

telephone number; the optician to whom the patient is referred and the reason for referral; the patient's relevant past medical history including hospital reference number (if known); and family/social history. The second side gives the patient's drug therapy and allergies; clinical history and findings, including blood pressure and urinalysis results; and the opinion required including boxes to tick when intra-ocular pressure or fundal photography are required. These details are signed and dated by the referring general practitioner. The third side is headed clinical notes and together with side four is left free for extra information, clinical notes and follow up as required.

Why should we not communicate with and utilize the skills of our ophthalmic colleagues more readily? Few general practitioners have immediate access to slit lamp examination for acute anterior eye conditions. Would it not be more appropriate to build up a better working relationship with our optometrist colleagues for urgent eye opinions than burden our local casualty department where examination may be carried out by a doctor with fairly limited skills in ophthalmology?

Harrison and colleagues have shown that properly equipped ophthalmic opticians are better able to diagnose accurately and refer patients with glaucoma than general practitioners.<sup>1</sup> Ocular hypertension is therefore best managed by the ophthalmic optician and, when appropriate, hospital referral arranged in conjunction with the general practitioner. Accurate and cost effective screening and follow up of the families of patients with glaucoma could also be organized by the optometrist.

Patients with more chronic visual problems, such as hypertensive or diabetic patients, could readily be referred, using the ophthalmic referral card to an optometrist. Harrison and colleagues have also shown that ophthalmic opticians have greater skills than general practitioners in the early detection of diabetic retinopathy.<sup>1</sup> It would, therefore, seem reasonable to refer diabetic patients to them for initial screening. Follow up, at mutually agreed intervals, could then be arranged in conjunction with the practice diabetic and hypertension clinics and any hospital ophthalmic referral be made by the optometrist and general practitioner in consultation.

Concern has been expressed that the restrictions on the availability of free sight tests deter people from using optometrists.<sup>2</sup> There are, however, important exemptions to those required to pay for sight tests. These include low income groups,

all diabetic patients, patients with glaucoma and anyone over 40 years of age with a family history of glaucoma in a parent, brother or sister — the main groups for which general practitioner-optometrist cooperation would be most beneficial.

The advantages of better communication and cooperation between general practitioners and optometrists would be: a better standard of ophthalmic care by both general practitioner and ophthalmic optician; a reduction in unnecessary hospital referrals; a shortening of waiting times for outpatient appointments; and savings to the National Health Service.

The optometrist working from our health centre has expressed support for the idea of inviting our local ophthalmologists to undertake occasional clinics in the ophthalmic suite. Such a development would allow a three way referral service for ophthalmological problems between general practitioner, optometrist and consultant ophthalmologists. This would be a helpful, cost effective service and the ophthalmic referral card could become a useful, efficient means of communication between all concerned.

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### Fatal cryptosporidiosis in association with Sheehan's syndrome

Sir,

Cryptosporidiosis is a common cause of acute gastroenteritis in immunocompetent individuals, particularly in children, and of chronic, persistent, severe diarrhoea in the immunocompromised.<sup>1-3</sup> Healthy young adults may acquire infection by family contact with children and the disease in this age group may be severe.<sup>2,3</sup> We report a fatal case of cryptosporidiosis in a 33 year old woman who had received thyroxine and hydrocortisone replacement therapy for Sheehan's syndrome for the previous six years.

The five month old son of the woman was admitted to hospital with a two week

history of diarrhoea; cryptosporidium oocysts were detected in the faeces and no other pathogens were present. The mother then became unwell with vomiting and diarrhoea and her partner was given general advice for gastroenteritis by a locum general practitioner. Four days later she died, following a sudden and rapid deterioration in her condition.

Post-mortem examination suggested dehydration and confirmed the features of Sheehan's syndrome, with a pituitary gland largely replaced by fibrous scar tissue. The adrenal and thyroid glands also showed severe atrophy. Cryptosporidium oocysts were detected in the faeces but no other enteric pathogens were present. A post-mortem blood sample showed an elevated urea level (10.8 mmol l<sup>-1</sup>) (suggesting dehydration) and a normal cortisol level of 301 nmol l<sup>-1</sup> which indicates that there had been no response to the stress caused by the severe infection.<sup>4</sup> Death was attributed to circulatory failure and no other natural disease was found.

Severe metabolic disturbance and death has been attributed to cryptosporidiosis in a small number of immunocompetent adults.<sup>3</sup> In this case, intramuscular hydrocortisone administered for the duration of the acute, gastrointestinal illness may have prevented the fatal outcome.<sup>4</sup>

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### Preventive care of elderly people

Sir,

In his editorial (September *Journal*, p.354) Dr Tulloch states that there is 'clear cut evidence from controlled trials that screening and functional assessment reduce institutional care significantly among elderly people'. This view is supported by four references, one of which is in Norwegian. The study by Hendriksen and colleagues<sup>1</sup> was conducted in

Denmark and required three-monthly assessment over a period of three years. The research reported by Rubenstein and colleagues<sup>2</sup> was conducted in an American hospital and involved specialist physicians and a multidisciplinary team working in what would be equivalent to a geriatric assessment unit in a British hospital. Both studies undoubtedly produced clear cut results, but cannot be generalized to the primary care situation in the United Kingdom as a justification for routine screening. Tulloch's own controlled trial was conducted in his Oxfordshire practice and did demonstrate less time spent in hospital in the study group.<sup>3</sup> However, in discussing these results the authors suggested that 'generalizations drawn from these findings must be made with great care as the practice involved is atypical in a number of respects'.

I have always believed that to improve the preventive and anticipatory care of elderly people it is necessary to find methods which are acceptable and feasible for all practices and not just those with a special interest in the care of elderly people. I also believe that it is important that general practitioners do not underestimate the anticipatory and proactive element of the existing routine care provided by general practice. I would prefer to build on this traditional role and am concerned about what may be lost through the fragmentation of care through a growing range of screening, special disease and health promotion clinics. I remain to be convinced that the new contract requirements will prove efficient and effective.<sup>4</sup> Moreover, it is disappointing that the mandatory and rigid requirements of the new contract appear to have inhibited and stalled the many exciting research projects of the 1980s exploring cost effective screening methods by removing justification for them.

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Sir,  
Dr Tulloch's editorial (September *Journal*, p.354) suggests that the Barthel index is the most commonly used instrument for measuring disability in the elderly. I cannot believe that I am alone in never having heard of this index. A straw poll of colleagues and consultant geriatricians, revealed no one who knew what this index was.

It is a pity that the author could not provide a reference for the source of this index, as I suspect that this omission will generate a considerable amount of work for medical librarians up and down the country.

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### Does nose blowing improve hearing in serous otitis?

Sir,

The paper on the effect of nose blowing on hearing in serous otitis is a fascinating piece of work (September *Journal*, p.377). I would like to suggest another factor which should perhaps be investigated — the venturi effect. This is the suction effect produced by passing a current of air transversely over the top of a tube. In flying, it is the basis of the air speed indicator. When I was a medical student, I was taught that whereas blowing the nose increased the pressure in the nose, pushing mucus back up into the sinuses, closing the eustachian tubes, sniffing by the venturi effect emptied the sinuses, opened the eustachian tubes and drew the mucus down from the back of the nose into the throat, from where it would be disposed of by swallowing. As my teacher pointed out, one inhales steam with menthol and eucalyptus and there is little point in blowing it out.

Since then I have advised adults with sinus problems and catarrhal children to sniff instead of blowing. This suggestion is initially greeted with surprise but later by grateful thanks. As I do not work in an ear, nose and throat department, I have never had a large enough series of patients to analyse, but I feel that this experience and theory could well be incorporated in the further work which Dr Heaf and colleagues are obviously going to carry out.

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### Randomized controlled trials

Sir,

I was surprised to read in the *Journal* the editorial on the price to be paid for randomized controlled trials (September *Journal*, p.355). Dr Charlton, an anatomist, suggested that the gain in objectivity achieved by randomized controlled trials makes management tend towards the routine application of simple algorithms, with depersonalization of the patient. This is often true of hospital practice and undergraduate teaching, but not of modern general practice where emphasis is placed on the individuality of the patient. The motto of the Royal College of General Practitioners is *scientia cum caritas*, which dispels the image of a practitioner of reductionist science. It is far from the truth to suggest that when patients tell the doctor their story it is ignored in favour of the findings of group trials. Exactly the reverse is the case as we endeavour to share the experience of the individual. On the other hand, we are greatly indebted to randomized controlled trials without which we should not place reliance on the *British national formulary* and other texts.

Dr Charlton writes of our oldest and greatest allies — natural remission and the placebo effect. In my view, these are the patient's, not the doctor's allies. Nor would I agree that alternative practices such as acupuncture and homoeopathy tend to use individualist factors far more effectively than does general practice.

We are on the verge of huge advances in medical science and must avoid falling back into medieval empiricism. I should like Dr Charlton to see how we train and relearn the importance of the unique personal charisma.

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### Rating scales for the assessment of vocational trainees

Sir,

The paper by Difford and Hughes is a useful contribution to the debate on trainee assessment (September *Journal*, p.360). However, their conclusion that 'the most useful way to achieve systematic assessment of vocational trainees is by the use of the 23 [Manchester] rating scales' does not appear to be supported by the evidence produced.

As the authors point out the main criteria for judging any assessment pro-