LETTERS

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Treatment of skin cancers in general practice

Sir,

Skin cancer is the second commonest cancer in both men and women. Most doctors would regard the treatment and management of primary skin cancer as being largely the field of the hospital consultant.

As a general practitioner in a five partner group practice, I have for the past six years been treating non-melanoma skin cancers. Over the five year period from July 1985 to June 1990 I confirmed a total of 69 non-melanoma skin cancers in 65 patients aged between 33 and 91 years, all of whom were registered with the practice. I treated 67 of these and referred the other two lesions for plastic surgery. The types of lesion treated, the methods of treatment and the recurrence rates are summarized in Table 1.

The results represent a 94% cure rate which compares very favourably with larger hospital based studies.[1] Although the numbers are relatively small, the recurrence rates are also similar to treatments followed up in hospital outpatient clinics.[2]

In my series, 24% of the skin cancers were treated by excision biopsy and 76% by liquid nitrogen cryosurgery. The choice of treatment depended on the size, the site, the histopathology, the age of the patient and the degree of inconvenience to the patient. The majority of facial lesions, where damage or distortion of surrounding structures was to be avoided, were treated by cryosurgery with excellent healing and cosmetic results. In lesions on the leg, particularly in patients with impaired skin health, surgical excision resulted in better healing.

The safety and effectiveness of cryosurgery depends on pre-treatment histology and a sound knowledge of the biological basis of low-temperature cryotherapy. An edge biopsy was taken from all lesions to be treated by cryosurgery. This was done at the previous month's clinic. It enabled me to know the exact pathology, and to remove any sutures, before undertaking cryosurgery. I carried out each excision, edge biopsy and all cryosurgery under local anaesthetic. Under the minor surgery clause of the new general practitioner contract, a fee can be claimed for each of the three procedures. Local anaesthetics and any sutures used are also reimbursable on a named FP10.

All the malignant lesions treated by cryosurgery in this study involved the use of a cryospray, a cryocone or a cryoprobe. This required an initial financial outlay on appropriate equipment. The technique, however, was relatively easy to learn. Costing the treatments used in my study showed a saving of over 50% for health centre based treatment relative to that provided in hospital outpatient clinics (£15.50 per treatment at the health centre and £35.40 per treatment at the hospital clinic based on 1987 figures).

General practitioners are ideally placed to detect all forms of skin cancer and pre-malignant conditions. My experience shows that, using the complementary modalities of surgical excision and liquid nitrogen cryosurgery, non-melanoma skin cancers can be treated as successfully in general practice as in hospital.

For the patient, receiving treatment in general practice means a shorter waiting time for treatment and better continuity of essential follow-up care, both of which are undertaken in familiar surroundings. For interested general practitioners, there is increased job satisfaction and greater use is made of their skills and those of their nurse. Primary health care is thus enhanced and considerable savings can be made to the National Health Service as a whole.

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Table 1. Non-melanoma skin cancers treated between July 1985 and June 1990.

	No. of cancers	No. (%) treated by: Excision	Cryosurgery	No. (%) of recurrences[a]
Basal cell carcinoma	45	7 (*16*)	38 (*84*)	3 (*7*)
Squamous cell carcinoma	16	8 (*50*)	8 (*50*)	0 (*0*)
Bowens disease (intraepidermal carcinoma)	6	1 (*17*)	5 (*83*)	1 (*17*)
Total	67	16 (*24*)	51 (*76*)	4 (*6*)

[a]Follow up to April 1991.

General practitioners' opinions of hospice care

Sir,

Although less than a third of patients die at home, the great majority spend an average 90% of the final year of their illness at home under the care of a general practitioner. Most general practitioners regard terminal care as an important part of their work, and many actively under-

take to improve their knowledge and expertise in this area. Nevertheless terminal care occupies only a small proportion of the average general practitioner's workload[1,2] and it is not surprising that many lack confidence in their ability to cope with bereavement[1,3] and symptom control, in particular pain control.[1,4-6]

One response to these problems has been the development and rapid growth of hospices. Hospice home care teams generally aim to complement, not replace, general practitioner care by offering expert advice and assistance in the management of patients dying at home. Knowledge of general practitioners' attitudes to hospices is therefore important in planning the future development of community services for the terminally ill. We are aware of only one published survey of general practitioners' attitudes to hospice care.[7] This north London study suggested that, while general practitioners were generally satisfied with the local hospice home care services, there was room for improvement regarding joint visiting arrangements and hospice nurse prescribing.

In order to learn more about the general practice perspective on hospice home care we conducted a postal questionnaire survey of 192 general practitioners in one south London family health services authority area. The findings showed that doctors were generally satisfied with the hospice service, except as regards the waiting time for admission (47% dissatisfied). Many general practitioners volunteered the complaint that, unless patients were registered with the hospice well in advance, it was difficult or impossible to admit them at short notice. Doctors who qualified in 1969 or before were significantly more satisfied than doctors who qualified after 1969 with: hospice waiting times (61% satisfied versus 40%, chi-squared test, $P<0.05$), communication with hospice staff (74% versus 42%, $P<0.01$), hospice bereavement counselling (85% versus 64%, $P<0.05$), and the overall quality of hospice home care (79% versus 57%, $P<0.05$). In contrast to previous studies, the majority of doctors were moderately or very confident in their ability to control pain in terminally ill patients (88% confident) and counsel the bereaved (76% confident). There were no important associations between doctors' assessment of their own ability to provide terminal care and their opinion of hospice services.

We conclude that, although most general practitioners were satisfied with local hospice care, younger doctors demanded a more flexible and responsive service. It may be that recent advances in terminal care, together with a greater emphasis on this in medical training, has led new general practitioners to be more exacting in the standards they expect of hospices.

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Asthma specific quality of life scale in a study of salmeterol hydroxynaphthoate

Sir,

Asthma can have a profound effect on the quality of life of patients, but the development of disease specific quality of life scales has been achieved only in recent years.[1-3] These scales have a potentially important application in clinical trials where it is now possible to evaluate the efficacy of treatment from the patient's perspective.

We report the use of a new asthma specific quality of life scale in a clinical study of salmeterol hydroxynaphthoate, a new long acting B_2 agonist. Clinical studies[4] have shown that salmeterol improves lung function as measured by conventional spirometry and morning and evening peak flow measurements. It has also been found that waking at night owing to asthma and the need for additional relief bronchodilators are reduced, and symptom scores improved.

Salmeterol reduces the diurnal variation in peak flow rate and there is evidence[5] that a large diurnal variation has psychological consequences. The clinical effects of salmeterol could therefore be expected to improve quality of life.

The living with asthma questionnaire[3] is a 68-item, 11-domain scale designed to provide an ordinal estimate of quality of life specifically for asthmatics. The questionnaire is a broadly focussed self-administered instrument suitable for clinical trials. In a double-blind, multicentre trial, mild asthmatics were recruited who either had a 15% reversibility in forced expired volume in one second (FEV_1) or peak expiratory flow rate (PEFR), 15 minutes after inhaling 400 μg salbutamol dry powder, or demonstrated a variation in morning to evening PEFR of at least 15% during a period of 14 days. Patients with a baseline FEV_1 value of less than 75% of the predicted normal value for their height, age and sex were excluded. After a baseline period, patients were randomized on a two to one basis, to either 50 μg salmeterol hydroxynaphthoate twice daily or matching placebo twice daily for six weeks.

Patients maintained symptomatic bronchodilator relief medication as required and normal prophylactic asthma medication was continued where used. In addition to regular measurements of conventional efficacy and safety parameters, the living with asthma questionnaire was administered to patients prior to active treatment and six weeks later at the end of the trial. Of the 422 patients who completed the trial, 122 patients receiving salmeterol and 73 patients receiving placebo completed valid responses to both questionnaires. As the scale is ordinal, patients were classified in terms of those whose quality of life had and had not improved (Table 1).

Table 1. Effect of salmeterol versus placebo on quality of life of asthmatics.

	% of patients whose quality of life was:	
	Improved	Not improved
Salmeterol ($n=122$)	*63.1*	*36.9*
Placebo ($n=73$)	*46.6*	*53.4*

Chi square = 5.1, $P<0.05$. n = number of patients in group.

In addition to the beneficial clinical effects of salmeterol (paper in preparation), the quality of life improved among significantly more patients in the salmeterol group than in the placebo group. The size of improvement cannot be inferred as there is no currently acceptable method of providing a quantitive estimate of quality of life change in asthmatics. Nevertheless, this study has demonstrated that salmeterol hydroxynaphthoate may improve quality of life in a group of mild asthmatics and that the living with asthma questionnaire is sensitive to the effects of different treatments