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.

The care of children with asthma in general practice: signs of progress?

Sir,

Prevalence rates for asthma in children in the United Kingdom are generally regarded as being between 10% and 12%. Underdiagnoses and undertreatment have been highlighted by several authors who have drawn attention to the need for general practitioners to be more aware of the problem of asthma in children.[1-4]

To investigate the diagnosis and management of asthma in general practice two contrasting practices with a known interest in the care of asthmatic patients were chosen for the study. One practice was a rural training practice in Aylsham, Norfolk (7900 patients) and the second was an urban practice based at Aldermoor health centre, Southampton (8400 patients).

There was a total of 3289 children aged 1–16 years in the two practices and from the morbidity registers it was found that 370 children (11.2%) had been given the diagnostic label 'asthma' (10% Aylsham, 12% Aldermoor). Of these children 212 had been registered since birth and the mean number of asthma consultations per child per year was 2.6 (median 1.9) with almost 50% of the consultations being doctor initiated in both practices.

Table 1 shows the range of treatments which had been used among these children. The proportion of children who had received prophylactic therapy was similar in the two practices. Although the Aylsham practice tended to prescribe more inhaled steroid and the Aldermoor practice more sodium cromoglycate, these findings reflect the policy in the Aylsham and Aldermoor practices to treat the underlying inflammatory process as well as providing symptomatic relief with bronchodilators. The use of nebulizers and oral steroids depicts the perceived severity of individual cases and situations where asthma may have been poorly controlled.

Table 1. Drug treatments used among the 212 children with asthma.

	No. (%) of children
Acute therapy	
Nebulizer treatment	37 *(17.5)*
Oral steroid therapy	7 *(3.3)*
Long term therapy	
Salbutamol	199 *(93.9)*
Inhaled steroid	93 *(43.9)*
Sodium cromoglycate	17 *(8.0)*
Theophyllines	17 *(8.0)*
Maintenance steroids	4 *(1.9)*

Twenty children (9.4%) had at least one admission to hospital and 25 children (11.8%) had at least one outpatient appointment for asthma. These results indicate that asthma care was predominantly in the hands of general practitioners. This fact is worth noting when considering reports from hospital studies which can only refer to a selected group of asthmatic children from a wide variety of general practitioners.

The level of 'diagnostic activity' in the two practices is in keeping with estimates of asthma prevalence in the UK and the emphasis on the use of prophylactic drug treatments is in line with current views on asthma care. We recognize that asthma in children includes a variety of sub-groups, some of whom are more vulnerable than others, and our intention is to develop methods of trying to identify 'at risk' children who require closer scrutiny and follow up. The fact that almost half of the consultations for asthma were doctor initiated provides evidence that regular review was a key feature of clinical care in the two practices.

We would like to stress that heightening awareness about asthma has to be balanced with an appreciation of the process of decision making in general practice where diagnostic precision is not always straightforward. In addition, measurements of outcome of care are not yet sufficiently robust to indicate whether 'higher diagnostic activity' actually leads to longer term improvements for patients. However, the first steps in 'setting the scene' for longer term follow up have been taken in the two practices described. The next step is to ensure that outcome measures encompass methods of evaluating children's capacity to use inhalers effectively, allied to an assessment of parental attitudes and coping abilities.

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Management of urinary tract infection

Sir,

The appropriate management of urinary tract infection remains controversial. In order to assess current trends in the management of urinary tract infection in Israel, a survey was conducted among 50 family physicians comprising 25 general practitioners, 15 board certified family physicians and 10 residents in family medicine. There were 32 women doctors and 18 men doctors and their ages were as follows: four physicians 20–29 years; 10 30–39 years; 16 40–49 years; 15 50–59 years; five 60–69 years. They all worked in walk-in primary care clinics. All the physicians who were asked to join the study participated. During a one month period one of us (G S) interviewed the physicians using a questionnaire with open questions regarding their opinions

about the most appropriate management of urinary tract infection.

Table 1 summarizes the main findings of the study regarding the need for laboratory investigations, the drug of choice and the duration of therapy. Twenty four physicians (48%) stated that they prescribed the same drugs and recommended the same length of therapy in male and female patients. When asked about antibiotic prophylaxis for urinary tract infection in females, 33 (66%) physicians would start prophylaxis after three or four episodes of urinary tract infection occurring during the previous three to six months. The remaining physicians had no definite answer to these questions, mainly owing to lack of experience with this particular problem. Only 26 (52%) physicians indicated a specific drug of choice for prophylaxis — cotrimoxazole (12 doctors), nitrofurantoin (10) and hexamine hippurate (four). Twenty four physicians did not consider that there should be any difference between prophylactic treatment in males and females.

Table 1. Physicians' opinions about the management of urinary tract infection (UTI).

	% of physicians answering yes ($n=50$)
Laboratory investigations	
Urinalysis before therapy	70
Urine culture before therapy	54
Urine culture after therapy	70
Optimal time from the end of therapy to reculture	
5–10 days	42
2–4 days	44
0–1 day	10
Drug of choice	
Cotrimoxazole	60
Nitrofurantoin	16
Cephalexin	10
Nalidixic acid	4
Amoxicillin	4
Norfloxacin	2
Ofloxacin	2
Doxycyline	2
Optimal duration of therapy	
7–10 days	82
>10 days	14
Single dose	2

n = number of respondents.

Recent recommendations suggest that urinalysis is not cost effective in the initial evaluation of patients with urinary tract infection,[1,2] but 70% of the physicians in this study felt that it should be performed. Over half of the physicians interviewed would perform urine culture but during the last decade, several articles have shown that urine cultures are unhelpful and unnecessary.[1-3] Follow-up cultures have been shown to be of value in the differential diagnosis of lower versus upper urinary tract infection and the appropriate timing appears to be between two and four days after completion of therapy.[4,5] In this survey more than half of the physicians stated a longer or shorter interval. Many recent clinical trials have supported the use of short courses of therapy for urinary tract infection in women, ranging from a single dose to three or four days.[1,2,6] In this survey most of the physicians proposed longer periods of antibacterial therapy. Surprisingly, almost half of the physicians interviewed indicated that their management of urinary tract infection would be essentially the same for male and female patients.

This study indicates that the actual management of urinary tract infection, as reflected by the opinion of family physicians, differs from that recommended in the literature.

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Knowledge of common inherited disorders among family planning clinic attenders

Sir,

The awareness of common inherited disorders (for example, sickle cell disease) among the population has implications for general practitioners involved in antenatal care. Haemoglobinopathies are usually detected antenatally by electrophoresis in the parents and by chorionic villus sampling or amniocentesis in the first and second trimesters of pregnancy. Increasing knowledge among the population of these conditions would allow pre-pregnancy screening tests to be carried out, and avoid the occurrence of late termination of pregnancy or missed diagnosis.

We studied the awareness of three inherited disorders among women attending the family planning clinics at the Royal Free Hospital in London. A total of 293 women were asked about their understanding of cystic fibrosis, sickle cell disease and thalassaemia and from where they obtained most of their information — school, family doctor, books, television or radio, friends, or from a sufferer.

The average age of the women was 32 years (range 17–50 years), and based on the occupation of their husband or partner, 70% were in social class 1, 2 or 3. Fifty per cent were of northern European ethnic origin and the rest were of mixed ethnic groups. Two thirds of the group had heard of cystic fibrosis and sickle cell disease but less than one quarter had heard of thalassaemia. Less than one quarter of the women who had heard of cystic fibrosis and sickle cell disease understood it could be diagnosed before birth and only 10% of those women who had heard of thalassaemia understood it could be diagnosed before birth.

Of those who had heard of one or more of these conditions, 51% had obtained their information from books, television or radio, 15% from friends, 13% from their family doctor, 11% from school, and 8% from a sufferer.

Genetic counselling does affect reproductive behaviour. This was demonstrated in a study[1] where Cypriot patients were asked when they thought people should be counselled regarding thalassaemia. Nearly all felt that counselling should be given prior to marriage, so that decisions about marriage and reproduction could be made responsibly.

Despite the benefits to be obtained from prenatal screening this study shows that many people still have a poor understanding of common inherited illnesses. Women obtain most of their information about these conditions from non-medical sources, and although this results in a high rate of awareness, their detailed knowledge of the conditions is poor. We feel that more information needs to be disseminated in general practitioners' surgeries and family planning clinics to increase patients' understanding of these conditions.

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