LETTERS

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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.

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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.

The 75 patients comprised: 27 with probable or definite rheumatoid arthritis; 32 with osteoarthritis; 16 with other disorders (including three with possible rheumatoid arthritis). There was no evidence of a large number of cases attending their general practitioners with very mild rheumatoid disease. Most patients were elderly (mean age 65 years); 12 patients were over 80 years. The majority were women (m:f 15:60).

Many patients had considerable functional impairment assessed by Steinbroker functional classes.[1] Over 70% were severely incapacitated or housebound. Osteoarthritis was the most frequent cause of such severe disability and it usually involved the hip in these cases. The osteoarthritis was often longstanding and the patients elderly. There was a direct relationship between functional impairment and age in all diagnostic groups.

Despite functional impairment only 31% of cases were attending rheumatology clinics and 17% orthopaedic clinics. Only five (25%) of the housebound patients attended rheumatology clinics and none were going to an orthopaedic clinic. More of the 27 patients with rheumatoid arthritis were seeing a rheumatologist than patients with other conditions and 15 (56%) were current clinic attenders. These clinic attenders were slightly younger and more often men (Table 1). The functional classes of the rheumatoid arthritis patients were similar whether or not they attended a rheumatology clinic.

Community support was received by 63% of the patients. The most widely used support was a home help in 29% of cases. Other support groups visited less frequently including physiotherapists in 27% of cases and occupational therapists in 21%. A minority of patients (32%) were registered as disabled.

This preliminary survey shows that many patients had considerable functional impairment owing to arthritis yet only a minority attended hospital clinics to see rheumatologists or orthopaedic surgeons. It would help general practitioners if there were agreed criteria for hospital referral, and clearer objectives to be gained from attending a specialist clinic.

We found considerable differences between rheumatoid arthritis patients attending and those not attending rheumatology clinics. The clinic attenders were more likely to have received slow acting anti-rheumatic drugs and corticosteroids, but functional capacities were similar in non-attenders and attenders. Recent studies of the outcome of hospital treatment for patients with rheumatoid arthritis casts doubt on the long term impact of slow acting anti-rheumatic drugs[2] and the results of this community survey support such a view. The precise role of outpatient rheumatology clinics in the long term management of rheumatoid arthritis needs further definition.

Table 1. Patients with rheumatoid arthritis: comparison of those attending and not attending rheumatology clinic.

	Attending clinic ($n=15$)	Not attending clinic ($n=12$)	All patients ($n=27$)
Mean age (years)	58	65	61
Mean disease duration (years)	9	8	9
Male:female (numbers)	6:9	1:11	7:20
Functional classes			
Mild impairment	5	4	9
Marked impairment (off work)	7	6	13
Severe impairment (housebound)	3	2	5
Drug therapy			
Slow acting drugs	5	0	5
Corticosteroids	8	1	9

n = total number of patients

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Management of the post-viral fatigue syndrome

Sir,

We read with interest Dr Ho-Yen's thoughtful paper on the management of the post-viral fatigue syndrome (January *Journal*, p.37) and welcome the renewed interest in practical management. Dr Ho-Yen's article is written in response to our previous paper on the subject,[1] and although there are differences between the two approaches, we must first point out the considerable areas of agreement between us, perhaps no more so than the emphasis on the role of the general practitioner, and of the crucial importance of a healthy doctor–patient relationship.

Many of the apparent differences between our approach and that of Dr Ho-Yen are, as he states, due to sample differences. Our experience is based on patients with chronic illness seen in specialist neurological settings with a mean illness duration of five years.[2] Dr Ho-Yen is familiar with patients with shorter illness durations, referred for a microbiological opinion. Many of the strategies advocated by Dr Ho-Yen are therefore designed for those in whom spontaneous recovery can still be anticipated. However, what about when such recovery has not occurred? In the two largest samples to date others have noted 'an alarming tendency to chronicity',[3] and it has been alleged that 'most of the cases seen do not improve, give up their work and become permanent invalids'.[4] The current therapeutic approach for these patients is obviously unsatisfactory.

How does such chronicity develop? Dr Ho-Yen criticizes the first stage of the model we proposed to explain such chronicity, and points out that far from initially adopting forced inactivity after a viral infection, many chronic sufferers did the opposite, and tried to exercise away the fatigue. We accept his observation. Dr Ho-Yen's comments do indeed coincide with our own clinical impressions: many patients report initially adopting such strategies, and find that these are unsatisfactory, leading to a rapid recurrence of symptoms. However, we suggest this is an even more convincing explanation of the remainder of the model we propose. Simple operant conditioning suggests that such a powerful experience of failure will lead to persistent avoidance, perhaps when the original need for it is no longer present. We also suggest that early and repeated exposure to uncontrollable, aversive and mysterious symptoms, such as the profound muscle pain that characterizes the syndrome, is another potent cause of the demoralization and helplessness so frequently found (Powell R, Wessely S, manuscript submitted for publication) and may in turn explain the high rates of mood disorder that have been observed in several studies.