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.

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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 ipratroprium, 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.

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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.

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Doctors and pharmacists — working together

Sir,

I wish to concur with the suggestion of Beswick and Elliot (letters, June *Journal,* p.259) that the drug information needs of general practitioners may be fulfilled by liaison with local community pharmacists, supported by drug information services. Indeed, this arrangement may be the only feasible solution to the probable escalation in drug information needs that may come about through the indicative prescribing scheme and its sequelae. It seems unlikely that there will be enough drug information pharmacists or clinical pharmacists when all practices are devising and updating their own formularies. General practitioners and community pharmacists could be brought together under the auspices of the family health services authority, with whom both are already in contract. The liaison could and should be led by medical and/or pharmaceutical advisers.

There are large gains beyond simple information sharing, for both participants. For community pharmacists it would bring them into a working relationship with local general practitioners which would be one of cooperation rather than antagonism. For general practitioners, the local community pharmacist may be seen as a relevant and useful information source, for example, in knowing which drug packaging is most suitable for elderly people. Such a new liaison would allow general practitioners to exploit the largely untapped resource that is the knowledge base of pharmacists.

This has already been proposed in one district known to me and is, hopefully, to be progressed through the local pharmaceutical and local medical committees, with the backing of the family health services authority and medical adviser. This may well be a model worthy of application more widely.

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What patients think of the way their doctor dresses

Sir,

I was very interested to read the paper on what patients think of the way their doctor dresses (July *Journal,* p.275). Unfortunately this study is flawed in several ways.

Some classic research from Oxford[1] showed that videos of 'still' subjects with and without spectacles were given different IQ ratings. When an interview of the same subjects was shown the IQ difference disappeared. I would contend that the comparison of still photographs, as used in McKinstry and Wang's study does not provide an adequate basis for assessment.

There are also problems with the images presented. For example photographs F, G and H of the woman doctor are different in more ways than simply her style of dress. The background in the three photographs varies slightly, with a stethoscope visible in photographs F and G, but not in photograph H. Advertisers use such subtle differences all the time.

This study has aroused a lot of interest in the medical and popular press and may have undue influence on the way in which doctors present themselves to their patients. I hope that it will prove possible to extend this study, perhaps to videotaped standard consultations in which the only variable is what the doctor wears. This should provide some interesting results.

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Reference

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General practitioners and work in the third world

Sir,

I was interested to read the letter on British doctors serving in developing countries (July *Journal,* p.304) and entirely agree with the points made by Dr Morris on the need to encourage and fund doctors from the United Kingdom to serve overseas.

In the 1980s when working in India, I discussed with the Joint Committee on Postgraduate Training in General Practice the idea of posts in developing countries being accredited as equivalent experience for vocational training. I would encourage others to follow up this idea. The Royal College of General Practitioners or the Overseas Development Administration could be encouraged to pay a grant to those successfully applying for such posts, each of which would need to be visited and accredited for suitability.

With regard to the need for umbrella organizations to facilitate overseas medical experience, readers might like to know that several such organizations are actively involved in the placement and care of doctors working abroad. The Bureau for Overseas Medical Service maintains a database of overseas posts, and runs excellent introductory courses for those planning to work overseas. The Medical Missionary Association publishes a regular list of urgent staffing needs in christian hospitals and health programmes overseas. Finally, InterHealth is a relatively new organization which offers a specialist screening, clinical, advisory and immunization service for those serving overseas and currently acts as medical adviser to many christian missions. It includes on its staff several physicians and psychiatrists with first hand overseas experience. I would gladly supply more information to anyone interested.

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Useful addresses

Bureau for Overseas Medical Service, Africa Centre, 38 King Street, London WC2E 8JY.
Medical Missionary Association, 224 Camden Road, London NW1 9HE.

Stroke and the carer

Sir,

I read with interest the recent editorial on stroke and the carer, by Cassidy and Gray (July, *Journal,* p.267) and agree wholeheartedly with the authors' plea for support for carers and adequate provision of information and counselling.

In my local area, concern was expressed by carers about the lack of user-friendly information, and to help remedy this, Forth Valley health board have produced a video entitled *Stroke: caring for someone at home.* As part of the pre-production planning, a number of carers were interviewed and they all emphasized their need for information on a continuing basis. Interestingly, the majority expected this to come from their family doctor.

It is clearly unrealistic to expect all general practitioners to be up to date with every available source of practical, social and emotional help for carers. I wonder whether it may be possible to encourage increased liaison between general practi-