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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,[1] 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 sensitivity or specificity of pelvic ultrasound but it is known that the technique is extremely accurate in identifying a pelvic mass.[2] 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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Breast self examination

Sir,

There has been much publicity over the past few years regarding the early detection of breast cancer. The Forrest report[1] 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.[2] 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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Erosive pustular dermatosis of the scalp following zoster ophthalmicus

Sir,

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

occurring in ageing and sun-damaged scalps of elderly patients and is characterized by recurrent pustulation, erosions, crusting and scars.[1] A recent article drew attention to the high incidence of antecedent local trauma.[2] Six of 12 cases had had shingles in the ophthalmic division of the trigeminal nerve before the characteristic changes of erosive pustular dermatosis appeared in the scalp (Figure 1). I have made a survey of the incidence of erosive pustular dermatosis in a series of patients who had been admitted to hospital with shingles affecting the scalp. I wrote to the general practitioners of all patients admitted with herpes zoster of the V_1, C_2 or C_3 dermatomes to the Infectious Diseases Unit, Chaddon Road Hospital, Somerset in 1980–85.

Forty four general practitioners were questioned about 58 patients and replies were received for 52 (27 male, 25 female). Forty eight patients had shown no evidence of erosive pustular dermatosis at the time of the survey although six had died and two had moved from the practice. For four patients the general practitioner suspected the diagnosis from the description in the circular letter but had not made the diagnosis before reading it. Two of these patients had died but both had persistent crusting which started at the time of their shingles and lasted until their deaths 18 months and three years later, respectively. I examined the other two patients — one showed a mixture of excoriations and actinic keratoses on a bald scalp and the other had flakes of adherent keratin and marked dysaesthesia on the right frontal scalp, presumably owing to lack of washing, but no crusts or pustules.

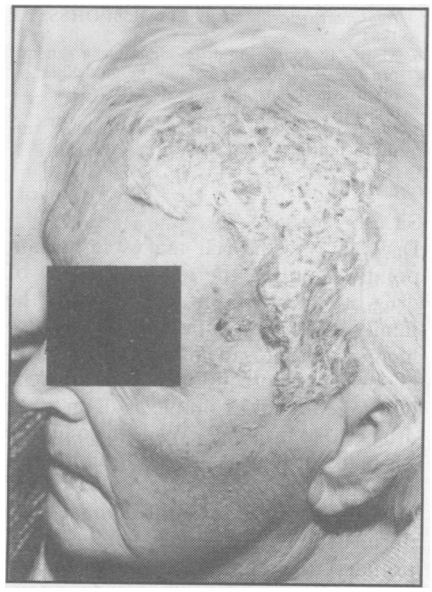

Figure 1. *Persistent crusting of the frontal scalp presenting 12 months after herpes zoster ophthalmicus. (Reproduced from reference 2 with permission of Blackwell Scientific Publications.)*

This survey suggests that erosive pustular dermatosis is an uncommon complication of herpes zoster affecting the scalp. The six cases reported earlier[2] had been collected from dermatology clinics in Avon, Somerset, and the Midlands over a six-year period. However, it is likely that more cases would be recognized if general practitioners and dermatologists were more aware of the disorder. Artefactual excoriation and accumulation of keratin owing to post-herpetic neuralgia need to be excluded. Debridement of the crusts, topical steroid applications and treatment of secondary infection with systemic antibiotics can all be helpful in the management of these patients, although the condition tends to run a protracted and relapsing course, sometimes until death from unrelated causes.

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Minimizing waiting times in open surgeries

Sir,

The assumption that 'for the majority of patients and doctors a well-organized appointment system has made life much more pleasant'[1] has been called into question, at least from the patients' point of view, by Allen and colleagues (April *Journal,* p.163), who found that satisfaction was related to the length of time patients spent sitting in the waiting room.

It is accepted that in a system with no appointments patients have to wait for long periods, but with some flexibility the waiting can be brought down to the levels of a well organized appointment system. I have found that the secret of success is to start with a nearly empty waiting room. This can be achieved by starting the surgeries about half an hour before the advertised starting time. The system is self-regulating, as during busy periods, patients arrive early 'to be seen first', and they are pleasantly surprised when they are invited in straight away. Because there are many things which can be done as well before as after a surgery, such as dictating letters and telephoning, it is not a strain on the doctor's time to arrive well in advance of the official opening of the surgery.

The essence of an 'open surgery' is that everybody is seen, and as the number of patients who attend a particular surgery is variable, the duration of the surgery should vary as well. Having two variable times instead of one, minimizes the waiting which necessarily occurs when the doctor starts with a crowded waiting room.

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Reference

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Hospital discharge communications: information given to patients with cancer

Sir,

The content of hospital discharge communications has long been under discussion in the medical journals.[1] It has been noted that often the report does not tell the general practitioner what information has been given to the patient concerning the illness.[2] If the diagnosis is cancer, it is especially important that the general practitioner should be aware of what the patient has been told.

In this four partner practice of 8000 patients, consultations were monitored between 1979 and 1986. A record was made of the names of patients in whom a diagnosis of cancer was first recorded between these dates. The first and second communications from hospital were then analysed.

A diagnosis of cancer had been made in 77 patients. For 68 (88%) of these patients, neither the first nor the second discharge communications made any reference to any information given. Letters concerning seven patients (9%) unequivocally informed the general practitioner of what the patient had been told, for six of these patients (8%) the information was given in the first communication and for one patient (1%) in the second. Letters concerning a further two patients (3%) contained phrases from which it could be inferred that the patient was aware of the diagnosis.

These findings suggest that even in the case of a patient with cancer, the discharge