult travellers should be advised to take 300 mg of chloroquine base weekly and 200 mg of proguanil daily, a week before travel, throughout their stay and for four weeks on return to the UK. In addition, measures to reduce contact with mosquitoes should be strongly recommended. It is probable that malaria breakthroughs will become increasingly common despite compliance with current prophylactic regimens. Any patients presenting with malaria or influenza symptoms subsequent to travel require immediate care; microscopic diagnosis is essential to ensure prompt and adequate treatment. *In vitro* testing of *P. falciparum* isolates is helpful to detect the spread of resistant strains.

P.A. PHILLIPS-HOWARD

D.J. BRADLEY

Malaria Reference Laboratory
London School of Hygiene and Tropical
Medicine
London WC1 E7HT

D. WAGHORN

Department of Microbiology
Mayday Hospital
Thornton Heath
Surrey

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Precautions after missed contraceptive pills

Sir,

The latest Family Planning Information Service leaflets state that if a patient misses a combined oral contraceptive pill for more than 12 hours, she should recommence pill-taking as soon as she remembers and is then unprotected for seven days. If a pill is missed in the last

week of the packet the patient should start a new packet after completing the old, that is without having a gap, and will be unprotected for seven days.

However, the advice given in the *Data sheet compendium* is sometimes more cautious but, more worryingly, at times less cautious than the above. As an example, 13 out of 25 data sheets for the combined pill state that a woman is unprotected if a pill is missed for 12 hours (the remainder imply that two pills have to be missed before she is at risk). Only 11 advise that women should take their missed pill in addition to the next due pill (the remainder advise omitting pills missed for greater than 12 hours or are vague on this advice). Twenty-three of the advice sheets state that the woman is not safe until the withdrawal bleed. This is over-cautious for pills missed in the first two weeks of a packet and less stringent than the Family Planning Association advice for pills missed in the last week of the packet. Only two data sheets are totally safe in recommending other forms of contraceptive for two weeks or until a withdrawal bleed, whichever is the longer, but again this is over-cautious.

The advice for progesterone-only pills is similarly confusing. Only three out of six data sheets point out that three hours is the time limit for safety, two state that being late with pill taking can reduce protection but do not state a time limit and one implies that at least two pills have to be omitted before protection is reduced and does not mention the need for punctuality in pill taking. Lastly, five of the six data sheets state that a woman is unprotected for 14 days and the other states until the next period, while the family planning leaflet states that protection is only reduced for two days.

When prescribing oral contraceptives we should perhaps tell our patients to ignore the information they receive with their pills.

D. METSON

29 Lochinver
Birch Hill
Bracknell
Berks RG12 4LD

Local oestrogen for recurrent epistaxis caused by familial telangiectasia

Sir,

Familial haemorrhagic telangiectasia (Rendu-Osler-Weber disease) is a distressing complaint typified by frequent severe nose bleeds. No remedy exists although systemic oestrogens have been considered effective in uncontrolled

studies.¹ I wish to report a case where topical oestrogens have effected a remarkable improvement.

The patient, a widow aged 69 years, had suffered from daily nose bleeds of increasing severity for 20 years and found application of 1 in 10 000 adrenalin to be the only effective solution. Because of embarrassment she had begun to avoid social contact and had become depressed and withdrawn. She was recommended to take systemic oestrogens by an ear, nose and throat specialist, but in view of a unilateral retinal artery occlusion which had occurred two years earlier I was unwilling to prescribe this. The patient and I discussed the matter and she agreed to try the daily application of small quantities of dienoestrol 0.01% vaginal cream to Little's area. Following this treatment she reported a dramatic cessation of her epistaxis for the first time in many years, remaining virtually symptom-free over a six month period. She used less than 5 g of the preparation over this period and her general demeanor and mood lifted considerably.

Dienoestrol cream (Ortho Dienoestrol) has been used for atrophic vaginitis for many years, but the medical officer to the manufacturer, Ortho-Cilag Pharmaceuticals Ltd, reports that no satisfactory measurements of serum levels after vaginal administration have been possible. Withdrawal vaginal bleeding is well documented but is probably a rare occurrence compared with the number of prescriptions issued. The medical officer considers that the tiny amounts of cream administered nasally would be unlikely to give significant serum levels, and is not aware of its use in this area before.

I would be most interested to know if this form of treatment for such a distressing complaint has ever been evaluated.

P.M.J. TOMBLESON

Crossways Surgery
Ditchling
Sussex BN6 8UQ

Reference

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Evaluation of a waiting list leaflet issued to general practitioners

Sir,

Since 1983 Brighton health authority has had a system of notifying general practitioners of the waiting list numbers and average waiting times in hospitals. A leaflet listing the main inpatient and out-

patient services in the district by individual consultant, specialty and hospital is produced quarterly by the information department and mailed to general practitioners by the local family practitioner courier system. The specialties are given in alphabetical order showing outpatient waiting times and numbers on inpatient waiting lists.

A new waiting list leaflet has now been designed incorporating some of the Korner inpatient waiting list statistics, for example the length of time patients have been on the list. In order to evaluate the usefulness of the leaflet and to establish whether other changes in format were required by the local doctors a specially designed questionnaire was mailed out with the June 1987 leaflet to all 170 general practitioners in the Brighton health district. After one reminder the overall response rate was 88%.

The majority of 149 doctors who replied (97%) stated that they found the leaflet useful and 97% wished to continue receiving it. Ninety per cent consulted the leaflet when a patient was referred to a hospital consultant, though only 15% did so every time. Less than a third of the doctors (31%) routinely told the patient about the differences in waiting times between consultants while 53% did so occasionally. The majority of general practitioners (71%) offered the patient a choice in whom they were referred to, based on the information in the leaflet and 7% occasionally did this.

The current quarterly leaflet appears to be useful to most general practitioners in Brighton and there was no overwhelming request to change the format, timing or content of the leaflet. However, although the majority of doctors offer the patient a choice based on the information contained in the leaflet, at least one third do not.

Other initiatives have also been taken in Brighton. Following a seminar entitled 'Teaching hospital doctors how to communicate with GPs', organized at the local postgraduate centre in May 1985 four evening meetings were held in four general practice surgeries and all the orthopaedic consultants in the district attended each meeting. They were able to meet local doctors on their home ground and to discuss referral practices and problems with waiting lists. Sixty-five per cent of the practices in the district were represented at these meetings. In July 1987 a series of sessions on the 'perfect referral' were arranged at the local postgraduate centre. Consultants from different specialties outlined what they would expect from the general practitioner in the patient referral letter, taking a common diagnostic