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.

Benefits of developmental screening

Sir,

Doubt has recently been cast upon the value of developmental examinations in pre-school children. Bain[1] writes 'setting aside two to three hours for routine examinations could be extremely unproductive'. Hall[2] opined that 'There is no justification for repeated developmental examinations on a routine basis of all pre-school children, and these should be discontinued, assuming the continued existence of a high standard of surveillance available to all children'. I thought it might be useful to report the work during one year of a developmental clinic in general practice by one observer — this may not be typical but it represents the work of an ordinary general practitioner with a list size of about 2500, including 130 children of four years and younger. Children are examined soon after discharge from hospital (usually at home) and at seven, 12, 30 and 48 months. Neonates have been excluded in this report.

At the seven months examination 15 out of 28 children were normal on the first tests; at 12 months 27 out of 31 were normal; at 30 months seven out of 15 were normal; at 48 months 13 out of 24 were normal. Those not normal were seen again approximately one month later for re-testing the problem elicited at the first examination, unless they had already been referred to a specialist. The results are shown on Table 1.

The high proportion of children at seven months with doubtful hearing was predictable and underlines the need for a better test at this age; a second test is quickly performed. Sometimes a symptomless otitis media is found. A total of 21 children were identified as having a new problem and referred to secondary care out of 98 examined (21%) is considerably higher than most other screening procedures.

While I agree with Dr Hall that history and observation are important, it is still necessary for general practitioners to go through (at least in their mind) the skills of gross motor, fine motor, and so on. 'If you miss something out you'll miss something.'

But there is a further argument. Many will claim that this work is not cost effective, that the amount of time and effort expended is out of all proportion to the achieved 'yield' of referrals. My own philosophy is different. If over nearly 30 years of doing this work I have improved the educational prospects of even one child (the main object of child health screening) I shall have felt those hours well spent.

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Table 1. Results of retest.

Problem detected	No. of cases	Outcome
7 months		
Doubtful hearing	11	10 normal at 2nd test (including 3 referred); 1 lost to follow-up
Doubtful vision	2	1 squint confirmed and referred; 1 poor visual acuity, normal at 2nd test
Gross motor delay	2	2 second exam confirmed (regular review for other problems)
12 months		
Doubtful hearing	1	1 second test confirmed and referred
Doubtful vision	2	2 second test normal
Squint	1	1 second test confirmed and referred
30 months		
Squint	1	1 normal at 2nd test
Speech delay	2	2 second test confirmed and referred
Unexplained weight loss	1	1 second test confirmed, observation
Behaviour problems	2	2 discussion and advice
48 months		
Doubtful hearing	2	2 referred and confirmed
Doubtful vision	8	4 referred and confirmed; 3 second exam normal; 1 lost to follow-up
Speech delay	2	2 second exam confirmed and referred
Developmental delay	2	2 referred
Undescended testis	1	1 referred

References

1. Bain DJG. Developmental screening for pre-school children: is it worthwhile? *J R Coll Gen Pract* 1989; **39:** 133-135.
2. Hall DMB (ed). *Health for all children.* Oxford University Press, 1989: 17.

Spirometry in general practice

Sir,

In 1985 I acquired a Vitalograph spirometer, and so it was of great interest to read Dr Smith and colleagues' letter (March *Journal,* p.123) about their hospital-based experience offering open access to spirometry with chest x-ray.

I work in a rural area surrounded by orange, avocado and mango orchards. Many patients suffer from hay fever, allergic conjunctivitis and asthma, made worse at blossom time. There is an addi-

tional group with covert respiratory illness who present with an irritant cough and tiredness, but who have no abnormal physical findings. My patient load is 1100 with an additional 400 girls at a boarding school. The practice nurse performed the majority of the lung function tests and I read the tracings — the combined time taking approximately 20 minutes.

During the five years we have performed lung function tests on 100 patients: 133 tests were done, 14 patients had two tests, six patients had three tests, and one had eight tests. In four patients we were unsuccessful owing to bad technique (three in children less than eight years old and one in a man aged 84 years). Twenty one patients had known respiratory illness, mainly bronchial asthma; but 19 patients who presented with a cough and non-specific complaints, who were clinically normal, had abnormal lung function tests. This group received specific therapy after a diagnosis was made, and good results were obtained.

My experience with the Vitalograph has given me an aid in diagnosis and treatment as important as the electrocardiograph machine. I am aware that availability might have caused increased use but pathology was found in nearly 20% of those examined.

I am in total agreement with Dr Smith as to the use of spirometry as an aid for assessment and diagnosis of lung disease. However, in the light of my positive experience I believe that lung function test measurement should be carried out in primary care centres. I do not accept that hospital referral is required because 'few health centres are able to offer their patients this facility'. The spirometer is relatively inexpensive and easy to use.

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Direct access for GPs to pulmonary function laboratory

Sir,

We have recently evaluated whether direct access for local general practitioners to our pulmonary function laboratory is of value in the management of breathless patients. Over a six month period, 24 general practitioners referred 73 patients to the laboratory where simple spirometry and peak flow measurements were performed, with reversibility studies and education in inhaler technique when appropriate. These tests were performed within one week of referral by an experienced technician, the patients not being seen by a physician. A total of 27 patients had normal results. Although the general practitioners had correctly predicted an obstructive defect in 38 (88%) of the 43 patients with airflow obstruction, their assessment of the severity of the obstruction was accurate in only 22 (51%) patients. Half of the patients in whom the general practitioner thought the airflow obstruction would be irreversible showed significant reversibility in the laboratory. As a result of the tests, the medication of 35 patients was changed by their general practitioner, and in reply to questionnaires the general practitioners of 21 patients said that the tests had prevented referral to a respiratory outpatient clinic. We believe that this service is a cost effective alternative to hospital referral for selected patients with breathlessness.

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Dietary advice and health

Sir,

The National Association of British and Irish Millers (NABIM) represents the UK flour milling industry and therefore has a natural interest in nutritional matters. For many years, much of nutrition was seen in terms of obesity and its prevention and starchy foods such as bread were mistakenly labelled as fattening. The position was, however, transformed in the early 1980s, with various reports by the Committee on Medical Aspects of Food Policy (COMA) recommending a fundamental shift in dietary patterns away from fat, and particularly saturated fats, towards carbohydrate, and particularly complex carbohydrates.

Despite this advice, the relationship between the main sources of energy in the diet has changed barely at all since 1980. At that time, 44.4% of calories in the UK diet derived from carbohydrate, 42.6% from fat and 13.0% from protein. By 1988, the figures were 44.4%, 42.0% and 13.6%, respectively, as drawn from the national food survey carried out by the Ministry of Agriculture, Fisheries and Foods.[1]

The public has become much more aware of nutrition and food matters. For example, a MORI survey reported in the *Sunday Times* on 1 October 1989 found that a healthy diet was important for 39% of people, with another 39% trying to eat healthily, but not at the expense of enjoyment. Common fallacies, however, continue to abound; in the same survey, nearly half the responders wrongly believed that starchy foods gave more calories ounce for ounce than foods high in protein. Perhaps as a consequence, more than half thought that most of our energy should come from protein.

Clearly, medical practitioners have an important role to play as a source of authoritative advice on healthy eating. On the other hand, they may not always be equipped to give it. An interesting study of local general practitioners by Bradford university published in February 1989[2] discovered an impressive correlation, in most cases, between responses and current dietary recommendations. The recommendations were not, however, always converted into practical advice. Furthermore, understanding in some areas was deficient. For instance 43% of general practitioners considered that complex carbohydrates were calorie-rich and should be avoided, especially on a weight reducing diet. In similar vein, a study of general practitioners and their practice team members by the National Dairy Council[3] found that 99% considered it important to have more fibre in the diet and 95% to have less fat. However, when asked about a principal source of this fibre and alternative to fat, only 36% recognized the importance of eating more starchy foods such as bread.

Perhaps doctors suffer from the welter of information on diet as much as their patients do. Certainly, there seems to be a lack of coherent advice drawing all the established recommendations together and converting them into practical form. In the continued absence of such advice, any change in dietary patterns is likely to be slow and haphazard. The medical profession has a part to play in rectifying this situation.

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References

1. National food survey committee. *1988 Household food consumption and expenditure.* London: HMSO, 1988.
2. McCluney J. *Nutrition and health — a GP survey.* Bradford: Horton, 1989.
3. Medical Research Factors Ltd on behalf of the National Dairy Council. *Healthy eating. Beliefs and advice. Summary of research into attitudes to healthy eating held by GPs and practice team members.* London: National Dairy Council, 1989.