LETTERS

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Pre-hospital management of infantile gastroenteritis

Sir,

Recommendations for the treatment of gastroenteritis in children have stressed the importance of oral rehydration solutions and withdrawal of milk feeds for 24 hours in bottle fed infants.[1] The use of antibiotics should be limited to specific indications such as giardiasis or shigellosis, and antidiarrhoeal agents should be avoided as they are ineffective and may be harmful.[2]

In view of these recommendations a survey was undertaken to assess the pre-hospital management of infantile gastroenteritis.

Between November 1988 and February 1989 100 patients under the age of two years were admitted to this unit with a primary diagnosis of gastroenteritis. All patients were referred or had been seen by their general practitioners or deputies since the onset of symptoms. Age, sex, duration of symptoms, reason for admission and fluid and drugs prescribed prior to admission were recorded in addition to treatment given on the ward.

There were 59 boys and 41 girls with a mean age of 9.2 months (range 0.5–23). The duration of symptoms ranged from 12 hours to 28 days with a mean of 5.9 days. The commonest reasons given for requesting admission were persistent symptoms (70) and dehydration (20); other reasons were pyrexia (two) and poor social circumstances or mother not coping (eight).

A total of 80 patients received commercially available oral rehydration solutions, seven were instructed to be given fluids only, and in 13 no change in feeding was advised (Table 1). Of the 16 patients given antibiotics nine had significant symptoms prior to the diarrhoea or vomiting such as cough, pyrexia, febrile fit or possible ear infection for which they were prescribed the drugs. Therefore seven patients received antibiotics primarily for gastroenteritis. The most commonly used antidiarrhoeal was kaolin (10) in addition to loperamide (two), and diphenoxylate (two).

Table 1. Pre-hospital management of infants with diarrhoea.

Drugs/fluids	Number of patients
ORS as only treatment	56
ORS and antibiotics	11
ORS and antidiarrhoeals	13
Antibiotics only	4
Antibiotics and 'fluids only'	1
Antidiarrhoeals and 'fluids only'	1
'Fluids only'	5
No treatment	9

ORS = oral rehydration solution. Fluids only: boiled water, salty water, lemonade, fruit juice.

Only one child required intravenous fluids on the ward and three received antibiotics for gut pathogens (salmonellosis (two), shigellosis (one)). Other conditions for which antibiotics were given to inpatients were urinary tract infection (two), ear infection (two) and cellulitis (one).

Two similar studies,[3,4] published in 1984 and 1985, found that only 12–30% of children admitted with gastroenteritis received oral rehydration solutions from their general practitioners, 8–18% were given antibiotics, and 5–20% antidiarrhoeals. The results of this survey show that the use of oral rehydration solutions has increased considerably and is becoming standard treatment in the management of gastroenteritis. However, some drugs, particularly antidiarrhoeals, continue to be prescribed inappropriately to a minority of infants.

Adequate data on the advice given to mothers was not obtained in this study but we believe the management of gastroenteritis in the community could be improved further by general practitioners giving precise instructions on how to administer oral rehydration solutions, for instance giving frequent small volumes from a spoon to a vomiting infant. It remains to be seen whether these changes bring about a reduction in the number of children admitted to hospital with gastroenteritis.

R Fox

Department of Infectious Diseases and Tropical Medicine
Monsall Hospital
Newton Heath
Manchester M10 8WR

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No endocervical cells

Sir,

What action should be taken on receiving a smear report which states 'No endocervical cells seen'? In my own practice we performed 660 cervical smears last year of which 6% were reported as showing 'no endocervical cells'. This year the figure will probably be higher. In my county this figure is low, and the county average is 31% but there are no clear universal guidelines indicating the significance of this finding. Conflicting advice was given in the *British Medical Journal*[1] but in the final analysis the decision whether to repeat the smear or not was laid firmly at the feet of the doctor taking the smear in the first place. I am reminded of a general practice colleague who had exactly this report on one of his receptionists in whom he felt duty bound to repeat the sample. It returned showing CIN I-II.

I cannot in my own conscience see how the screening procedure can be acceptable if the area in which 70% of squamous cell carcinomas arise has not been sampled. My own approach therefore is to repeat all of them, but I know that this is not a universal habit even within my own practice. On the occasion of a second sample returning with the same report, then I inform the patient of the result and suggest

a repeat in another year.

On the occasions on which two consecutive smears are reported as showing 'no endocervical cells' I am left wondering whether timing in the cycle makes a difference, since there are undoubtedly some times when the cervix appears dry and the quantity and quality of the sample seems poor. Our local histopathologist does not agree with this suggestion but then he is not taking the sample. It would be interesting to know what other general practitioners do in this situation.

M F McGHEE

69 Barroon
Castle Donington
Derby DE7 2PF

Reference

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Women's experiences of miscarriage

Sir,

Trevor Friedman (November *Journal*, p.456) raises some important points in his paper on women's experience of miscarriage. Unfortunately I believe his paper is inherently flawed.

His study only includes women who were admitted to hospital. As most spontaneous miscarriages are managed by general practitioners in the community, a question central to a study of this kind must be, 'Why was the woman admitted?'. Although medical indications might make up a substantial proportion there is no doubt that many women are admitted because the general practitioner feels the woman or family cannot cope in the community with primary health care. Reasons for this will be numerous but will include dissatisfaction with the treatment offered by the general practitioner.

Does the mental state of women being admitted to hospital differ from those who are not? Does the psychiatric morbidity of women after a miscarriage depend upon whether they were admitted or not?

Is not the very title of the paper misleading as it deals with women whose general practitioner did not manage their miscarriage?

JAMES CAVE

The Cottage
High Street
Kingston Blount
Oxfordshire OX9 4SJ

Health care in deprived areas

Sir,

Dr Bedford's excellent editorial (October *Journal*, p.398) raises once again the important issue about the link between socioeconomic deprivation and poor health. The main problem in the white paper *Promoting better health*, of increasing the proportion of income from capitation fees, has been highlighted by Douglas Black[1] and re-emphasized by Michael Drury.[2] The recent Consumers' Association report[3] has shown once again that what patients really want is more time with their general practitioners, not less. The capitation fee change will have the opposite effect.

Both Alastair Donald[4] and Michael Pringle[5] have recently suggested that the capitation issue will have major adverse implications for patients in areas of deprivation. This, and the imposition of high targets for preventive procedures, are likely to widen the health and quality divide in primary care. At the recent RCGP spring general meeting the chairman of council accepted as a reference to council the following resolution from the Wessex faculty 'This meeting asks council to note with concern the findings of the recent publication *The nation's health*, in particular that the social class gap in mortality and morbidity has shown no improvement since the Black report, and in many aspects has widened. This meeting further asks council to urge the government to take these findings into account in its future health care planning and social policy'. We would endorse this and submit that this issue is a major priority for the government, the medical profession and this College.

As Dr Bedford remarks, we should not talk about the inner cities, but rather areas of deprivation. It is important that we do not overlook the 'forgotten' areas of deprivation, which are our large peripheral council estates, where unemployment, morbidity, poor housing, and numbers of pre-school children are high. A commitment to these areas does not just require the general practice deprivation supplement, but also more targetted resources for nursing, health visitor, midwifery and community psychiatric services.

It is now nine years since the Black report was published and it appears that this major issue is still largely neglected.

JOY A MAIN
PAUL G N MAIN

Hartcliffe Health Centre
Hareclive Road
Hartcliffe
Bristol BS13 0JP

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Effect of small group education on the outcome of chronic asthma

Sir,

In their letter (November *Journal*, p.479) responding to our observations on their paper, White and colleagues imply that we are advocating the use of a more complex methodology in the search for statistically significant results. This was not our intention, indeed rather than putting forward an overly elaborate analysis we were proposing a more closely focused approach.

We take this opportunity to make some more general comments which we hope will be of use to other researchers.

The aim of any clinical trial is to uncover the real effect of the intervention being evaluated. To aid this process and the reporting of such studies in the medical journals a set of fundamental recommendations suggested by Professor Pocock have been generally accepted by medical statisticians and epidemiologists.[1] The paper by White and colleagues contravened several of these recommendations.

1. The study should identify a small set of patient responses (primary endpoints) in advance of carrying out the study and to be used in the evaluation of the trial. The asthma study had nine measures of morbidity but no indication of their relative importance. Thus it is hard to know what conclusions could have been reached had only some of the measures shown a consistently significant difference between the intervention and control groups.

In their letter the authors say that they 'confirmed the null hypothesis so uniformly ..' Apart from the fact that one cannot confirm an hypothesis only attempt to refute it, their failure to demonstrate a significant difference between the groups of general practitioners (not the patients as stated) has two interpretations. Either the intervention does not have the clinical effect that the researchers were looking to detect or the study lacked the power to detect the true clinical effect at that level of significance owing to a small study size.

However, neither the reduction in morbidity the authors considered clinically