LETTERS

Preferences for salbutamol delivery systems among young asthmatics
Stephen Recaldin and Frank Smith 257

Circular random case analysis
H. Martin Davies 257

Elevation of serum cholesterol and triglycerides as a complication of amiodarone therapy
J. Cantor 258

Dangers of steam inhalations: case report
T.C. O'Dowd 258

Referral of women with chronic pelvic pain
R.W. Beard 258

International travel medicine
Jonathan H. Cossar, et al. 259

What influences doctor's prescribing
R.G. Troup 259

Computer prescribing
M.P. Ryan 259

Telephone advice in patient management
John Pitts 259

Night calls - the patients' view
John Halsall 260

Staff for general practice
Sandra E.A. Gower 260

'Brittle' diabetes
G. S-B. Kelly 260

Quality of care
George Godber 260

Working for patients
Tom Davies, et al; *Kevan J. Thornley; D.J. Davies* 262

What kind of College?
Chris Barry; S.J. Cornell 263

Richard Colman: GMC candidate
Richard Colman 264

Social programme at Brighton
Sally Gray 264

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.

Preferences for salbutamol delivery systems among young asthmatics

Sir,

In 1988 there were at least four new developments for administering bronchodilators. Each claims to have an advantage in ease of use or efficacy but little emphasis seems to have been placed on patient acceptability.

In a four week cross-over study of young asthmatics who required regular salbutamol medication we found that there was no difference in the perceived or measured effectiveness of three commonly used delivery systems. In five to nine year olds where coordination is a problem a Ventolin Rotahaler (Allen and Hanburys) was compared with a Ventolin Volumatic (Allen and Hanburys) and in nine to 13 year olds an ordinary aerosol inhaler was compared with the breath actuated Rotahaler. However, there was a great variation in the acceptability of the different methods. No clear trends emerged and personal choice seemed an important factor. Understandably the Volumatic was perceived as too large and very embarrassing to use in public. Most younger children preferred to use the Rotahaler at school, while some were maintained on the Volumatic at home. Among the older children there was a clear preference for the aerosol inhaler, not based on efficacy, but on perceived acceptability by peers.

Instruction and breath activated devices overcome the problem of coordination. However, no device will be accepted and used unless it is convenient and does not cause embarrassment. This may indicate a role for specific health education within schools. The parents of the younger children, particularly, appreciated the extra information about the disease that they received and the use of peak flow meters, and we feel there is a place for an interested doctor in a practice to supervise the routine care of asthmatic children. This would ensure that the children and their families were using the delivery system(s) that suited them best.

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Circular random case analysis

Sir,

I should like to report an educational technique which is used in the Gwynedd vocational training scheme. It combines elements of the objective structured clinical examination (OSCE) and random case analysis.

Trainees are asked to prepare 12 consecutive consultations using a sheet similar to that used for the log diary of the MRCGP examination and to prepare an aide memoire. Those trainees doing hospital posts are asked to record 12 consecutive admissions.

Trainers are invited to attend the half-day release programme for the circular random case analysis and each mans a station. The trainees move around at set intervals from one station to another. The trainer at each station selects one of the trainee's cases at random and questions the trainee on that particular case. The trainee is allocated marks for his or her performance and also for communication skills. The trainers are asked to document any comments they have on each trainee's performance. The trainer ticks the log diary indicating which case has been discussed.

Since there are more trainees than trainers a proportion of the stations are unmanned and at these the trainees are either set multiple choice questions or a short topic question.

At the end of the random case analysis there is time for discussion and both trainers and trainees are encouraged to discuss their experiences. The results of all the trainees are tabulated and distributed to each participant. Each trainee is given a letter of identification to preserve anonymity. The comments by the trainers on the individual trainee's performance are only given to that trainee.

The random case analysis, as an addition to the OSCE has the advantage that the time taken by the course organizer to set up the programme is much less than to set up an OSCE. It is, therefore, possible to do random case analysis more often. It gives trainees experience in presenting and discussing their cases with different trainers, increasing their confidence and preparing them for the MRCGP oral examination. Each trainee is able to compare himself with his peer group in the marks allocated for performance and skills, and he also has specific feedback from the trainers' comments.

Circular random case analysis increases trainers' experience of carrying out case analysis and allows them to meet all the trainees on the scheme. It also gives the trainer experience of the standards of the trainees as a group. Course organizers receive feedback on the progress of the trainees throughout the three-year vocational training programme. Circular random case analysis also provides feedback on the attitudes and skills of the trainers taking part.

My experience of circular random case analysis is that trainers, trainees and course organizers find it both useful and enjoyable, and it helps to achieve some of the educational aims of the Gwynedd vocational training scheme.

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Elevation of serum cholesterol and triglycerides as a complication of amiodarone therapy

Sir,

I would like to report the case of a 62-year-old man who was started on amiodarone for lone atrial fibrillation in October 1983. Prior to this the fibrillation had not been controlled by propranolol hydrochloride or sotalol hydrochloride. The fibrillation was quickly brought under control with amiodarone 200 mg daily. All possible causes of episodic fibrillation had been excluded before starting any therapy.

In February 1988 he remained free of attacks and attended for routine check up. It was decided to include him in a check of cholesterol and triglyceride levels in those with cardiac problems. His cholesterol level was found to be 8.6 mM and triglyceride level 4.1 mM. His high density lipoprotein cholesterol level was 1.4 mM and cholesterol: HDL cholesterol ratio was 6.4. A check on his diet showed that in virtually all respects it was exemplary. Both his parents were alive and in their nineties. Perusal of his case notes showed that in April 1987 his cholesterol and triglyceride levels were normal. After consultant referral it was decided to reduce the amiodarone dosage to 100 mg daily and add flecainide acetate 50 mg twice daily. In addition he was advised to tighten up on his diet still further despite his weight being satisfactory.

By July 1988 there was a significant reduction in levels and in December 1988 cholesterol and triglyceride levels were normal at 6.2 mM and 2.2 mM, respectively. Up to the time of writing there has been no recurrence of atrial fibrillation. The patient has lost weight (between four and seven pounds) with minimal alteration in diet.

In March 1988 the patient's amiodarone level was 1.1 mg l^{-1} (range 0.6–2.5) and desethylamiodarone level 1.1 mg l^{-1} (range 0.6–2.5). In September 1988 his amiodarone level was 0.4 mg l^{-1} and flecainide level 224 mg l^{-1}.

Perusal of the literature reveals that this side effect of amiodarone has been reported on several occasions.[1,2] Patients commencing treatment with amiodarone should have their cholesterol and triglyceride levels checked before commencing treatment and then at regular intervals. It seems reasonable to assume that the elevation of lipid levels with this form of therapy is atherogenic.

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Dangers of steam inhalations: case report

Sir,

The patient, a busy mother, was in her second day of an upper respiratory tract infection. She was particularly troubled by a blocked nose and decided to make herself a menthol inhalation. She placed some water in a large mug and added a blob of Vick's mentholated preparation and placed it in her microwave to heat for a couple of minutes.

With her seven month old child balanced on her left hip she removed the bowl of mentholated water with her right hand and noticed that there was a skin of Vick on the surface. She immediately reached for a metal teaspoon to stir the Vick into the hot water while lowering her face to inhale the steam. The contents exploded into her face. Fortunately, the child was unharmed but the mother received first degree burns of her neck, lower jaw, right zygoma and forehand. She saw the contents bursting out and thinks she closed her eyes as a reflex response. Her burns have taken three weeks to settle.

Mentholated steam inhalations are widely advocated for upper respiratory tract infections. With the increasing use of microwaves in homes it is to be expected that they will be used for quick preparation of such inhalations. Although the mechanism of this reaction is not clear this case serves as a reminder of the danger of such procedures.

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Referral of women with chronic pelvic pain

Sir,

Dr Guirgis' letter (December 1988 *Journal*, p.567) highlights the lack of knowledge about the aetiology and management of chronic pelvic pain in women. He describes well the ritual of investigations to which these women are subjected and points to the considerable waste of resources and the adverse psychological effects on women who show no improvement and questions whether all the investigations are justified. While this is a valid question it is not possible to answer until the aetiology of the pain is known in the large number of women who have no obvious cause for it at present. While our work[1] confirms the limitations of laparoscopy as anything but a means of excluding visible gynaecological pathology, I cannot agree with his implication that there is a 'psychogenic' rather than 'organic' cause for chronic pelvic pain.

All our work[2] suggests that vascular congestion associated with ovarian dysfunction, detectable on pelvic venography and ultrasound scanning is the cause of the pain. It is true that psychotherapy results in a significant improvement in the severity and frequency of attacks of pelvic pain[3] but that is true of all forms of pain elsewhere in the body. We have recently completed a randomized control trial of medroxyprogesterone acetate (50 mg a day) given orally continuously for four months, designed to partially supress ovarian function. This treatment has resulted in a significant reduction in pain among women with pain resulting from pelvic congestion despite a strong placebo effect.[4]

There is a basic flaw in the logic of modern medical thinking which assumes that if an organic cause for pain is not revealed by modern methods of investigation, the likely cause for the pain is 'psychological'. Such a conclusion is the refuge of those who find it difficult to tell their patients that they do not know the cause of pain, and seriously damages the self-esteem of the patient. Hopefully, in time, pelvic congestion will come to be accepted as a form of pathology that may well have its origins in emotional disturbance but which is eminently treatable.

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