LETTERS

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.

Use of anti-D in general practice

Sir,

Efforts to avoid preventable disease should be central to general practice. One such area concerns the use of anti-D immunoglobulin to minimize the number of cases of haemolytic disease of the newborn. Some women still develop rhesus antibodies that could have been prevented. To reduce further the incidence of seroconversion, attention needs to be focussed on the following areas:[1]

— Appropriate use of anti-D immunoglobulin by obstetricians and gynaecologists for hospitalized patients: ensuring that all rhesus negative women who deliver or have a hospital abortion are given anti-D within 72 hours.

— Provision of a comprehensive anti-D prophylaxis programme for all pregnant rhesus negative women at 28 and 32 weeks.[2,3]

— Ensuring that effective guidelines exist and are implemented for the management of bleeding episodes in early pregnancy, which may not require hospital admission (both threatened and complete miscarriage).

I recently conducted a study among east Berkshire general practitioners to examine the knowledge, attitudes and practice regarding the use of anti-D when confronted with episodes of bleeding in early pregnancy. Because of a disappointingly low response rate it is impossible to draw hard conclusions but several points were clear. First, that knowledge of current guidelines is far from complete. Secondly, that those respondents who are aware of the guidelines did not always adhere to them even in the case of bleeding at 13 weeks gestation. Thirdly, that well over half of the 39 respondents felt that rhesus negative women with bleeding in early pregnancy were not being identified and treated adequately in their practice.

There are several reasons, none of them entirely adequate, for the above failures. Current guidelines were issued by the DHSS in 1976 and revised in 1981.[4] These state no lower time limit for the use of anti-D, and stress the role of the general practitioner in ensuring that 'anti-D immunoglobulin is given to all rhesus negative women following abortions, especially those who have had spontaneous abortions'. Anti-D is also recommended after threatened abortion. The absolute need for anti-D prior to 12 weeks when no instrumentation of the uterus has taken place is, however, being increasingly questioned,[5] and the national guidelines are under review (Entwistle C, personal communication).

The shortage of anti-D has also created problems, but with stocks now increasing, this is no longer a reason for failure.[6]

In addition to problems due to ignorance as demonstrated in the Wessex area,[7] there are logistic difficulties.[8,9] The rhesus group of the woman is often not known to the general practitioner even after obstetric booking, and it is not always easy for the general practitioner to request this prior to hospital booking. To obtain the blood group when the bleeding occurs can provide its own logistic problems, especially at weekends.

In order to minimize these problems, better planning and communication are required. Identifying all rhesus negative women before a bleeding episode should ensure appropriate action. Pre-conceptual screening (for example, for those receiving contraceptive services) is ideal, but expensive. Alternatively blood can be taken when pregnancy is diagnosed. This result, whether rhesus positive or negative, can be recorded prominently on the notes and cooperation card, and the woman informed. Repetition of the blood grouping, unless transfusion is required, should not be necessary in this or subsequent pregnancies. The woman should be notified of her rhesus status, and its significance if negative. Documentation should be provided, preferably in a robust, portable form (for example 'smart cards').

Rhesus sensitization in early pregnancy is relatively uncommon, but in the cases where it occurs, it can be a tragedy. Attention to these areas would allow general practitioners to prevent more of these tragedies.

DAVID ROSS RUSSELL

16 Walnut Parkway
Monclair
NJ 07042
USA

References

1. Mollison PL, Engelfreit CP, Contreras M. *Blood transfusion in clinical medicine.* Oxford: Blackwell Scientific Publications, 1987: 667-672.
2. Tovey LAD, Tavener JM. A case for the antenatal administration of anti-D to primigravidae. *Lancet* 1981; **1:** 878.
3. Tovey LAD, Townley A, Stevenson BJ, Tavener JM. The Yorkshire antenatal anti-D immunoglobulin trial in primigravidae. *Lancet* 1983; **2:** 244.
4. Department of Health and Social Security. *Haemolytic disease of the newborn.* London: HMSO, 1976 (addendum 1981).
5. Everett CB. Is anti-D necessary in the domiciliary treatment of miscarriages? *Br Med J* 1988; **297:** 732.
6. Entwistle CC, Tovey LAD. Supplies of anti-Rh(D). *Br Med J* 1988; **286:** 132.
7. Everett CB, Ashurst H, Chalmers I. Reported management of threatened miscarriage by general practitioners in Wessex. *Br Med J* 1987; **295:** 583-586.
8. Hussey RM. Why women are not receiving anti-D prophylaxis. *Br Med J* 1987; **294:** 119.
9. Contreras M, De Silva M, Chalmers PE. Why women are not receiving anti-D prophylaxis. *Br Med J* 1986; **293:** 1373.

Arthritis in inner city general practices

Sir,

The management of peripheral arthritis in the community and the type of patients seen by general practitioners have not been previously studied in detail. We evaluated 75 consecutive patients attending two group general practices with peripheral arthritis as their primary diagnosis in the City and Hackney district. This is an inner city area of considerable deprivation. Our objectives were to define the type of joint disease present, its effect on function, and the hospital treatment and community support received. All patients were seen at home by a community nurse specialist in rheumatology and their general practitioner records were reviewed.