

ments about the organization of care within practices and agree that evaluating care 'needs to be carried out using hard outcome measures'.

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Reference

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Introduction to psychosexual medicine

Sir,

I read with much interest the replies (*March Journal*, p.126) to my review of *Introduction to psychosexual medicine: for doctors, nurses, students, and other health professionals* (January *Journal*, p.45).

I am reminded that, despite the full title, the book is 'written by doctors primarily for doctors'. My criticism of the book has led to me being labelled a 'red under the bed'. Nothing could be further from the truth, but such comments do tell us a lot about the value systems of some

members of the Institute of Psychosexual Medicine.

Since 1976 I have worked alongside doctors in both hospital and primary care settings, first as a qualified nurse, and then as a psychologist. For the past three years I have been witness to the very busy and often hectic lives of general practitioners. I have always admired the way these professionals share their medicine with both their colleagues in other health professions and with their patients. I would do them all a disservice to recommend a book that does not easily relate to the practicalities of their every day practice life. If this results in being identified as an academic Luddite then so be it.

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Voluntary euthanasia

Sir,

I read the discussion paper by Dr Bliss on

euthanasia (*March Journal*, p.117) with interest, particularly since reference was made to the Hippocratic oath. The relevant part of the oath, which was not quoted, is 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel'.

The author wants the rights of children to make decisions for their parents who are incapacitated by age or dementia to be recognized. However, rights can only be recognized and exercised provided the rights of others are not transgressed. Quite simply, the right I have to swing my arm ends where another person's nose begins. To make children the arbiters of life and death for their parents is untenable in a civilized society, particularly one which outlaws the death penalty for criminals. The doctor is not there to act as an executioner at the behest of the younger members of a family.

Let us maintain the Hippocratic tradition.

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DIGEST

This month ● diagnostic testing ● febrile convulsions ● arthritis ● breast cancer ● smoking

Routine diagnostic testing

THIS article looks at whether routine diagnostic testing is beneficial to the practice of medicine. Although the comments are mainly levelled at junior hospital doctors the underlying message is applicable to medical practitioners in all fields.

There has been convincing evidence over the years that many common diagnostic tests are a waste of time and money and yet despite this the number of requests for these investigations continues to increase. It is often the junior hospital doctors who are the culprits although most senior medical staff cannot escape criticism. The article explores the reason for doing so many tests, such as fear of missing a diagnosis, reassurance for the clinician and for the patient as a result of the increase in prevention and screening and also an increasing fear of medical litigation. It is interesting to note that research among medical outpatients has shown that routine haematological and urine tests contributed to less than 1% of diagnoses while 73% of diagnoses were made on basic history and physical examination alone.

It is suggested that investigative departments should screen requests more rigorously and lay down guidelines for the

junior staff. In addition, medical students should be taught more about health economics and cost-effective decision-making in their undergraduate career. In the light of the government's strive for cost efficiency and the introduction of practice and hospital budgets, the use of diagnostic tests may well be an area that general practitioners and vocational trainees will have to reassess.

(M K)

Source: Anonymous. Routine diagnostic testing. *Lancet* 1989; 2: 1190-1191.

Phenobarbitone in the prevention of recurrent febrile convulsions

THE position of phenobarbitone as a useful drug in the prevention of recurrent febrile convulsions has recently been questioned by clinical studies which report behavioural and cognitive side effects as well as experimental work which has shown deleterious effects on developing neurones. Workers in Seattle have carried out a randomized controlled trial on 217 patients aged between eight and 36 months who satisfied the criteria of the National Institutes for Health for consideration of prophylaxis — very young,

more than one febrile seizure, family history of epilepsy, lengthy focal or multiple seizures (*Pediatrics* 1980; 66: 1009). Study subjects received riboflavin as placebo or 4-5 mg kg⁻¹ of phenobarbitone per day with riboflavin for two years. The end points were recurrence of seizures and scores on the Bayley scales of infant development and Stanford-Binet scales of intelligence adjusted for age and level of function.

After two years the mean IQ was 8.4 points lower in the phenobarbitone group than in the control group (95% confidence interval, -13.3 to -3.5, $P = 0.0057$). Six months after medication had been gradually reduced and then discontinued the mean IQ remained 5.2 points lower (95% confidence interval, -10.5 to 0.04, $P = 0.052$). The proportion of children remaining free of subsequent seizures did not differ between the treatment groups.

The authors conclude that phenobarbitone depresses cognitive performance in children treated for febrile seizures and that this disadvantage, which persists for several months after drug treatment, is not offset by the benefit of significant seizure prevention. They suggest that as other agents have not proven effective further studies are needed to evaluate newer

drugs. In the meantime 'intermittent treatment with other agents such as diazepam given rectally can be considered'.

(F S)

Source: Farwell JR, Lee YJ, Hirtz DG, *et al.* Phenobarbital for febrile seizures — effects on intelligence and on seizure recurrence. *N Engl J Med* 1990; 322: 364-369.

Treatment of chronic arthritis with amantadine

THE cause of most forms of chronic arthritis is unknown but many believe there is some form of infective 'seed' sown in a particular genetic 'soil'. This paper reports a small group of patients all born in 1963, who shared a similar juvenile onset form of arthritis. Of the 13 patients 11 had high titres of antibodies to influenza A (H2N2), the virus which was epidemic in the year of the study.

The antiviral agent amantadine was used in a double blind placebo controlled four month trial in 10 patients. The drug was then given openly to the control patients for a further four months. After the first four months all four patients on the active drug improved, one considerably, but the six control patients deteriorated slightly. After the next four months, three of the six controls were also improving.

Amantadine is not known to have any antirheumatic effect in itself. These results suggest that persisting influenza A is contributing to the arthritis in these patients.

(O T)

Source: Pritchard MH, Munro J. Successful treatment of juvenile chronic arthritis with a specific antiviral agent. *Br J Rheumatol* 1989; 28: 521-524.

Breast cancer and screening

KNOWLEDGE and attitudes to cancer of the breast are changing rapidly. A recent report from the Westminster hospital suggests that tumour excision and radiotherapy is adequate in most cases, and this certainly avoids disfigurement. Wider excision is preferred by other surgeons, but the radical mastectomy is now rarely advised.

Small tumours have a better prognosis than larger ones and trials in New York and Sweden showed a reduction in mortality of 30% following screening, but only in women between the ages of about 50 and 55 years. Pilot studies in Edinburgh and Guildford unfortunately found no significant difference in the mortality rate at five year follow up between women screened and their controls, but it is thought that a longer follow up may show benefit. A small number of cancers can-

not be seen on a mammogram by radiologists even when a cancer is known to be present. In addition, below the age of 35 years the normal breast is so dense that tumours are unlikely to be seen on an x-ray.

Mammography screening was started in North Yorkshire in September 1989 (Hop-ton DS, lecture at York postgraduate centre). Women between the ages of 50 and 65 years are invited by letter to attend a local mobile mammography screening unit. Two films are taken. If no abnormality is found the women are reassured, and told they will be asked to attend again in three years time. They are advised to examine their breasts regularly in the meantime, as about one in three cancers develop in less than three years. Up to 10% of the mammograms are inconclusive. Further investigations are arranged at the assessment clinic in York, using clinical examination, more x-rays, ultrasound and fine needle aspiration. If biopsy is required, a letter is sent to the patient's general practitioner, who will arrange for this to be done by a surgeon, usually at a local hospital. Stereotactic x-ray localization may be needed, but some 70% of radiologically detected tumours are palpable. In the first two months of mammography at the York unit, 500 women were screened, and one breast cancer was found.

Even the most optimistic estimates of the benefits of mammography do not suggest that screening will reduce the mortality by a high percentage. There is no doubt that experience with mammography will lead to much research about breast cancer, which develops in 24 000 women in the UK every year. Work in mammography clinics will also lead to better discussions with patients about their fears and hopes. For this reason, if no other, we should encourage our patients to attend mammography clinics.

(G P)

Sources: Roberts M. Breast screening: time for a rethink? *Br Med J* 1989; 299: 1153-1155. Forrest APM. Screening for breast cancer: the UK scene. *Br J Radiol* 1989; 62: 695-704. UK trial group. First results on mortality reduction in the UK. Trial of early detection of breast cancer. *Lancet* 1988; 2: 411-416. Wells MG, Walsh MT, Lee JR. A review of breast carcinomas missed by mammography. *Br J Radiol* 1989; 62: S11. Barr LC, Brunt AM, Goodman AG, *et al.* The primary management of breast cancer: is breast conservation feasible for all patients? *Ann R Coll Surg Engl* 1989; 71: 390-394. Forrest APM. Breast cancer: 121 years on. *J R Coll Surg Edinb* 1989; 34: 239-248.

Twins, smoking and mortality

'SMOKERS die of lung cancer and coronary heart disease because they have a gene which makes them both a smoker

and causes the underlying coronary heart disease and lung cancer'. The constitutional theory of the association between smoking and disease is one which has been banded around from time to time by representatives of the tobacco industry. Although the vast majority of the public and the medical profession realize that smoking causes cancer, this rearguard action may be one of the reasons that between 30 and 40% of the British population still smoke.

An elegant longitudinal prospective study has been carried out in Finland to examine this constitutional theory. Twelve thousand pairs of twins were surveyed in 1975 about their smoking and other lifestyle habits. Two thousand eight hundred same sex pairs in which one twin smoked and the other did not were then followed-up for at least 12 years, using the mortality data and record linkage systems available in Finland. The twins were divided into those who were current smokers and former smokers and also separated into monozygotic and dizygotic pairs.

The study found a significant excess of deaths from all causes in smokers compared with non-smokers, especially in male current smokers. The relative risk of death in male current smokers was 13.0 for monozygotic twins and 2.4 for dizygotic twins. There was a trend towards an increased number of deaths in women former smokers, but owing to the small numbers of deaths this did not become statistically significant.

More detailed examination of causes of death showed that more smokers died from coronary heart disease and lung cancer. Mortality was dose related with heavy smokers having a relative risk of 4.0 and light smokers 2.5 for monozygotic twins and 2.0 and 1.7 respectively for dizygotic twins.

The authors also examined confounding factors such as alcohol intake, personality type and other environmental factors and found no significant differences between smokers and non-smokers.

This is one of the largest twin studies to be carried out on smoking. Thus, with its prospective longitudinal design over 12 years it allows causal relationships to be determined. The results appear to firmly and finally knock the constitutional theory of the association between smoking and disease on the head. Smoking is public enemy number one to a healthy lifestyle.

(J A)

Source: Kaprio J, Koskenvuo M. Twins, smoking and mortality: a 12-year prospective study of smoking-discordant twin pairs. *Soc Sci Med* 1989; 29: 1083-1089.

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