and not distended, and there was a large inflamed, tender irreducible umbilical hernia. A diagnosis of strangulated umbilical hernia was made.

At operation a small hernial sac containing gangrenous omentum was found; loops of bowel appeared normal. The omentum and infected skin were resected and the umbilicus reconstructed. The child's recovery was uneventful and he was discharged the following day.

A search of the literature revealed only 11 children with strangulated umbilical hernia in total worldwide,[2-11] despite umbilical hernia being an extremely common condition. Among the 11 reported cases, delay in presentation was common ranging from 21 hours to nine days. In this case, delay while awaiting an urgent clinic appointment was associated with the need to excise infected skin and gangrenous omentum. Unlike inguinal and femoral hernias, the majority of umbilical hernias in children will disappear completely with increasing age. Thus, the present policy of expectant management should continue.

Parents often seek and receive reassurance early on when the large size of the hernia is causing them alarm. One could postulate, however, that the risk of strangulation will occur much later, when the hernial orifice is becoming smaller prior to complete closure. Parents should be instructed that in the unlikely event of the hernia becoming irreducible or painful, they should seek prompt medical attention. Primary care physicians should refer such cases to their surgical colleagues as emergencies, as with incarcerated hernias at any other site.

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General practice and drug misuse

Sir,

The letter by George and Martin is to be welcomed (July *Journal*, p.302). General practitioners have always been in the front line with regard to the management of drug users and have regularly contributed to the debate on the care of drug abusers in the community.

The progress of the human immunodeficiency virus and the acquired immune deficiency syndrome has seen 'harm minimization' emerge as the primary role of the treatment of intravenous drug abusers.[1] The issue of prescribing for intravenous drug abusers is central to such an approach and has been strongly advocated in the recent Department of Health guidelines for doctors.[2]

We do, however, have some reservations regarding the methodology of George and Martins' survey and of the conclusions they draw from their data. A sample of general practitioners attending a seminar on drug abuse is likely to comprise those who would be more likely to have an interest in drug abusers and would therefore be favourably disposed to them. As a result, the sample may not be representative of all West Sussex general practitioners. We were surprised that injectable methadone seems to have been the focus of the authors' enquiries with regard to prescribing and that general practitioners were not asked about oral methadone. The Department of Health guidelines[2] recommend that 'straightforward elements' of care (an example of which is the prescribing of oral methadone) are to be taken on by 'any doctor', while 'more complicated interventions', such as the prescribing of injectable drugs, should be dealt with by doctors with 'relevant specialized training, expertise and back-up'. If such guidelines were to be followed, most general practitioners would not be expected to prescribe injectable drugs to intravenous drug abusers.

The authors feel their data present a 'more hopeful view' of shared care as some 60% of their sample were willing to engage in the management of intravenous drug abusers. However, even among this interested group of general practitioners, 40% implied no willingness to be involved, 21% would not accept a new patient with a history of drug abuse and 56% were unaware of any drug abusers on their lists. There is ample evidence that general practitioners find drug abusers a difficult patient group,[3,4] and that general practitioners are wary of prescribing for them.[5] We feel that it is likely that the results would have been less hopeful in a truly representative sample.

Recent work has shown how intravenous drug abusers can be cared for successfully in a general practice setting[5,6] and has highlighted the need for improved liaison between specialist drug treatment agencies and the general practitioner.[5,7] If 'harm minimization' is to become a reality, the general practitioner will have an increasingly important role to play. It is essential that general practitioners have a say in what functions they are prepared to fulfil and what support they will require from specialist agencies. This can only be achieved by canvassing the views of representative samples of general practitioners in different geographical areas.

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Sir,

I read with great interest the article by Ronald and colleagues on their practice's response to the local problem of drug misuse (June *Journal*, p.232). This is a topical issue, another practice with a large population of drug misusers having also reported its findings recently.[1]

There are interesting differences in the approaches reported by the two practices and my own which, presumably reflect the attitudes of the doctors involved and the