

# 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.

## The new H<sub>2</sub>-antagonists — are we prescribing them?

Sir,  
Two new H<sub>2</sub>-receptor antagonists — nizatidine and famotidine — have been available since autumn 1987. Do these new drugs offer any real benefit over their established rivals cimetidine and ranitidine? In August 1988 an article in the *Drug and Therapeutics Bulletin*<sup>1</sup> concluded that the new H<sub>2</sub>-receptor antagonists do not offer any important clinical advantage over cimetidine or ranitidine. It advised using cimetidine on the basis of cost and ranitidine when avoidance of anti-androgenic effects or drug interaction was required.

We would like to report the results of a questionnaire sent to all 349 general practitioners in the greater Belfast and North Down area to determine to what extent they were prescribing nizatidine and famotidine and why they had chosen to prescribe these newer drugs.

Of the 349 questionnaires sent out 231 (66%) were completed and returned. Only 66 (29%) of the 231 general practitioners had prescribed nizatidine, famotidine or both — 37 at the request of the hospital, 18 on their own initiative and 11 under both circumstances. Of the 231 doctors 113 (49%) were aged 40 years or under and 131 (57%) were vocationally trained. Among the 29 general practitioners who initiated prescribing of nizatidine and/or famotidine 20 (69%) were aged 40 years or under and 20 (69%) were vocationally trained, suggesting that it is younger doctors who are more willing to alter their prescribing habits.

The most frequent reason for prescribing nizatidine or famotidine was that there had been no improvement when a patient was prescribed cimetidine or ranitidine (21 doctors). Other reasons included side effects with cimetidine and/or ranitidine (three doctors) and the availability of a calendar pack (two doctors). Three doctors had tablets available in their bag when

called out at night and three wished to try out the new drug(s). Some doctors gave more than one reason. None of the general practitioners felt that the smaller size of the famotidine tablet (40 mg) compared with the equivalent cimetidine (800 mg) and ranitidine (300 mg) tablets had influenced their prescribing.

Table 1 shows how the general practitioners received information about the new drugs. The majority learnt about the drugs by direct information from the pharmaceutical companies. Twenty eight of the 29 doctors who initiated prescribing of these new H<sub>2</sub>-antagonists had received information about them from meetings with pharmaceutical representatives.

**Table 1.** Sources of information about nizatidine and famotidine.

Source	Number (%) of GPs (n = 231)
Medical mailings	183 (79)
Advertisements in journals	176 (76)
Pharmaceutical representatives	171 (74)
Published research work	59 (26)
Hospital/lecture	40 (17)
GP colleagues	19 (8)

n = total number of GPs.

The approximate costs of 28 days' treatment for once daily dosage are cimetidine (800 mg) £17, ranitidine (300 mg) £26, nizatidine (300 mg) £26 and famotidine (40 mg) £27. Two hundred and four doctors (88%) knew that ranitidine is more expensive than cimetidine. When asked to rank all four H<sub>2</sub>-antagonists in order of cost for daily maintenance therapy 66 (29%) put ranitidine as the most expensive, 47 (20%) nizatidine, 84 (36%) famotidine and 17 (7%) cimetidine (the remaining 17 were not able to answer this question). The newer drugs cost no more than ranitidine yet 56% of the general practitioners considered them to be more

expensive. This misapprehension might well contribute to a lower prescribing level.

It can be concluded that the two established H<sub>2</sub>-antagonists, despite the disadvantages of side effects (cimetidine) and cost (ranitidine), are still popular with general practitioners and that the two newer drugs are trying to compete for a limited share of the market.

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## *Enterobius vermicularis*: a possible cause of intestinal colic?

Sir,  
I believe it is still a common assertion in many textbooks that infestation with threadworms is a relatively benign affliction causing no symptoms beyond, in some instances, pruritis ani. Apart from its postulated role in the aetiology of appendicitis,<sup>1,2</sup> it is uncommon to find a reference to the threadworm as a cause of abdominal pain — indeed some authors clearly doubt that even vague abdominal discomfort can be attributed to infestation.<sup>3</sup>

Recently, I have seen two children who presented with colicky abdominal pain in the absence of an obvious cause. The first, a 15-year-old boy, had recurring bouts of pain over a four-month period until he was observed to have, and treated for, threadworms. His symptoms resolved immediately after treatment and have not recurred. The second child, a boy of 20

months, developed an apparent bout of colicky abdominal pain which resolved spontaneously within half an hour. Two days later, his mother observed live threadworms at his anal margin and the family were duly treated with piperazine citrate.

Interestingly, in neither of these cases was pruritis ani a feature, even in retrospect. Accepting that threadworm infestation is relatively common and in many cases probably asymptomatic,<sup>4</sup> it becomes very difficult to establish a causal relationship to abdominal pain. Nevertheless, one has to question whether such a relationship may exist, what possible biochemical, immunological or other mechanism could explain it, and whether a potentially treatable cause of abdominal pain is occasionally being overlooked. It seems excessively dogmatic to assert that threadworms never cause significant abdominal pain, even when confined to the bowel.

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## Effectiveness of anti-smoking advice from doctors who smoke

Sir,

General practitioners who smoke may adversely influence their patients' smoking habits. This is supported by a study which has shown that doctors who smoke deliver less advice to patients on how to stop smoking than doctors who do not smoke,<sup>1</sup> and it is well known that anti-smoking advice given by general practitioners is one of the most important means of helping patients to stop smoking.<sup>2</sup> However, there is no direct evidence to suggest that doctors who smoke are any less effective in stopping patients smoking than non-smokers.

My general practice trainee year was spent in a group practice in Salisbury where one of the doctors smoked. I conducted a survey of 646 patients and the results indicated that the doctor who smoked had fewer patients who gave up smoking than the doctors who did not

smoke (23% versus 37%,  $P<0.05$ ). Furthermore, a higher proportion of the patients who chose to consult the smoking doctor were smokers compared with those who consulted the non-smoking doctors (43% versus 37%,  $P<0.01$ ).

These results must be interpreted with caution because the survey looked at only one practice with a retrospective questionnaire and there was no biochemical validation of the patients' self-reported smoking behaviour.

However, the evidence suggests that doctors who smoke need to be aware that they may, indirectly, be jeopardizing their patients' health and that they must make greater efforts to help their patients to give up smoking.

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2. Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *Br Med J* 1979; 2: 231-235.

## 'Patient care' and patient benefit

Sir,

The public voice of medicine is fulsome with the term 'patient care'. An impartial observer may feel that its use is axiomatic — what are doctors for but patient care? — but the bland term neatly suggests laudable purpose and is thus a useful rallying-call with which to court public support and even approbation. However, the term is ambiguous. An unhealthy supposition is to equate 'patient care' with quality medicine. More 'patient care' does not equate with better quality practice. The present trend for auditing — of prescribing, referral rates, investigation rates and the like — important though it be, is no substitute for evaluating outcome.

The following case histories illustrate how 'patient care' constitutes the frame rather than the picture.

**Case 1.** A 40-year-old patient attended the general practitioner with unusual symptoms. The patient was convinced that he had a particular disorder. The general practitioner disagreed and reassured the patient, who returned a fortnight later with the same symptoms. As a further reassurance, the general practitioner refer-

red the patient on to a specialist. The specialist did all the appropriate tests, found no hard evidence of disease but treated with medication 'just in case' — the patient developed an allergic reaction to the drug and died.

**Case 2.** A 76-year-old lady, irrepressably jocose, had a 20 year history of angina. She was intractably obese and at one of her visits to the doctor for more of her usual angina pills the doctor found her blood pressure raised such that she 'might get a stroke if it's not treated'. Shocked and grateful, she left with her new pills only to return within the month to report that she felt tired and glum (unaccustomed sensations for her). The doctor changed the medication but this, too, did not suit. Another change made no difference. After this, the lady stopped the pills herself and felt better before long. When she returned to confess, the doctor administered a mild rebuke, noted her blood pressure was still raised, repeated the warning about stroke and insisted upon medication — which she fearfully took. Several months on, the lady remarked she had never felt well on her pills and regretted ever having had her blood pressure taken because life had not been worth living since then.

It is hard to see how either doctor could have served his patient worse. Nevertheless, both doctors could claim thoughtful 'patient care'; even to have 'gone by the book'. Such news is likely to confound rather than console patients and relatives, for it suggests the same thing could happen again.

The picture is incomplete without a reference to patient satisfaction which, though a pivotal aspect of practice, is a poor reflection of quality practice. Results accruing from the fashion for auditing patient satisfaction should, therefore, not be overrated or allowed to blur the issue of outcome. Mistaken belief and expectation of what they need can lead patients to be the victims of appeasement — of inessential prescribing, investigation and referral — as case 1 demonstrates. Patient satisfaction will be seen to follow the audit of outcome of medical practice, the latter being the key to a quality health service.

The outcome may be simple and self-evident (for example the results of appendectomy, insertion of a pacemaker, or treatment with thyroxine) or less simple and less obvious (for example the result of treatment with antiarthritic drugs, antidepressants, tranquillizers or antihypertensives, the care of the terminally ill or care of the aged). Sometimes it may be impossible to audit outcome but, in truth,