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

felt that visualization of the tympanic membrane was important for diagnosing otitis externa.

This survey demonstrates that although there is widespread knowledge that aural toilet, antibiotics and steroid ear drops are appropriate treatment for otitis externa, there are a number of general practitioners who appear to have difficulty in making this diagnosis. The pattern of our clinic referrals leads us to believe that this is because aural toilet is not being performed by general practitioners and thus the diagnosis cannot be made. Is this because the facilities in general practice are inadequate or should ear, nose and throat departments be doing more to teach the technique of aural toilet? Is it a suitable procedure for general practice?

In addition, eight respondents would treat patients with otitis externa with antibiotics alone. Antibiotics and steroid ear drops are appropriate treatment for both otitis externa and chronic otitis media.[1] We would suggest that if the diagnosis is in doubt a short course of ear drops should be prescribed to accompany the antibiotics; this has few, if any, risks and much potential gain.

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Trainees' knowledge of AIDS and HIV

Sir,

I read with interest, and concern, about general practitioner trainees' lack of knowledge about the acquired immune deficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) (October *Journal*, p.401). I agree that there should be improved teaching about HIV infection for trainees: they should be aware of the problem, not only for their patients but also for their self-protection.

The problem of managing needlestick injuries in general practice is discussed in a letter from Lockie and colleagues in the same issue (October *Journal*, p.431). The suggestions in this letter are a succinct summary of the recommendations in the official guidelines.[1,2] I would add that the general practitioner could also contact the local National Health Service occupational health department, as NHS occupational physicians are involved with needlestick injuries and occupationally acquired HIV infection. They should be able to give the best current advice, or know the 'local expert'. There has been a suggestion that zidovudine should be given within an hour of exposure to HIV infected blood as prophylaxis,[3] but there has been debate about this approach.[4,5]

There is likely to be a local or regional policy agreed between NHS occupational physicians, virologists and consultants in communicable diseases: it would be advisable for the general practitioner managing the needlestick injuries to be aware of this policy.

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Vocational training

Sir,

The paper by Dr Styles on the training experience of doctors certificated for general practice in 1985–90 (December *Journal*, p.488), raises doubts about the relevance of vocational training. At a time when the thrust of government policy is to care for mentally ill patients and elderly patients with long term illnesses at home rather than in hospital, it is surprising that less than half of trained doctors submitted any post-registration experience in care of the elderly or in psychiatry in 1990 (41.7% and 40.7% respectively). It is not clear whether in the general practice trainee year any remedial tuition is provided to cover these deficiencies.

We should not perhaps be surprised, therefore, that the government found it necessary to impose a new contract on general practitioners in which elements of care of the elderly are spelt out.[1] Social services departments rely on general practitioners to assess the social, physical and mental well being of patients.[2] However, there may be doubt whether many recently trained general practitioners can fulfil that function efficiently. It appears that much vocational training may not be relevant to the needs of growing sections of the population.

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Confiding relationships in elderly people

Sir,

We were interested to read Dr Walsh's letter (February *Journal*, p.80), but feel that he has missed the point of our paper (November *Journal*, p.459). General practitioners assessing the whole population of elderly people need to know if lack of confiding relationships is a strong predisposing factor for depression, as it appears to be in younger people. Our study, carried out by two nurses and one trained lay interviewer, replicates the screening approach that some primary care teams are now applying to the assessment of elderly people. The questions asked were not as comprehensive as those that might be asked in full psychiatric or psychotherapeutic assessment, but that is the nature of screening. The questions on depression were derived from the comprehensive assessment and referral evaluation (CARE) interview schedule, which has been well validated against diagnoses made by experienced psychiatrists,[1] and probably represents a more thorough assessment than most general practitioners achieve in routine history taking.

Screening and casework should not be confused. Our study did not imply that lack of confiding relationships should not be enquired about during individual consultations, nor that it was not implicated in the causation of depression in some cases. Our results suggest, however, that enquiring about confiding relationships does not merit inclusion as a routine question when screening elderly people. The value of psychotherapeutic approaches in some older people with psychological problems is well documented[2] but we should avoid generalizing from this experience to whole populations.

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