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Skin lesion excision in general practice

Sir,

Removal of small skin lesions by general practitioners appears to be becoming more popular since the introduction in April 1990 of a financial incentive to perform minor surgical procedures.[1-3] Advantages to the patient include the availability of local treatment and the ease of long term follow up. Research was undertaken in Grampian region to assess trends in general practitioners' practice of skin biopsies over a four year period.

All 1192 skin biopsies sent to the pathology department at Aberdeen Royal Infirmary by general practitioners in the Grampian region over four six month periods from 1 April to 30 September between 1987 and 1990 were studied. Information collected included provisional diagnosis, histopathological diagnosis and adequacy of excision.

After April 1990 there was a twofold increase in the number of skin biopsies taken (Table 1). This increase was significantly greater than the increases observed over previous years ($P<0.01$, chi square test) and was noted throughout Grampian region. Particularly striking, however, was the contribution made to this increase by Aberdeen general practitioners whose contribution increased nearly five fold ($P<0.001$) from previously low numbers of biopsies.

Non-benign lesions (malignant lesions and carcinomas in situ) accounted for 72 (6%) of the 1192 lesions excised. Most malignant lesions were squamous carcinomas, basal cell carcinomas or malignant melanomas although one lymphoma and one Merkel cell tumour were identified. Less than one third of biopsies (22) with a non-benign histopathological diagnosis had such a diagnosis (or an indication of suspicion) written on the request form from the general practitioner. The proportion and actual number of histologically incompletely excised lesions rose significantly over the four years ($P<0.01$, Table 1). Over the four years incompletely excised malignant lesions comprised four squamous carcinomas, three basal cell carcinomas, one malignant melanoma and one Merkel cell tumour. Five of these nine cases occurred after April 1990.

Table 1. Number of skin biopsies received from general practitioners in the Grampian region over the six month period April to September between 1987 and 1990.

	1987	1988	1989	1990
Total no. of biopsies	151	225	255	561
No. of incompletely excised biopsies	8	18	20	77
No. of biopsies from GPs in Aberdeen	22	36	35	153

The rise in the number of skin biopsies by general practitioners may be partly artefactual owing to specimens being sent in, which previously went unexamined, but presumably the rise mainly reflects financial remuneration available since April 1990. The striking increase in the number of biopsies sent in from general practitioners in Aberdeen, probably reflects the previous lack of incentive in an area with good access to hospital outpatient clinics.

The increase in the number of lesions which were histologically incompletely excised may partly reflect the increasing use of cautery to ablate the base of such lesions after surgical excision. Letters in the *Journal*[4] (February, p.82) have emphasized the increasing enthusiasm for the use of cautery in general practice. In this study, the question cannot be addressed as the method of lesion removal or of subsequent therapies were rarely mentioned on the request form. Such request form details, as well as mention of whether the lesion is being removed for cosmetic reasons, would aid future studies in trying to gauge whether adequate excision could be discounted given it was not an aim of surgery in the first place. It might be argued that since the overwhelming proportion of lesions being tackled are benign, inadequate excision has few significant implications for the patient. It would seem appropriate, however, to encourage good practice and ensure complete excision in all cases, especially since in our study a third of the non-benign cases were not recognized as such before excision.

It is, therefore, timely that recent guidelines on minor surgery in general practice recommend that, as a minimum, a doctor should provide evidence of satisfactory attendance at a recognized theoretical course, together with evidence of practical experience in minor surgical procedures (The Royal College of General Practitioners and the General Medical Services Committee. Minor surgery in general practice, 1991).

PAUL A J BROWN
NEIL M KERNOHAN
LOUISE M SMART
PETER ATKINSON
SUSAN ROBINSON
DAPHNE RUSSELL
KEITH M KERR

Departments of Pathology and Public Health
University of Aberdeen
Foresterhill
Aberdeen AB9 2ZD

PRATIMA SAVARGAONKAR

Department of Pathology
University of Manchester
Manchester

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3. Hilan KJ, Johnson CP, Morton R. Effect of general practitioner contract on referral of specimens for histological examination. *BMJ* 1991; **303**: 1180.
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Use of accident and emergency services

Sir,

I enjoyed Jeremy Dale's thought provoking editorial on patients attending accident and emergency departments with general practice problems (March *Journal*,

p.90). To discover why patients preferred to attend accident and emergency departments rather than seeing their general practitioner, a study was undertaken in my practice looking at all new attendances at accident and emergency departments over one year (1 March 1990 to 28 February 1991).

In order to check the accuracy of the practice records I collected all discharge letters received from accident and emergency departments and checked these against the computerized record of attendance kept by each accident and emergency department. Less than 2% of the attendences were not present in both records. I also checked a sample of patient records and again there were less than a 2% discrepancy. If a patient attended with the same problem on two occasions this was counted as two attendences but attendences for follow-up appointments were not included.

In the three doctor practice of 4812 patients, there were 833 new attendances at accident and emergency departments over one year (173 per 1000 patients) and of these 808 were at the local district general hospital. Attendances at weekends or public holidays accounted for 29.9% of attendances. There were 505 self-referrals, 263 general practitioner referrals, 48 referrals by employers and 17 referrals by the police.

Patients were discharged home with follow up by their general practitioner in 68.5% of cases, 19.0% were admitted to hospital, 12.1% were referred for follow up in the outpatient department and three patients died in the accident and emergency department.

A total of 531 cases were considered to be appropriate referrals to the accident and emergency department, as agreed by myself and the local accident and emergency consultant; this included all of those patients who had been referred by their general practitioner. It was considered that 266 cases may reasonably have been treated by either accident and emergency staff or by a general practitioner; such cases included patients attending with sprained muscles and joints, grazes and bruises, skin infections and some other infections. Thirty six cases were considered to be inappropriate attendances at the accident and emergency department. The diagnoses in this group were muscular pain (nine patients), conjunctivitis or a stye (eight), hayfever or an allergy (four), ear wax (three), panic attacks (three), urinary tract infection (two), headache (two), gastritis (two), chronic osteoarthritis (two), and mild sunburn (one).

I telephoned these patients within one month of their visit to the accident and emergency department. When asked to explain why they had attended the accident and emergency department rather than contacting their general practitioner the reasons given were convenience (nine patients, most of whom either worked in the hospital or were visiting it anyway), thinking the problem was serious (five), wanting immediate attention (five), not wanting to bother the general practitioner (four), wanting a second opinion (three), being sent by employer (three), panic (three), not realizing they could contact the general practitioner at the weekend (two), because the chemist was closed (one), and wanting an x-ray (one).

I therefore agree with Dr Dale's statement that there is 'no clear cut boundary between problems that belong in accident and emergency departments and those of general practice' and I would support the further development of appropriate planning and provision for primary care in accident and emergency departments, as approved by the Royal College of General Practitioners.

JILLIAN M MORRISON

Department of General Practice
University of Glasgow
Woodside Health Centre
Barr Street
Glasgow G20 7LR

Prophylaxis against malaria

Sir,

Prophylaxis against malaria must be safe, effective, acceptable and appropriate. Any regimen should also be simple and easily remembered by the prescriber. We recommend the use of chloroquine and proguanil together for all malarial areas and all patients except for those at high risk, typically people travelling for prolonged periods or to areas with high levels of drug resistance, and those with special risks such as aid workers.[1] There is no evidence that these drugs when used for prophylaxis have any life threatening side effects.[2] Our recommendation is supported by a risk benefit analysis.[1]

It is important to realize that conflicting advice will lead to reduced compliance. Visitors to West Africa who did not comply with their chemoprophylactic regimen were at a two and a half times greater risk of infection than fully compliant users.[3]

Nevill and colleagues have suggested that personal protection such as the use of insect repellents, sleeping in screened accommodation with mosquito nets and covering exposed areas after sunset, plays as effective a role in the prevention of malaria as do prophylactic drugs.[4] Indeed, Manson as long ago as 1900 demonstrated that the attack rate can be reduced by 10 times if suitable protection against mosquito bites is used.[5]

We interviewed a randomly selected group of travellers departing from terminal four at London's Heathrow airport for malarial areas over a two day period in March 1989. A directly administered questionnaire with predominantly yes/no responses was used. Children under five years, doctors, nurses and non-United Kingdom citizens were excluded. All 100 travellers identified who fulfilled the inclusion criteria agreed to take part in the study. Of the 100, 64 were male; 32 were business travellers.

Fifty of the travellers had visited their general practitioner prior to departure. Seventy of the travellers had been offered advice about antimalarial chemoprophylaxis and were taking the recommended medication; 60 had received correct instructions on the usage of these drugs. Only nine travellers were advised about other methods of personal protection such as the use of insect repellents.

If the incidence of imported malaria is to be reduced the health knowledge of patients travelling abroad must be improved. At the surgeries where we practise patients seeking advice or immunizations for foreign travel complete a proforma listing destinations and other relevant information. In conjunction with the patient's notes the general practitioner can therefore evaluate an appropriate prophylaxis regimen. Patients are specifically advised on how to take antimalarial tablets and on the need to take additional precautions, and are routinely supplied with the Department of Health leaflet *The traveller's guide to health.*[6]

All travellers should be encouraged by non-health agencies such as travel agents and airlines to seek medical advice before travel. Those travellers who do are likely to be better informed, especially those attending general practices where a clear policy exists.

PETER R BARKER

The Surgery
Prospect House
High Street
Great Missenden
Buckinghamshire HP16 0BG

GRAHAM A W HORNETT

The Surgery
Wonersh
Guildford
Surrey GU5 0PE