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Premenstrual syndrome

Sir,

Premenstrual syndrome was first described in 1931 by Frank, who ascribed the symptoms to an excess of oestrogen and treated women with oophorectomy.[1] Premenstrual mood and physical changes are present to some degree in most women secondary to the endocrine changes of the menstrual cycle especially just prior to menstruation. In 5–10% of women these changes are severe and consist of bloating and oedema (fluid retention), headaches, breast pain and swelling, change in bowel habit, mood change, irritability and depression.[2] Doubt remains about the pathophysiology of premenstrual syndrome and its relationship with biological, psychological and social phenomena.

The syndrome is most commonly reported by women in the fourth decade and is associated with greater parity, stress and lack of exercise. Management often remains empirical, including counselling about hormonal changes, diet, exercise, lifestyle and suppression of ovulation. Sympathy and understanding are crucial, together with support from husband, family, friends and general practitioner. Treatment is difficult because the symptoms are often aggravated by underlying problems such as stress or family disharmony, or may be superimposed upon preexisting psychiatric or psychological disorders.

In my practice, which has 9974 patients and 2628 women aged 18–56 years, 76 women with a current, active diagnosis of premenstrual syndrome have been identified. Their median age is 38 years (mean 37 years; range 18–56 years with a peak in the age range 32–47 years). Almost all are receiving some form of treatment, most commonly progesterones and/or pyridoxine. Ten women are receiving two drug treatments.

Taylor and colleagues reported that a neurotic subgroup of women in the childbearing age are more likely to report premenstrual changes than stable women.[3] Of the 76 women in my practice 35 (46%) have documented episodes of clinical (often recurrent) depression and of these 24 have received antidepressants, most commonly tricyclic antidepressants. Furthermore, 30% of the women have documented evidence of marital problems including four who have suffered physical abuse by their husbands.

Treatment for these women is at best empirical and often placebo. Many women presenting with symptoms of premenstrual syndrome are depressed or suffering psychosexual or marital disharmony. Such women may be more prone to this syndrome or may present with acceptable or fashionable premenstrual symptoms in an attempt to seek help for interpersonal problems. These women must be given the opportunity to discuss their underlying concerns. Only when these are identified can specific and constructive management be arranged.

ANDREW N ALLAN

Health Centre
Midland Street
Long Eaton
Nottingham NG10 1NY

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Management of chlamydial cervicitis in general practice

We read with interest the article by Owen and colleagues (July *Journal,* p.279) on the management of chlamydial cervicitis in general practice and wish to comment on some of their conclusions.

We feel that women diagnosed as infected with *Chlamydia trachomatis* should be referred to a department of genitourinary medicine wherever possible, for several reasons. First, such departments possess special expertise in contact tracing. Optimal contact tracing comprises a great deal more than merely advising the patient to inform her sexual partner(s) of the need to seek medical advice. It necessitates taking a careful sexual history, discussing with the patient how best to inform her partners and issuing contact slips for the contacts to present to the physicians whom they consult. In cases where the patient feels unable to inform her contacts directly, the health adviser may do so by telephone, letter or a home visit. Full contact tracing can seldom be achieved on a single occasion. It often requires multiple interviews with the patient to reinforce the importance of notifying sexual partners. It may be necessary to communicate with other departments and physicians in order to establish whether the contacts have attended. In departments of genitourinary medicine this process is carried out by full-time, experienced health advisers.

As the authors state, there is a regrettable paucity of hard evidence concerning the effectiveness of contact tracing for chlamydia in genitourinary medicine departments in the United Kingdom. However, it is important to realize that their paper contains no information about the effectiveness of contact tracing. A study in the United States of America has shown that field follow up by disease intervention specialists (health advisers) is much more effective in getting partners to attend than contact slip notification or patient notification.[1]

Secondly, a further benefit from referral will be comprehensive screening for coexistent sexually transmitted diseases. Although quite extensive microbiological tests were carried out in this study (not all of which are available to all general practitioners), there were deficiencies, for example in not testing for gonorrhoea at sites other than the cervix (urethra, rectum, pharynx), in not performing serological tests for syphilis and in not offering human immunodeficiency virus (HIV) antibody testing.

Thirdly, antigen detection tests for chlamydia do produce false positive results. The authors quote a paper by Stamm[2] as stating that the MicroTrak (Syra) test has a specificity of 97%. However, the same paper gives the positive predictive value of this test as only 79% in an intermediate prevalence population (the difference arises because the positive predictive value of a test is affected not only by the specificity of the test but also by the prevalence of the condition in the population studied). This means that around one in five of the women with a positive result will be incorrectly diagnosed as having a sexually transmitted disease. The distress this may cause can be readily appreciated and may be avoided by referral to a department of genitourinary medicine with access to tissue culture for chlamydia by way of confirmation.

It should also be noted that no conclusions can be drawn from this study as to the comparative effectivenes of managing cervical chlamydial infection in general practice as against a department of genitourinary medicine, since no comparison was made. The authors quote results of previous studies which showed similar re-isolation rates for chlamydia after treatment. However, they might also have referred to other studies conducted in genitourinary medicine departments which had substantially lower re-isolation rates of between 0% and 3%.[3-5]

Physicians concerned about preventing the long-term sequelae of chlamydial infection in women (infertility, ectopic pregnancy, chronic pelvic pain) must welcome any expansion of screening into areas such as family planning clinics, termination clinics, well woman clinics and general practice. If chlamydial infection is diagnosed in these settings, however, we believe that referral to a department of genitourinary medicine should take place wherever possible. We recognize that a proportion of women will not accept referral, but control of chlamydial infection is more likely to be achieved by such a collaborative approach.

DAVID WHITE
KEITH RADCLIFFE

Department of Genitourinary Medicine
The General Hospital
Birmingham B4 6NH

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Asthma care in general practice

Sir,
I read with interest the editorial by Kevin Jones (June *Journal,* p.224) on the British Thoracic Society's guidelines for the management of asthma in adults. I am concerned that it seems to have been written before the corrections were published.[1] I think Kevin Jones erred in suggesting that the role of oral theophylline be relegated to adjunctive therapy.

Much has been made of the relative merits of the various bronchodilator agents and the innumerable patentable devices in which they are presented. Discussion with colleagues confirms that there is widespread concern that recently the style of drug promotion has tended towards the needs of marketing rather than to the established practice of advertising sound information. The *Public eye* television programme (BBC 1991) found that prescribers had mistaken promotional material regarding salmeterol to mean that problematic evidence of a different anti-inflammatory action made it an important new advance. In fact the report concerned had concluded with the comment that further work would be required to determine whether any such effect existed.[2]

Drugs long out of patent, such as theophylline and ipratropium, suffer from a sort of negative promotion in these circumstances. There is plenty of statistically validated evidence that theophylline is effective in chronic as well as acute asthma,[3] and the British Thoracic Society guidelines give recommendations of the quantities of the drug which are likely to prove safe and effective when given daily as two doses of a slow release oral preparation.

The problem is that asthma care does not seem to be improving. For 20 years or more this has been blamed on the general level of ignorance in the profession. The guidelines are a further effort to reduce this. But they make no difference, because young asthmatics still die in the hands of the most experienced experts. We need to use every treatment available, singly or in combination as needs dictate, and give up our pursuit of the simplistic idea that one drug should be enough. It is clear that the worse the asthma, the more general practitioners have to prescribe combinations of treatments.[4] At least we have stopped advising our patients to go away and live in a warmer climate, or in the mountains, as our predecessors did for patients with intractable respiratory problems.

GEORGE J ADDIS

49 Whittingehame Court
Glasgow G12 0BQ

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Curettage and cautery of skin conditions in general practice

Sir,
Dr Sundle's letter on curettage and cautery (August *Journal,* p.345), in response to my letter on the treatment of skin cancer in general practice (May *Journal,* p.213), was most useful.

Curettage and cautery are simple and inexpensive to undertake. While I agree with Dr Sundle that the procedure is very useful for the treatment of some benign and some potentially malignant skin lesions, it should be used selectively for the treatment of basal cell carcinoma. Dr Sundle alluded to this but perhaps further clarification would be helpful.

Curettage biopsy is useful if one wants to differentiate between an area of solar keratosis and a superficial basal cell carcinoma, or for confirming an area of Bowen's disease. The subsequent cautery is usually curative in treating all of these lesions. Experience and research have shown that the technique can also be used effectively for the treatment of well-defined basal cell carcinomas of up to 13 mm in diameter.[1] The curettage and cautery must be thorough and repeated at least once. The Volkmann spoon must have a good cutting edge — this is not always the case in my experience of hospital outpatient clinics. Satisfactory histopathology allows precise knowledge of the cell type, and one can decide whether the original curettage and cautery have been adequate, or whether further treatment, possibly using a different method, is required.

Curettage and cautery are not suitable methods for the treatment of invasive, morphoeic, sclerosing, ill-defined or larger basal cell carcinomas. When treating non-melanoma skin cancers, the best cure rates are achieved by ensuring a minimum tumour-free margin of 4 mm when employing excisional surgery[2] and a 5 mm tumour-free freeze margin when using liquid nitrogen cryosurgery.[3] It would be very interesting to know the recurrence rates in Dr Sundle's series when using curettage and cautery for the treatment of basal cell carcinoma.

Squamous cell carcinoma, which is potentially a much more invasive skin cancer, should not be treated with curettage and cautery by the inexperienced practitioner. The procedure may be useful in obtaining biopsy material in an unconfirmed squamous cell cancer, but only with a view to either complete excision or thorough cryosurgery. However, most histopathologists, in my experience, would prefer an incisional, full-thickness edge biopsy.

In summary, one has to be selective when treating non-melanoma skin cancers by curettage and cautery. While the procedure is simple and convenient to carry out in general practice, I feel that it should be regarded as complementary to surgical excision and cryosurgery if the patient is to receive the most effective treatment.

ARTHUR D JACKSON

Holmes Chapel Health Centre
London Road, Holmes Chapel
Cheshire CW4 7BB