

there are very few cases to which the question: 'Has the patient benefited from medical intervention?' cannot be met with an answer of 'Yes' or 'No'. A negative answer should not be seen as a disgrace so much as an education; the mistake is not to ask the question.

A single prefix may be the answer: 'Beneficial patient care'. Were this new term to be used with the same frequency as the old, it would not of course have the same public relations appeal — it implies alternatives. However, it is likely to make true quality assessment, each time a doctor treats a patient, habitual; and so prompt, if necessary, beneficial adjustments to future practice.

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## Breast self examination

Sir,

David Mant (*May Journal*, p.180) correctly summarizes the consensus of the literature on breast self examination in asserting that there is no evidence that it is effective in reducing mortality from breast cancer. However, there is equally no evidence that it is not effective. Quite simply it has never been practised on the scale and with the reliability necessary to settle the matter. This is because even those women who respond favourably to the offer of appropriate instruction require intensive guidance, supervision and continued reassurance if they are to remain both motivated and confident in their ability to distinguish the normal from the abnormal.<sup>1,3</sup>

However, as Dr Mant says, women are likely to examine their breasts whether or not they are taught breast self examination. There would be much to be said for ensuring that such examination is done so as to achieve an optimal balance of sensitivity and specificity and to limit the anxiety which may be the main outcome of ineffective practice. This is unlikely to be achieved by posters and pamphlets but it might well be achieved in general practices able and willing to invest the necessary resources. Although it may remain formidably difficult to subject the efficacy of breast self examination to formal appraisal, there must surely be some benefit from ensuring that what will inevitably be done is done more effectively.

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3. Hobbs P, Haran D, Pendleton LL. The use of breast self-examination as a screening modality. *J Inst Health Educ* 1985; 23: 124-133.

Sir,

Dr Mant's editorial (*May Journal*, p.180) seeks to promote critical debate and appraisal of the role of breast self examination in the prevention of breast cancer. There are two complementary, but distinct, issues here: the validity of breast self examination as a screening test, and the importance of the early diagnosis of breast cancer in reducing morbidity and mortality. Whereas the value of breast self examination as a screening test may be in doubt, the importance of early diagnosis of breast cancer is not.

Lundgren points out the differing response of Swedish and British women to the discovery of a palpable breast lesion.<sup>1</sup> Swedish women present with less advanced breast cancer than their British counterparts, which is reflected in a superior mortality to incidence ratio in Swedish women compared with British women (36% and 60% respectively). Furthermore, it must be remembered that much of the morbidity and mortality from breast cancer occurs outside the 50-64 years age group which is targeted for mammography. In the St Helens and Knowsley district in 1987, there were 86 deaths from breast cancer, of which at least 55 (64%) were among women who would not have been within the target population for mammography.

To discourage breast self examination because of its questionable validity as a screening test may well discourage women from presenting early with palpable breast lesions, and lead to an increase in morbidity and mortality. A crucial health promotion role exists for general practitioners in encouraging properly conducted breast self examination and with it increasing the awareness of the potential benefits of early diagnosis of breast cancer. It may yet be shown that at a particular age or in other specific groups, breast self examination is an effective screening procedure, most likely in women over 40 years of age.

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## Screening and the new contract

Sir,

The government's proposed new contract states that we are now to screen everyone from the age of 16 years every three years until the age of 74 years, and annually (by home visit) thereafter. This raises the ethical question of whether as responsible general practitioners we should be involved in this activity.

First, as far as I am aware there is no evidence that triennial screening of the young is of any value. Furthermore, actively encouraging the fit young to attend may 'medicalize' health and a paper by Dr Stoate (*May Journal*, p.193) suggests that screening may actually cause psychological harm to healthy volunteers.

Secondly, while there is some evidence that annual screening of over 75 year olds may be of value, there is no comparative evidence to state that one method is better than another (for example, letter followed by a visit if indicated versus selective visits of those not seen in the previous year). One could also postulate that social services screening of the elderly would be of more value than medical screening, since social support is what the elderly usually need. I am not aware of a comparative study being done. Visits to those elderly who already attend surgery will encourage dependence on visiting by the general practitioner.

Finally, the kind of screening proposed has not been shown to fulfil the criteria for screening mentioned by Stoate.

As a doctor I should not be actively involved in something that could damage peoples' health. The contract stipulates that I must. Is there an answer to this dilemma?

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## Screening: the case against

Sir,

When I first read the title of Dr Stoate's paper, 'Can health screening damage your health?' (*May Journal*, p.193), I assumed

that it was about the health of general practitioners rather than that of patients. At a time when there are so many articles on burn-out and depression among our profession, I expected it to provide further evidence that health promotion and the screening of healthy adults are a rod for our own backs. The government wish regular screening programmes to be set up when there is scanty, if any, evidence in their favour.

We now have the facility to scare people on an unprecedented scale and the raising of awareness of health problems together with its usual bedfellow, heightened anxiety, cannot really be viewed as healthy. If we are going to mention asymptomatic conditions, which the doctor rather than the patient defines as important, then we had better prepare ourselves for more work, counselling people through years of worry.

After all the hard work we may put in, people will eventually move house or die. We may like to feel that we are indispensable, but the truth is otherwise. Feelings of frustration, anger, loss and guilt are as much a part of our experience as that of our patients. Burn-out as a result of performing medical work which is not proven to change the course of disease or its outcome, is of no use to the doctor or his patients.

We should be spending at least as much time looking to meet our own needs as we spend looking after those of our patients and as a profession we should be far more zealous in the care of our fellow members than we are at present.

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## Asthma — still a challenge for general practice

Sir,

In his discussion paper Kevin Jones gave a comprehensive overview of the primary care management of asthma (*June Journal*, p.254). One omission was that of drug-induced or exacerbated asthma. The drugs most commonly involved are beta-blockers, and non-steroidal anti-inflammatory drugs including aspirin, both of which are widely prescribed. The Committee on Safety of Medicines continues to receive reports of deaths owing to bronchospasm in patients receiving beta-blockers.<sup>1</sup> Most of these deaths occurred in patients with asthma or a history of obstructive airways disease, and were therefore preventable.

In 1986 I undertook a retrospective

survey of all patients aged 17 years and over discharged from Selly Oak hospital in 1985 with a primary discharge diagnosis of asthma. One hundred and sixty five patients were identified, and the notes of 136 (82.4%) were traced. Four patients, aged between 63 and 75 years, were taking beta-blockers on admission. Propranolol was the agent involved in each case and it had been taken for between one week and 18 months prior to the onset of asthmatic symptoms. The asthmatic symptoms had lasted from one to four weeks before admission, and in two patients had worsened suddenly over one and five hours, respectively. Two patients were moribund on admission and would have died but for immediate medical intervention: one required ventilation for one day. All four patients left hospital alive and well. The patient who required ventilation was known to be asthmatic and had received propranolol on the advice of the hospital in spite of this. The other three patients were undiagnosed asthmatics.

It is impossible to predict from the chronicity or severity of asthma which patients are likely to bronchoconstrict with beta-blockers, nor whether the induced bronchospasm will be minimal or life threatening. The period between starting beta-blockers and a severe attack of asthma is similarly variable. Although cardioselective agents are considered to be safer, the degree of bronchospasm produced in asthmatics is unpredictable.<sup>2</sup> Thus all beta-blockers should be contraindicated in patients with asthma. In addition, all patients for whom beta-blockers are being considered should be screened for symptoms suggestive of asthma and undiagnosed asthma should be considered in any patient who becomes dyspnoeic while taking beta-blockers.

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Sir,

Dr Kevin Jones (*June Journal*, p.254) highlights some of the main deficiencies of asthma care and suggests three major points that practices should address — prevalence of asthma, asthma therapy and

follow up.

As general practitioners we should ask ourselves several specific questions concerning the management of asthma in our practices:

1. Is the cumulative prevalence of asthma in the practice between 10 and 15%?<sup>1,2</sup>
2. Is the incidence of new cases of asthma in the practice over 9% per year per partner with an average list size?<sup>1</sup>
3. Is the therapy asthmatics receive appropriate? Are their drug delivery systems and inhaler techniques suitable? Are patients who use symptomatic bronchodilators regularly receiving preventive regimens?
4. What percentage of acute exacerbations of asthma requiring emergency treatment are successfully treated in the practice? (Over 80% in some trials.<sup>3</sup>)
5. Do the asthmatics who experience recurrent exacerbations requiring emergency treatment despite adequate prevention regimens (approximately 8% of the asthma population) know when to obtain medical advice? Do they possess a peak flow meter? Do they know their predicted and best ever peak expiratory flow readings (often considerably different in this group) and have they been instructed to act accordingly if the value is less than 60-70% of normal?<sup>4</sup>
6. Is there a recall and follow-up system appropriate to the needs of the whole spectrum of the asthma population in the practice?

The answers to these questions not only reflect the standard of care we provide for our asthmatic patients but also provide a measure of one important aspect of clinical care that is suitable for internal or external monitoring.

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Sir,

Kevin Jones (*June Journal*, p.254) has written a plea for improved asthma care in general practice. What has been omitted and is absent from most review articles on this subject is the reluctance of many general practitioners to implement this