LETTERS

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Use of antibiotics and antifungal agents in herpetic gingivostomatitis

Sir,

Despite its falling incidence, herpes simplex infection remains common.[1] Most primary infections, which may be asymptomatic,[2] are acquired in childhood, where they manifest as gingivostomatitis. The incidence of herpes virus infections is higher in deprived areas.[3]

A retrospective review of 43 cases of gingivostomatitis among children admitted to a regional infectious diseases unit over a 24 month period suggests that general practitioners are uncertain about the diagnosis and treatment of this condition. While our sample may be biased, it suggests that current practices should be reviewed.

The 43 cases were clinically similar, and of the 25 which were investigated virologically, 22 had positive cultures for herpes simplex virus. An obvious prodrome, lasting between one and three days, was noted in only eight cases. Four patients had been unwell in the week leading up to admission (two with gastroenteritis and two with chest infections). Treatment prior to hospitalization consisted of: nystatin (five patients), amphotericin (one), aminopenicillin (ampicillin, amoxycillin or co-amoxiclav) (nine), erythromycin (four) and aminopenicillin plus nystatin (five). Two of the five patients who received acyclovir prior to admission had received antibiotics beforehand. In the three instances when an antibiotic had been prescribed for prodromal symptoms it was erythromycin. This is likely to represent the choice of antibiotic for 'pyrexia of unknown origin', and it seems unlikely that erythromycin increases the incidence of ulceration. Bacterial culture grew light growths of normal oral flora, and occasional light growths of yeasts.

From discussion at the time of admission, and because nystatin was the commonest therapeutic agent prescribed prior to admission, it appeared that many of the cases were being misdiagnosed as thrush or bacterial stomatitis. At the time of presentation all of the children had painful mouths (often present before ulcertion), displaying typical shallow, grey-white, based ulcers in the anterior part of the mouth, and 23 had secondary lesions. The greyish-white ulcers are quite distinct from the white raised lesions which are the usual sign of candidiasis in children. The latter are confined to mucosal surfaces and are less associated with systemic illness. Many children have light growths of candida on oral swabs, as did a number in this series. We did not use antifungal agents in these circumstances and had no problems with thrush.

Only five children had received acyclovir prior to admission, without obvious benefit. Our policy is to give acyclovir in the first two days of illness (except for very mild lesions), though there is no conclusive evidence to show benefit at present.[4] Certainly treatment probably needs to be given very early. No children required intravenous fluids or had late complications.

Herpetic gingivostomatitis may be diagnosed on clinical grounds,[5] and if confirmation is required, herpes simplex virus is easily cultured. Thrush should be easily distinguishable, and if treatment for possible bacterial stomatitis is desired, penicillin V is active against all normal pathogens, and is less likely to cause adverse events than many agents.

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Testicular self examination: evaluation of an educational leaflet

Sir,

With optimal management, more than 90% of patients who present with advanced anaplastic germ cell tumours of the testis[1] can probably be cured. Those failures that do occur are usually in patients with very bulky disease and high tumour marker concentrations at presentation.[2] Most of those with stage 1 disease will require no further treatment after the initial orchidectomy.[3] Delays in diagnosis are largely due to the failure of patients to report testicular abnormalities promptly.[4] These delays are associated with a greater frequency of poor prognostic characteristics.[5] It is therefore preferable that testicular cancer is diagnosed early.

The Yorkshire Regional Cancer Organization has prepared a leaflet (published by McCormack Ltd, Leighton Buzzard) which describes the purpose and technique of testicular self examination. We have evaluated its effects on knowledge of testicular cancer among students of the University of Bradford and on attendances at the university student health service.

Testicular self examination leaflets were made available to students when they collected their grant cheques over a period of two terms. Consultations for scrotal complaints in the student health service were recorded by the medical officers there during the terms. The following term, a questionnaire was administered to a random group of male students in order to assess what proportion had seen the leaflet and what they knew of testicular cancer. The interviews were conducted by students recruited for this purpose. Student health service consultations after the survey were monitored as before.

Interviews were carried out with 720 men, 33.1% of the male students in the

university in October 1988. Of these, 122 (17%) had taken the leaflet. Leaflets were passed on by some students so that 168 (23%) in all had read it.

Testicular self examination had been performed at least once by 54/154 readers (35%) but by only 4/148 (3%) of non-readers. Only 19 students made a regular practice of testicular self examination. Significantly more (108/160, 68%) readers than non-readers (118/492, 24%) knew that the purpose of testicular self examination was to detect testicular cancer ($P<0.001$, 95% confidence intervals for difference, 35.3% to 51.7%). Of 158 readers who gave an opinion as to the age at which testicular cancer occurs, 19(12%) stated 15–40 years, which is the range given in the leaflet, and 110 (70%) gave ages within that range. Of 83 non-readers eight (10%) gave the 15–40 years range and 34 (41%) gave ages in that range. Readers also displayed some knowledge about the technique of testicular self examination, but there was no difference between the groups in knowledge of testicular cancer symptoms that are given in the leaflet.

There were 15 consultations at the student health service for scrotal complaints during the period of monitoring, seven following the first distribution of the leaflet, two after the second and six following the interviews. All but one took place within 10 days of the leaflet distribution or interview period. No testicular tumours were seen.

University students form an ideal group for education about testicular cancer because most of them are in the early part of the age range of greatest incidence. These results show that simply placing the testicular self examination leaflet to be collected is not an effective way of distributing it. The leaflet is an effective method of imparting information in that most of those who read it receive the important message that testicular abnormalities may indicate a curable cancer. The amount of detail recollected about the process of testicular self examination was, however, small.

The importance of information about testicular cancer in encouraging young men to perform testicular self examination was shown by Steffen.[6] An argument against teaching potential patients about testicular cancer is the fear that primary care facilities would be overloaded with young men concerned about this disease.[7] The present study and that of Vaz and colleagues[8] have shown that this is groundless. However, there are valid questions to be raised about the amount of resources devoted to this exercise. A system which equips the patient himself to recognize the disease early and which costs little to administer is an economical approach. The testicular self examination leaflet seems an appropriate option but it needs to be distributed in such a way as to ensure a high take-up rate. Further studies of this are in hand.

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Long to short consultation ratios

Sir,

Our practice would like to express its appreciation of the research on long and short consultations recently reported by Professor Howie and colleagues (February *Journal,* p.48).

I had the good fortune to hear Professor Howie's presentation of his group's preliminary findings at the 1990 Spring meeting of the Royal College of General Practitioners. Professor Howie demonstrated that, in consultation sessions with more than 12 patients, slow doctors performed less well and felt more stressed than faster doctors. We found that we were a practice of five 'slow' doctors and one 'intermediate' doctor. At that time our sessions involved seeing 16–18 patients, booked at 10 minute intervals, and it was quite usual to be running up to an hour late at the end.

We have now reorganized our appointment times so that each session is divided into two halves of eight or nine patients each, with an interval of at least 30 minutes in between. As a result, we are unanimously agreed that we are subjectively very much less stressed, we have time for a guilt-free cup of coffee and sessions running even 30 minutes late have become unusual.

We can vouch for the practical application of research findings.

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Sir,

Professor Howie and colleagues have published an article of interest to all general practitioners (February *Journal,* p.48), which has confirmed many peoples' assumption that the quality of consultations is affected by constraints on time.

His ultimate conclusion, that long to short term consultation ratios may be used to measure quality of care in the future does not, however, seem to be valid in the light of current trends within general practice.

Two of the three issues highlighted as being dealt with more effectively in 'long' consultations were long term health problems relevant to patient care, and health promotion. For many general practitioners both of these issues will be seen to be more appropriately dealt with in the health promotion clinics encouraged under the new contract, rather than in standard consultations. This introduces a new variable. When health promotion clinics are used this will be reflected in fewer 'long' consultations and thus a fall in the long to short consultation ratio for both 'faster' and 'slower' doctors. This would not necessarily indicate a fall in quality of care, indeed many would argue that quality of care of long term health problems, for example, diabetes, asthma and hypertension, is improved in the health promotion clinic setting.

It is likely that although the standard surgery consultation length may fall in these patients, total time spent with them may increase. This will not necessarily be followed by an increase in patient satisfaction as patients may not be happy about attending a variety of separate clinics on separate occasions.

The effect of health promotion clinics on consultation time is not predictable either, with some general practitioners claiming to run 20–25 per week while my own experience in an eight partner practice is of considerably less.

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