medication and cough preparations. It can also be useful to look at changes that occur over time in the management of such common primary care conditions.

In the mid-1970s Stott carried out a study of the management of childhood upper respiratory tract infection, under which label he included coryza, cough, tonsillitis, pharyngitis and non-specific upper respiratory tract infection.[1] At the same practice, the notes were studied of children aged nine years or less presenting with the same diagnoses just over a decade later (1986–88) and the management of upper respiratory tract infection compared (Table 1).

Table 1. Comparison of the management of upper respiratory tract infections in children in one practice in mid-1970 and mid-1980.

Treatment and outcome	% of children: Mid-1970 study (*n* = 471)	Mid-1980 study (*n* = 277)
Advice only	*30.4*	*44.4*
Antipyretics:		
Paracetamol	*26.1*	*24.2*
Aspirin	*5.7*	*0*
Cough preparation	*30.6*[a]	*8.0*[b]
Antibiotics	*38.6*	*31.8*
Bronchodilators	*0.8*	*2.5*
Complications	*5.9*	*8.3*
Repeat consultation for same episode	*24.2*	*26.7*

n = number of children. [a] 20 different preparations. [b] Three different preparations.

While there have been several major changes over a decade in how one practice manages upper respiratory tract infections in children, there has been little change in the outcome measures — complications and return rates. Of particular note is the rise from 30% to 44% of patients leaving the consultation without a prescription. The dramatic decline in both the percentage of patients receiving a cough preparation and in the number of different cough preparations used by the practice can be attributed to the introduction of the limited list in the mid-1980s. There has been only a slight decline in the proportion of patients receiving antibiotic medication. With the recent higher profile given to asthma, together with continuing uncertainty over establishing the diagnosis, particularly in young children, it will be interesting to see if the use of bronchodilators in the management of upper respiratory tract infections continues to rise. The complete cessation of the prescribing of aspirin to children with upper respiratory tract infections is a result of the warnings of the association between Reye's syndrome and the use of aspirin in childhood infectious episodes.

Such comparisons over time provide important insights into how and why changes occur in the management of common primary care conditions.

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Clinic for prevention of osteoporosis

Sir,

A clinic for the prevention of osteoporosis was established in a group practice in January 1988 and an assessment was made of its first year.[1] During the year, 582 women, approximately half of the practice cohort of women patients aged 40–60 years, had been invited and 252 (43.3%) attended the clinic.

Since then, the remainder of the cohort (682 women) plus 112 new women patients were contacted by post and invited to attend the clinic; 429 women attended. The total acceptance rate for the 1322 women was 51.5% (681 women).

A questionnaire was sent to the first group of 582 women one year after the first invitation and a similar questionnaire was sent to the remaining group of 628 women and the 112 new patients 18 months after their initial invitation. Responses were received from 1014 women (76.7%). Characteristics of attenders and non-attenders are shown in Table 1.

Table 1. Characteristics of attenders and non-attenders of the osteoporosis clinic.

Characteristic	Attenders (*n* = 564)	Non-attenders (*n* = 450)
Mean age (yrs) (range)	54.9 (41–64)	55.0 (41–64)
% smokers	*13.7*	*21.6*
% of HRT users	*26.6*	*10.9*
% in social class		
1	*33.7*	*22.4*
2	*36.5*	*31.8*
3	*21.4*	*30.2*
4	*4.8*	*8.9*
5	*2.3*	*4.9*
Unclassified	*1.2*	*1.8*

n = number of women in group. HRT = hormone replacement therapy.

Clinic attenders tended to be in higher social classes and to be non-smokers. Women of lower social class and women who smoke are therefore less likely to attend a preventive clinic for osteoporosis.

This clinic represents one model of the available strategies for the prevention of osteoporosis which have been discussed recently.[2] The practice also holds a hormone replacement therapy screening and supervision clinic where those patients who are considering hormone replacement therapy can see the doctor and nurse and obtain screening and information. Both the osteoporosis clinic and the hormone replacement therapy clinic have been approved by the family health services authority for funding as preventive clinics. They offer comprehensive advice, screening and supervision to women in an attempt to prevent both osteoporosis and cardiovascular disease.

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GPs' diagnosis and management of the discharging ear

Sir,

In order to assess general practitioners' diagnosis and management of the discharging ear we sent a postal questionnaire to 150 local general practitioners. The survey listed a number of features of history and examination which might occur in otitis media or otitis externa. General practitioners were asked to list those points they thought were important for making the diagnosis for otitis media or externa.

A total of 114 doctors (76%) responded. Appropriate treatment was described for otitis media (antibiotics and aural toilet) by all 114 respondents (100%) and for otitis externa (aural toilet, antibiotics and steroid ear drops) by 104 (91%). Ninety two per cent of responding general practitioners selected the same five factors as important in making the diagnosis of otitis media and yet there was no such consistency or certainty for diagnosing otitis externa. Only 32% of respondents