cess are its validity, reliability and feasibility. The Manchester rating scales have serious drawbacks in all three areas. The paper quite rightly points out that the scales do have face validity and discusses the difficulty of determining predictive validity. However, it is striking that at four months into the trainee year 89 out of 134 trainees were rated by their trainers as being better than the average general practitioner. Few of us would accept that this number of trainees could be better at general practice than the average general practitioner. What then was the rating scale actually measuring?

As far as reliability is concerned the authors acknowledge that the trainer is the only person with enough information to carry out the assessment. If reliability means the ability to generate consistent scores on different occasions and with different assessors then it is clear that the Manchester ratings are not reliable in this sense. If the examiners were intensively calibrated, this problem would be diminished but some of the evidence presented to indicate that trainers were using the scales consistently, such as the variation in the number of points used by trainers, might well indicate that some people mark near the centre of any scale while others mark at the extremes, as is commonly observed. A simple way of elucidating this would be to look at trainer marking to see if the range varies with successive trainees.

From the point of view of feasibility it is pointed out that in the second year 38% of trainers carried out the assessment programme. In many regions trainee assessment now figures strongly in the criteria for reselection of training practices. In the light of this a response rate of 38% to a 'voluntary' assessment programme does not seem particularly high. In the west of Scotland region the response rate for our programme of multiple choice papers and objective structured clinical examinations is more than 80%. It must also be borne in mind that, as the authors acknowledge, the Manchester rating scale is an indirect assessment based on other assessment methods. The true measure of the feasibility of the rating scales is the feasibility of the methods used to obtain the necessary information.

An area that was not touched on was the perceived value of the rating scales by the trainers and trainees. In a survey of trainees in the west of Scotland[1] the Manchester rating was the only one of five assessment methods not rated to be useful by those trainees who had used it. An alternative approach to trainee assessment, which has now been established in this region, is the use of a balanced package of assessment tools which are then looked at as a group rather than combined into a set of rating scales.

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Reference

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Erythrocyte sedimentation rate and plasma viscosity

Sir,

The study by Dinant and colleagues of the discriminating ability of the erythrocyte sedimentation rate (September *Journal*, p.365) concludes that the test still deserves a place in the general practitioner's daily routine. Nevertheless, they acknowledge that problems with the test have led to alternatives being recommended. One of these is the plasma viscosity estimation[1] and since this test is provided by the local pathology laboratory I decided to assess its usefulness.

A plasma viscosity of 1.72 centipoise is generally taken as the upper limit of normality.[1] In the two year period August 1989 to July 1991 I ordered 140 plasma viscosity estimations as part of my normal work, usually as a screen for occult pathology; 42 (30%) were at levels of 1.73 centipoise and above. On follow up for at least three months (and often for at least a year) four patients have been found to have malignant or chronic inflammatory disease (one of these patients had a plasma viscosity less than 1.72 centipoise). However, in none of these four patients was the plasma viscosity helpful in making the diagnosis, and in several patients with elevated results unnecessary follow up and investigation was arranged.

A comparison of the use of plasma viscosity and the results of Dinant and colleagues for the erythrocyte sedimentation rate reveals: sensitivity 75% and 53%, respectively; specificity 71% and 94%; positive predictive value 7% and 48%; negative predictive value 99% and 91%. Thus these two tests are not greatly different in their value to general practitioners. They frequently produce false positives and cannot be relied upon to be positive even in cases of temporal arteritis,[2] one of the classic conditions they are supposed to identify.

Once again we return to careful history taking, judicious examination and selective investigation as the foundation of accurate diagnosis in our patients. Experienced doctors will also use a 'wait and see' approach to distinguish those patients with a high probability of disease from those with a low probability. A useful general screening test for occult pathology in general practice may remain an illusion.

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Asthma care

Sir,

Dr Struthers (letters, September *Journal*, p.387) displayed a lack of understanding of the nature and management of asthma in his criticism of the papers on this subject (June *Journal*, p.224, 227, 232). Instead of criticizing those doctors who have helped pioneer improved community based asthma management as well as research, he should focus on the employers who fail to recognize that asthmatic people can lead a normal life given proper management.

Dr Struthers refers to overdiagnosis and overtreatment of asthma; I know of no evidence to support this statement. In fact there are good reasons for using the diagnostic label 'asthma'. First, it results in appropriate therapy with reduced morbidity for the patient.[1,2] Secondly, it is now accepted that children do not 'outgrow' their asthma,[3-6] and it is now regarded by many experts as a chronic incurable disease, subject to remissions of variable duration. Finally, by recognizing the chronic nature of asthma, with the responsibility of ensuring long-term follow up and the provision of emergency medication, health professionals may help reduce the unacceptably high mortality and morbidity from this disease.

If doctors do not take asthma seriously, how can patients be expected to act appropriately when symptoms arise? Retrospective studies on asthma deaths have shown that patients, their families as well as their doctors underestimate the symptoms and severity of attacks.[7,8]

How can Dr Struthers justify his com-

ment that doctors use 'flimsy indications' for prescribing inhalers, when a consensus meeting of experts[9] agreed that all but patients with the mildest asthma should receive anti-inflammatory treatment, that is sodium cromoglycate, nedocromil, or inhaled topical steroids? The agreed indication for prescribing one of these drugs was when the patient needed to use a relief bronchodilator every day. Most experts have difficulty in deciding the long-term duration of therapy and yet Dr Struthers writes about allowing medication to continue long after it was needed.

Finally, I would suggest that doctors who are advisers to various employment agencies should become better informed. They could then put their efforts into advising their employers to revise their guidelines. Well treated asthma should not impede anyone's career opportunities, as evidenced by the many famous athletes who represent their countries despite the need for asthma medication.

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Sir,

The letter by Dr Struthers (September *Journal*, p.387) seems to reinforce the attitude that if a bad practice is in place one should follow its rules rather than seek to change them.

In the light of our present knowledge of the physiology and management of asthma, surely it should be the responsibility of medical advisers to let the armed services know that asthma need in no way be a handicap to any potential candidate. Presumably had Dr Struthers examined Mark Spitz he would have advised him that he should not swim for the American olympic team. There are many examples of fine achievements both in athletics and in other fields by people who are asthmatic and effectively managed. Perhaps the National Asthma Campaign could extend its education process to include those in authority in the armed services.

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Shortbread wrist

Sir,

A middle-aged Scottish expatriate housewife consulted her American family physician for severe, acute bilateral wrist pain exacerbated by movement of the thumbs. The pain was worse on the right and had been present for four days. No history of acute injury was elicited. Both history and physical examination were classical for de Quervain's syndrome and the condition responded rapidly to rest and non-steroidal anti-inflammatory medications.

The physician was puzzled as to the aetiology of the condition and questioned the patient more closely at the follow-up visit. The only unusual activity reported prior to symptoms was an increase in baking. The patient usually baked weekly for her family, but following a function for which she had prepared shortbread, she received many requests for the recipe from her American friends and neighbours. None had succeeded in successfully preparing the shortbread, causing the patient to bake multiple batches of shortbread as gifts. There appeared to be a causative relationship between the increase in shortbread production and development of symptoms. Further, preparation of a 'test batch' for consumption by the investigating physician, reproduced the symptoms in a milder form.

Scottish shortbread is an unusual baking product as it contains no liquid ingredients. In the classical form, the three ingredients, flour, sugar and butter are combined as a result of vigorous kneading. The hypothesis that human sweat acts as a binding agent is unlikely due to the prevailing ambient temperature of Scottish kitchens at the times of year of maximum shortbread production. It has been suggested that a genetic predisposition is necessary to obtain the correct technique for successful binding of ingredients. The inability of others to reproduce the shortbread in this case lends credence to this belief but this issue is highly controversial, particularly in British literature. An additional controversy exists over the ability of mechanical devices such as mixers or food processors to reproduce the characteristics of classical shortbread.

This patient had lived in the United States of America for five years and did not bake shortbread regularly. Expert consultation suggests that her technique had become faulty, resulting in excessive wrist action with the thumb extended. There is, however, a lack of consensus on the optimal technique and marked regional differences in kneading practice. The patient plans to review technique at her next visit to a centre of excellence of shortbread production.

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Headaches caused by exhaust fumes

Sir,

I have recently come across a cause of headaches that I had not previously entered in the differential diagnosis.

A 21 year old woman came to see me complaining of headaches. She found that they were not as bad at the weekend as during the week and that they tended to be worst in the first part of the morning and later in the afternoon. I found nothing significant on examination and I simply arranged to see her again in 10 days. On her return she indicated that she had taken her car in for servicing and that the exhaust pipe had been found to have several holes. The exhaust pipe had been replaced and since then her headaches had disappeared. It would seem that the headaches related to the exhaust fumes circulating through the car.

I shall try and remember to enquire about the state of my patients' car exhausts if they complain of headaches. It would obviously be more pertinent in situations where there was a definite time relationship between the headaches and travelling to and from work by car.

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