What shall I write in the notes?

Sir,

The recommendation in the editorial 'Classification of psychosocial disturbance in general practice' (September *Journal,* p.356) that the voice of primary care be heard, is a cry from the heart. We need a multiaxial system which can describe not only structural factors, but also factors of context and feelings in psychosocial disturbance, because all three affect diagnosis, management and outcome. Biological classification is useful, but inadequate for the unrefined end of the trade in which we work.

So what do we write in the notes? If we cannot yet classify adequately, we can follow the respectable tradition of describing what we see; but this is not easy with the constraints of time and Lloyd-George notes. For what it is worth, my own system is based on the work of the late Dr Chekhov, of Moscow, recorded in the style of Harold Pinter.

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Otitis media with effusion

Sir,

I wish to comment on Dr Burke's review article (September *Journal,* p.377). It is true that otitis media with effusion is more frequently present in younger age groups than is often suspected, particularly in bottle-fed infants. It is accepted that cow's milk intolerance exists in so far as bowel distal to the duoenum is concerned, and this must be because such bowel mucosa does not present an effective immunological barrier. There is no evidence that middle-ear mucosa is any different in this respect.

Whatever the cause of eustachian tube dysfunction, it is surely hypoventilation of the middle ear cleft that is the cause of so-called glue ear. Further, there is an obvious anatomical difference between a child and an adult — a child's eustachian tube points upwards, whereas an adult's should point downwards, and function normally. It should not be a surprise, therefore, that a normal child's eustachian tube function is predisposed to failure.

In my experience, early effusions are thin and straw-coloured; it is delay in instituting effective treatment which makes this a rare sight in National Health Service hospital practice. Whether thick or thin, like any other stagnant collection of tissue fluid, (secondary) infection is likely.

Cholesteatoma formation, in the main, arises from the build-up of squamous debris in non-self-cleaning attic retraction pockets, which themselves cannot form unless a pressure differential exists across the tympanic membrane. Further, middle-ear inflammation, from whatever cause, is capable of producing intra-epithelial transformation to squamous cell type behaviour, and consequent cholesteatoma formation, and this may occur in the presence of an apparently normal tympanic membrane.

Thus, glue ear not only causes fluctuant hearing loss, otalgia, structural damage to the fibrous stroma of the tympanic membrane and educational problems, it also predisposes the risk of cholesteatoma formation, a potentially fatal disease.

At worst, grommet insertion may leave a residual central perforation of the drumhead, but such cases are by definition 'safe' ears. In contrast, unresolved negative middle-ear pressures will inexorably lead to progressive attic disease, cholesteatoma formation, and an 'unsafe' ear.

I cannot accept that medical treatment of this condition remains a sensible option, particularly the use of systemic steroids. The symptoms, signs and complications are caused by a relative middle-ear vacuum and it seems logical to relieve the pressure differential across the eardrum by causing an iatrogenic 'safe' perforation rather than allowing nature to create an 'unsafe' perforation.

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Direct access to hospital investigative facilities

Sir,

The main point of the editorial by Price and myself (April *Journal,* p. 135) seems to have been missed by Drs Ross and Martin (Letters, September *Journal,* p.391).

It is meaningless to state in isolation that use of their laboratory by general practitioners is growing much faster than hospital requests. This could simply be due to general practitioners doing the work themselves instead of referring to hospital doctors, a procedure which is far more efficient in every respect. Charging general practitioners for investigations will simply result in a reversal of this trend and will cost their health authority more money in the long run.

If, on the other hand, Drs Ross and Martin could prove that this increase has occurred when general practitioner referral rates have also gone up they may have a point — but I doubt it. Using their figures, the number of pathology requests by hospital doctors is still 57% greater than the number of requests by general practitioners. The efficiency of general practice open access is usually demonstrated when laboratories publish data that includes the number of general practitioners using the facilities compared with the number of hospital doctors, the numbers of patients actually investigated and the population served. If Drs Ross and Martin had this data they may be able to ascertain why they are faced with this dilemma. Like many budget managers nowadays they have to find a service to cut somewhere, but they are looking in the wrong direction.

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Sir,

I was interested to read the letter by Ross and Martin (September *Journal,* p.391). As a general practitioner who uses the service provided by their laboratory I would dispute their assertion that the editorial by Hobday and Price (April *Journal,* p.135) was misleading because it was based upon a reference from 1973.

In May 1989 the Northampton trainee group carried out an audit of general practice workload in Northampton and the findings substantiate the statement of Hobday and Price that 'a low level of general practitioner usage of pathology services has been demonstrated'. Seven general practitioners (two trainers and five trainees) in separate practices recorded data from 1400 consecutive consultations. It was found that a mean of 10.5% of consultations (range 4.0–16.0%) resulted in an investigation being initiated (2.5% of consultations resulted in a haematological investigation). Furthermore, 4.9% of consultations (range 1.0–8.5%) resulted in a referral, mostly to hospital outpatient departments, suggesting that 95.1% of illness episodes are dealt with in general practice.

These findings substantiate Hobday and Price's statement and I would hope that in the light of this evidence, Ross and Martin will review their proposal that general practitioner access to laboratory facilities should be restricted.

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