

Further investigation showed clear cerebrospinal fluid with no evidence of infection, and electrolytes which showed a sodium level of 122, potassium 3.3, bicarbonate 17, urea 3.3 and glucose 7.0 mM. Chloride was not estimated. A computerized tomography scan showed no abnormality and an EEG showed an excess of high voltage slow wave activity, particularly posteriorly (probably post-ictal).

The patient was observed overnight. During the course of the night he had a diuresis (volume unfortunately not measured) and he awoke the next morning fully oriented with only a slight headache. Electrolytes on the following day showed sodium 137, potassium 3.9, bicarbonate 21 and urea 3.2 mM. He has been well since then and a further EEG three weeks later showed considerable improvement with a mild excess of posterior slow wave activity only.

Questioning of the parents did not reveal a family history of migraine or epilepsy. There was no history or evidence of ingestion of other drugs. His parents reported that they supervised his use of Desmospray and gave him one puff (10 µg) in each nostril before bed. On occasion, however, they have given two puffs when they felt that it had not gone in properly. They reported that the boy did not drink at night after taking his desmopressin. He did tend to excessive drinking during the day, however.

Although desmopressin has previously been recorded as safe for use in nocturnal enuresis³ there is evidently a risk of hyponatraemia, despite its use according to instructions. The pharmacological effects of desmopressin are noted to last more than 12 hours⁴ and it is possible that this child was drinking excessively in conjunction with the 'tail' of the effect of desmopressin.

We recommend therefore that desmopressin be used with caution in childhood enuresis. In particular, having ascertained that the child has a normal blood pressure, urine free from infection and no history of renal problems, we would advise that desmopressin is only administered at least one hour after a last drink and that the child takes no drink whatsoever during the night. We feel that if the child drinks excessively during the day the use of desmopressin should be contraindicated.

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References

1. Fjellestad-Paulsen A, Wille S, Harris AS. Comparison of intranasal and oral desmopressin for nocturnal enuresis. *Arch Dis Child* 1987; **62**: 674-677.
2. Simmonds EJ, Mahony MJ, Littlewood JM. Convulsions and complications after intranasal desmopressin in cystic fibrosis. *Br Med J* 1988; **297**: 1614.
3. Wohl RA, Boichis H, Orda S, et al. Desmopressin in nocturnal enuresis. *Arch Dis Child* 1982; **57**: 137-140.
4. Blackett PR, Seeley JR, Altimiller DH, Males JL. DDAVP in diabetes insipidus. *Clin Pharmacol Ther* 1981; **29**: 793-797.

Telephone consultations

Sir,

We welcome the comment (February *Journal*, p.79) on our report on telephone consultations in a general practice (December *Journal*, p.566). Dr Halle rightly emphasizes the danger of litigation when managing requests for visits by giving telephone advice alone but, in common with the findings of other surveys, most of our callers sought medical advice not a home visit. Quantitative information on the risks of litigation after telephone consultation compared with face-to-face consultation would be most valuable. In litigation-conscious North America, an estimated 132 million telephone consultations took place in 1975 (15% of 'ambulatory' contacts); clearly the threat of litigation is outweighed by the perceived advantages.¹

We agree with Dr South that there are many questions to be answered, but we remain unconvinced by his subjective conclusion that the disadvantages of telephone consultation outweigh the advantages. The questions he poses are apt but, in the UK context, answers are not available and conclusions from studies in other countries are equivocal.² Dr South perceives the benefits to patients to be 'banal'. Other doctors do not share his opinion, and neither do patients.² Through the telephone, patients may gain access to an additional service, not necessarily an alternative one.

The telephone consultation is here to stay and should be taken as seriously as the face-to-face one. Presently, there is no clear evidence that the quality of telephone care is inferior.² Protocols and manuals for telephone work have been developed in North America and the issues of communication skills, sensitivity to patients' needs, decision making and documentation are being grappled with.¹ Should general practitioners in Britain not be following suit? Data from the 1985 general household survey showed that 7% of general practitioner-patient contacts took place over the telephone (about one half of the North American figure) which is not insignificant.²

If our small surveys^{3,4} stimulate further debate, research or developments in this neglected area, our aims will have been accomplished.

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References

1. Curtis P, Evens S. Doctor-patient communication on the telephone. *Can Fam Physician* 1989; **36**: 123-128.
2. Hallam L. You've got a lot to answer for, Mr Bell. A review of the use of the telephone in primary care. *Fam Pract* 1989; **6**: 47-57.
3. Bhopal JS, Bhopal RS. Outcome and duration of telephone consultations in a general practice. *J R Coll Gen Pract* 1988; **38**: 566.
4. Bhopal JS, Bhopal RS, Gilmour WH, Fallon CW. An audit of incoming telephone calls to a practice. *Update* 1988; **37**: 848-851.

GPs' advice to travellers

Sir,

The interesting article on general practitioners' advice for travellers to Turkey (April *Journal*, p.148) supports a report in the spring edition of the *Journal of the Medical Defence Union*.¹ This gave the results of a postal survey of general practitioners concerning their vaccination programmes and advice for foreign travel. The results of this questionnaire suggested that nearly two-thirds of general practitioners do not routinely follow strictly the recommended immunization schedules for travel abroad. In 1987 a survey of general practitioners' attitudes to malaria prophylaxis found that a substantial proportion modified the specialist advice they received.² In 1987 a further study demonstrated that 98% of 'at-risk' travellers receiving advice from their general practitioner subsequently carried anti-malarial tablets. However, only 46% of those receiving advice could name any other method of personal protection against malaria.³ Is the general practitioner (in addition to the traveller) at risk if the information he supplies is inadequate or out of date? One must now be aware of the prevalence of meningococcal infection, Japanese encephalitis and other exotic diseases. Is the whole range of problems associated with overseas travel now such a dynamic and specialized area that it should be left to specialized clinics?

British Airways medical services for travellers abroad (BAMSTRA) has been formed by British Airways and the medical advisory service for travellers