

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 V₁, C₂ or C₃ 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

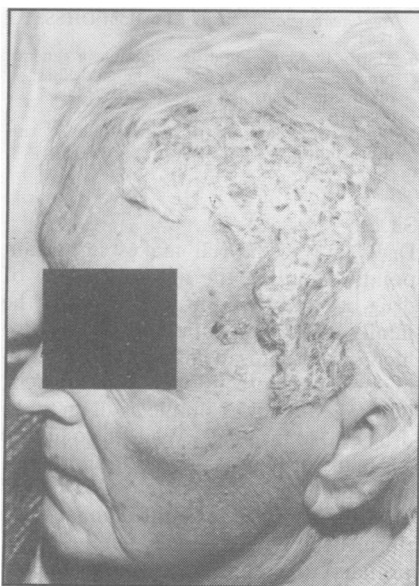


Figure 1. Persistent crusting of the frontal scalp presenting 12 months after herpes zoster ophthalmicus. (Reproduced from reference 2 with permission of Blackwell Scientific Publications.)

adherent keratin and marked dysaesthesia on the right frontal scalp, presumably owing to lack of washing, but no crusts or pustules.

This survey suggests that erosive pustular dermatosis is an uncommon complication of herpes zoster affecting the scalp. The six cases reported earlier² 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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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