

## LETTERS

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**Note to authors of letters:** Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

### General practitioner access to pelvic ultrasound

Sir,

General practitioner access to pelvic ultrasound is variable. Of 10 district general hospital X-ray departments contacted in the west Midlands, only three allowed direct access to pelvic ultrasound examinations without prior consent from the radiology department. In a review of direct access scans in the Wolverhampton area, a questionnaire was sent to the general practitioners concerned between three and 15 months after the scan to assess the results.

Replies were received for 82 (75%) out of 110 patients. All the patients were women with an average age of 38 years (range 19–73 years). Pelvic pain was the presenting complaint for 35 women (43%), clinically suspected pelvic mass for 19 (23%), abnormal menstrual cycle for 16 (20%), location of intrauterine device for seven (9%) and abdominal distension for five (6%).

For 52 women (63%) no abnormality was seen, while for 13 (16%) there was a positive report suggesting possible hospital referral. For 17 women (21%) an equivocal report was obtained, either a descriptive report of ovaries or possible adenexal masses outside the accepted normal ovarian measurements,<sup>1</sup> or possible fibroids.

The subsequent management of patients by general practitioners was as follows: reassurance without further investigation or treatment by general practitioner, 37 women (45%); general practitioner treatment, nine (11%); further investigations by general practitioner, three (4%); and referral to hospital consultant, 33 (40%).

Thus 49 patients (60%) were managed by the general practitioner alone while 33 patients (40%) were eventually referred to hospital consultants. Of the latter, 14 (17%) had a pelvic ultrasound examination which had not demonstrated any abnormality.

This study did not assess the sensitivi-

ty or specificity of pelvic ultrasound but it is known that the technique is extremely accurate in identifying a pelvic mass.<sup>2</sup> In this study the 11 scans (13%) which did not confirm the initial clinical suspicion of a pelvic mass resulted in simple reassurance being given to the patient by the general practitioner without referral to a specialist. In none of the 33 patients referred to hospital consultants was a pelvic mass missed by the initial ultrasound scan.

Radiological departments may be reluctant to offer general practitioners open access to pelvic ultrasound because of limited machine and operator availability. Increasing demand for diagnostic ultrasound continues from many clinical areas. The results of this retrospective study suggest that general practitioner access to pelvic ultrasound may influence subsequent patient management. Only a large prospective study could truly assess the economic and clinical aspects of such a service. However, pelvic ultrasound is of undoubted clinical value for the clinical problems encountered by general practitioners in this study.

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#### References

1. Lees WR. Ultrasound: gynaecological imaging. In: Sutton D (ed). *A textbook of radiology and imaging*. 4th edition. Volume II. Edinburgh: Churchill Livingstone, 1987: 1253-1269.
2. Lawson TL, Albarelli JN. Diagnosis of gynaecologic pelvic masses by grayscale ultrasonography: analysis of specificity and accuracy. *Am J Roentgenol* 1977; **128**: 1003-1006.

### Breast self examination

Sir,

There has been much publicity over the past few years regarding the early detection of breast cancer. The Forrest report<sup>1</sup> concluded that mammography was the most appropriate method of screening asymptomatic women. However, the report also noted that breast self examination should not be disregarded completely. For this reason I sent a

questionnaire to 200 women registered with a semi-rural, mainly middle-class practice to establish their current self examination practices and future expectations.

Overall, 125 women responded (63%) and of these 52 (42%) reported an adequate frequency of breast self examination.<sup>2</sup> Twenty-five women (20%) never examined their own breasts and only 32 (26%) routinely examined their axilla while examining their breasts. Thirty-seven women (30%) had never been taught self examination techniques. One surprising result was that 87 women (70%) would appreciate breast examination when in the surgery for another reason while 79 (63%) said they did not mind who performed this examination — a male doctor, female doctor or practice nurse. One hundred and nine women (87%) would appreciate the ready availability of breast examination leaflets in the surgery.

It would appear, therefore, that the proportion of women in the community carrying out adequate breast self examination is still low. However, contrary to popular belief, many women would welcome opportunistic teaching; perhaps this is a role for the practice nurse. Women do not seem worried or embarrassed by the open availability of leaflets on this topic and perhaps general practitioners could take this simple step to improve breast self examination techniques.

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#### References

1. Forrest P. *Breast cancer screening*. London: HMSO, 1987.
2. Smith E, Burns T. The effect of breast self-examination in a population based cancer registry. *Cancer* 1985; **55**: 432-437.

### Erosive pustular dermatosis of the scalp following zoster ophthalmicus

Sir,

Erosive pustular dermatosis of the scalp is a non-infective inflammatory disorder