

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.

BONNIE SIBBALD

JOHN SIMPSON

Department of General Practice and
Primary Care
St George's Hospital Medical School
London SW17 0RE

References

- Haines A, Booroff A. Terminal care at home: perspective from general practice. *Br Med J* 1986; **292**: 1051-1053.
- Barritt P. Care of the dying in one practice. *J R Coll Gen Pract* 1984; **34**: 446-448.
- Blyth A. Audit of terminal care in a general practice. *Br Med J* 1990; **300**: 983-986.
- Keane W, Gould J, Millard P. Death in practice. *J R Coll Gen Pract* 1983; **33**: 347-351.
- Woodbine G. The care of patients dying from cancer. *J R Coll Gen Pract* 1982; **32**: 685-689.
- Reilly P, Patten M. Terminal care in the home. *J R Coll Gen Pract* 1981; **31**: 531-537.
- Copperman H. Domiciliary hospice care: a survey of general practitioners. *J R Coll Gen Pract* 1988; **38**: 411-413.

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 B₂ agonist. Clinical studies⁴ 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 evidence⁵ 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 questionnaire³ 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, multi-centre trial, mild asthmatics were recruited who either had a 15% reversibility in forced expired volume in one second (FEV₁) 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 FEV₁ 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 quantitative 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

and is therefore a useful additional efficacy measure for clinical trials.

M E HYLAND

Department of Psychology
Polytechnic South West
Plymouth PL5 8AA

G COWARD
F UPCHURCH

Allen and Hanburys
Stockley Park West
Uxbridge, Middlesex UB11 1BT

K P JONES

Primary Medical Care
University of Southampton
Aldermoor Close
Southampton SO1 6ST

References

- Guyatt GH, Berman LB, Townsend M, *et al.* A measure of quality of life for clinical trials in chronic lung disease. *Thorax* 1987; **42**: 773-778.
- Quirk FH, Jones PW. Patients' perception of distress due to symptoms and effects of asthma on daily living and an investigation of possible influential factors. *Clin Sci* 1990; **79**: 17-21.
- Hyland ME, Finnis S, Irvine SH. A scale for assessing quality of life in adult asthma sufferers. *J Psychosom Res* 1991; **35**: 99-110.
- Britton M. Salmeterol: three months comparison with salbutamol in asthmatic patients. *Eur Resp J* 1990; **3**: 226.
- Hyland ME. The mood-peak flow relationship in adult asthmatics: a pilot study of individual differences and direction of causality. *Br J Med Psychol* 1990; **63**: 379-384.

Ultrasound in the diagnosis of symptomatic breast disease

Sir,

We are fortunate in having an ultrasound service at our local cottage hospital, available on an open referral basis for antenatal examinations or general ultrasound. We have used this facility to explore the value of screening breast lumps which present in our local surgical out-patients department.

Ultrasound is a safe, convenient, non-invasive test which lessens the need for formal biopsy, thus decreasing costs and providing reassurance to the distraught patient. Using this test Smallwood and colleagues have found a greater accuracy in the diagnosis of breast lumps, particularly when breasts were dense or a featureless density had been recognized on mammography. As about 50% of women in the UK today will experience symptoms of benign breast disease during their reproductive years and as one in 14 of these will develop cancer of the breast at some stage, any test which increases the accuracy of diagnosis and diminishes the anxiety of the patient must be welcomed.

We have recently scanned 100 consecutive patients referred to our local surgical clinic for whom a clinical

diagnosis and possible course of action had been planned prior to the scan. A Siemens Sonoline S1 with a 5 MHz linear transducer and stand-off gel were used, the examination being performed in the supine position. On localization of the lesion a Polaroid picture was taken and an accurate measurement of the extent of the lesion made. The clinical diagnosis reinforced by the scan was then discussed with the patient by the clinician and a decision taken about necessary treatment — a possible biopsy, review at a future clinic or aspiration. If the latter was required, it was carried out immediately and the patient re-scanned to reassure her that all the fluid had been removed. Using such a combined approach, our biopsy rate has diminished as we have become more confident in the extra diagnostic evidence supplied by the use of ultrasound.

We also submit that fear, perhaps one of the most commonly observed symptoms in association with breast lumps, is more rapidly dispelled by this combined approach. Even a simple description of the ultrasound image enables patients to overcome some of their ignorance and when shown the characteristics of a cyst or a smooth-walled fibroid adenoma clinical reassurance is immediately enhanced.

Ultrasound scanning is of no help as a screening procedure and does require the presence of skilled staff at the clinic. However, we feel that with the implementation of the Forrest report and the inevitable increase in the pick-up rate of breast lumps, increased use of ultrasonography will benefit first our patients and secondly an ailing National Health Service.

J D CHURCH

St Thomas Court
Church Street
Axminster EX13 5AG

Reference

- Smallwood J, Guyer PB, Dewbury KC, *et al.* The accuracy of ultrasound in the diagnosis of breast disease. *Ann R Coll Surg Engl* 1986; **68**: 19-23.

Patients' duration on a practice list

Sir,

Little is known about the average length of time a patient is registered with his or her general practitioner. The 1990 report of the standing medical advisory committee¹ gives a figure of 12 years, quoted from a personal communication from Difford.

From annual audits I have calculated the registration length of patients registered with my practice at any time

during the period 1 January 1966 to 31 December 1989. Analysis by age cohort revealed the following results.

Of all the cohorts, the women patients aged between 25–29 years have been registered with the practice for the shortest length of time (mean 5.3 years, standard deviation (SD) 7.1 years). By comparison, male patients of the same cohort have been with the practice for a mean of 5.8 years (SD 6.5 years). The cohort with longest duration on the list is female patients aged between 55 and 59 years, being registered with the practice for a mean of 16.2 years (SD 6.4 years). The male cohort of that age group has been with the practice for 14.6 years (SD 7.2 years). The mean duration on the list is 9.6 years (SD 7.5 years) for all female patients and 9.9 years (SD 7.2 years) for male patients.

It would be helpful for computerized general practitioner records to show how long the patient has been on the list. No software is yet offered that does this, and yet it is often relevant to the decision-making process, as well as being of interest.

MICHAEL J JAMESON

7 Marlborough Gate
St Albans
Hertfordshire AL1 3TX

Reference

- Standing Medical Advisory Committee for the Secretary of State for Health and the Secretary of State for Wales. *The quality of medical care*. London: HMSO, 1990.

Assessment of elderly people in general practice

Sir,

The first of the two papers by Iliffe and colleagues (January *Journal* p.9, 13) draws attention to the advantages of proper assessment of elderly people, while the second suggests that this could be satisfactorily done on a mainly opportunistic basis.

The first paper reported that 65% of patients assessed had seen their general practitioner in the previous three months and of these 78% were seen at the surgery. It would be interesting to know what proportion of unmet need was discovered in the 65% group of patients 'seen' as opposed to the 35% 'not seen' by their general practitioners. However, unless the former group were assessed by their general practitioners for risk factors, then opportunistic screening had not taken place.

We were one of four practices in Devon recruited in 1976 for the King's Fund trial into care of the elderly in Devon using an annual at-risk register card, and are the