Envenomation by the lesser weever fish

Sir,

Every summer, British bathers are stung on their feet by the venomous fish, the lesser weever (*Echiicthys vipera*) which lives on the sea bed. The fish injects a holocrine venom into the bather when it is trodden on. The effects of this envenomation have been overstated in the literature.[1] An account of a fisherman who amputated his finger to relieve the pain of envenomation by the greater weever fish (*Trachinus draco*) dates from 1782,[2] before opiates, paracetamol and salicylates were available. There have been three reports of death following envenomation by the greater weever fish but these all occurred before antibiotics had been discovered and were more consistent with secondary sepsis than a venom effect.[3-5] The greater weever fish differs from the lesser weever fish in that it is a larger fish which lives in deeper water; it will sting fishermen who unwittingly handle it in their nets.[6]

While studies document the morbidity consequent on greater weever envenomation,[7,8] and note that a typical victim will take a week to recover, no such study exists for envenomation by the lesser weever fish. We sought to establish the morbidity arising from envenomation by the lesser weever fish on beaches in Caswell Bay in Wales; Tintagel, Cornwall; Gunwalloe, Cornwall; and Christchurch, Dorset between 1 April and 28 August 1990. Consecutive bathers presenting to the lifeguard with an acutely painful limb, consistent with envenomation while bathing, were included in the study. Records were completed for 24 cases. The cases were treated by immersion of the stung limb in water as warm as could be tolerated for five to 20 minutes (mean 10.3 minutes). The mean interval between envenomation and leaving the lifeguard's care was 29.9 minutes (standard deviation 18.3 minutes). Twenty three of the 24 cases (96%) were recorded as having less pain after treatment than before.

A follow-up questionnaire was sent to these 24 patients and to a further 23 patients who were not entered into the first part of the study, because they were stung and given hot water treatment on a non-study beach. Thirty nine questionnaires were returned completed. All 39 respondents said their pain was improved with hot water immersion. Only nine respondents had additional treatment after the initial hot water treatment: four received paracetamol alone, one received reimmersion of the limb in hot water and paracetamol therapy, one reimmersion alone, one removal of the embedded spine, one tetanus immunization and one a topical analgesic spray. One patient, who did not have any further treatment, developed 'a painful lump which discharged four weeks later'. While 18 of the 39 patients (46%) had had pain lasting less than an hour, and only 8 (21%) described pain lasting over six hours, 19 patients (49%) said that their foot was not entirely normal 24 hours after the sting. This discomfort lasting for 24 hours or more may be due to a foreign body reaction.

We conclude that cases of presumed envenomation by the lesser weever fish occurring on British beaches can be adequately treated by removal of any obvious foreign material from the wound, immersion for 10 to 20 minutes in water at about 40 °C and paracetamol analgesia.

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Patient or consumer?

Sir,

With increasing pressure towards consumerism in the National Health Service[1,2] there is a perception that doctors are patronizing the people they see by calling them patients. Indeed many of our nursing colleagues and paramedical workers already prefer the term 'client'. On 10 June 1991 a one day siminar titled 'What's in a name?' was arranged by the Department of Postgraduate Medical Education at Glasgow University with funding from the Nuffield Provincial Hospitals Trust. The purpose of the meeting was to explore the issues surrounding terminology. In preparation for this meeting I sampled the views of 28 general practitioners whom I met in the week before the meeting and 110 adult patients attending an evening surgery in my four partner training practice in Blantyre, Strathclyde on 16 May 1991.

A total of 102 patients replied to the questionnaire. When asked 'When you go to see a doctor do you think of yourself as a client, consumer, user or patient?' 101 patients chose 'patient' and one 'user'. When asked if they felt that any of the terms should specifically not be used the numbers objecting and the reasons given were: client (eight respondents: sounds like a lawyer; expect to pick up a bill), consumer (12 respondents: business term; too formal; suggests money is more important), user (11 respondents: implies guilt; sounds like some sort of drug addict; can mean liberty taker). General comments from respondents about the possibility of changing the term from patient emphasized the warmth of the relationship between general practitioners and their patients, for example, 'To most patient (s)he is a friend and adviser'.

Of the 28 general practitioners surveyed all except one preferred to continue to use the term 'patient'. The only exception was one doctor who had worked in a predominantly fee for service environment in Australia and New Zealand. He felt that use of the term 'customer' might be beneficial in forcing doctors to recognize their responsibility to satisfy patients' demands for better access to more pleasant services. Despite this, the overwhelming view of both doctors and patients in this small, selective study is that there is no great desire to drop the term 'patient' in favour of any alternatives.

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Computerized health information

Sir,

I was interested to read the report by Stanley and Tongue (December *Journal*, p.499) which confirms our own experience with *Healthpoint* in Glasgow.[1,2] *Healthpoint* is a public access health informa-

tion system which, to the user, appears as a coloured screen in 'video arcade' type box. There are about 100 topics of health information and over 900 screens of information. Information has mainly been abstracted from leaflets supplied by the Health Education Board for Scotland and has been edited by health professionals in the Glasgow Institute of Public Health.

Between March and September 1991 six *Healthpoint* units were moved between 14 sites in and around Glasgow. Like the system described by Stanley and Tongue, *Healthpoint* included internal monitoring of the screens viewed. We also observed users, carried out interviews with users and conducted a questionnaire survey of potential users.[2] The five topics most frequently selected by the public were contraception, alcohol, the acquired immune deficiency syndrome (AIDS), women's health and sexually transmitted diseases. Unlike Stanley and Tongue, there was a similar selection of topics at each site.

Trying to put a value on such a service is difficult; there is no intention to charge for use but the 'willingness to pay' approach provides one estimate. Each unit costs approximately £3000 and assuming a conservative estimate charge of 10 pence per user, the approximate time needed to recoup the value of *Healthpoint* at each site was calculated. This took into account a 'discount' for abuse by children under 12 years and the number of days available during the week on average. Nine of the 13 sites would recoup the cost within the likely five year life of the machine.

In the second phase of evaluation, 10 *Healthpoint* units were moved to Clydebank, a town on the outskirts of Glasgow and placed in a chemist, post office, library, two in a health centre, social security office, public house, technical college, sports centre and housing office. After being in place for six weeks a street survey of an opportunistic sample of 300 people in the shopping mall on weekday mornings were interviewed (100 aged under 30 years, 100 aged 30–49 years, and 100 aged 50 years and over; 50% male). Only people who had been to at least one of the 10 sites were included in the sample. They were asked, for each site, if they had been there, if they had seen *Healthpoint* and if they had used it. Seventy four per cent had seen it and 25% of the 300 respondents had used it.

Both the report by Stanley and Tongue and our own experience show that the use of computers is a good method of making general health information available to the public.

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Detection of colorectal cancer

Sir,

David Mant and colleagues have discussed the importance of screening for colorectal cancer and the difficulties involved (January *Journal,* p.18).

Colorectal cancer is the commonest cancer in non-smoking men and second only to breast cancer in women, survival is related principally to the stage at which the disease is diagnosed and deaths from colorectal cancer outnumber those from cancers of the breast and cervix combined.[1,2] Since most colorectal cancers probably arise from benign adenomas, the case for population screening to detect these is strong but the methodology remains uncertain and cannot be recommended until randomized controlled trials have demonstrated a decline in mortality rates.[3] The best chance of influencing outcome therefore depends on early detection of symptomatic disease. In practice this means responding appropriately to patients with lower bowel symptoms, in particular to rectal bleeding.

In a recent questionnaire study of functional bowel symptoms in 1620 subjects registered with eight general practitioners, 20% had experienced rectal bleeding, 15% in the previous 12 months.[4] Only about one third of these patients had consulted a general practitioner. Rectal bleeding was found to be commonest in younger patients (30% in men aged 20–29 years, compared with 15% in men aged 50–59 years). Consultation rates rose with age and were generally higher in women. It is of concern, however, that 14% of people aged 40–69 years had experienced rectal bleeding and yet only 34% of these had sought medical advice.

In patients referred to hospital with a diagnosis of rectal bleeding, as high as 10% may have malignancies and 30% a neoplastic condition.[5] However the prevalence of these disorders in general practice is much lower and the proportion of patients with local ano-rectal conditions correspondingly greater. General practitioners have to tread a narrow and potentially hazardous diagnostic path between overinvestigation and inappropriate reassurance. With increasing age, the likelihood of malignancy rises and middle-aged and older patients deserve an adequate and well considered explanation for their symptoms.

A serious obstacle to early diagnosis is highlighted by Mant and colleagues: it can only be achieved if people accept the offer of a health check or consult their general practitioner. The major stimulus to consultation is concern about the potential seriousness of symptoms[6] and there is evidence to suggest that this may also influence the response to an invitation for a general health check.[7] Until the effectiveness of faecal occult blood screening in reducing mortality from colorectal cancer has been proven, there is a case for a sensitive initiative aimed at raising public awareness of the significance of rectal bleeding.

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The health of the nation from a local perspective

Sir,

Can general practitioners influence the health of the nation? When the Cambridge and Huntingdon Royal College of General Practitioners group discussed *The health of the nation,* the government's green paper,[1] it was concluded that what general practitioners do is not enough in isolation; we can only have some influence as part of an integrated policy for change.

When we considered smoking, one of our members described how his practice