

and have a pecuniary interest in doing so, it is important to show we are not doing harm. In view of the costs in terms of time and money involved, it is important to show that we are doing some good.

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Screening elderly people

Sir,

One of the reasons for considering screening elderly people to be worthwhile is that it may reveal previously undiagnosed problems in those screened. This may result in an increased uptake of medical services.^{1,2} However, as those patients aged over 75 years come to have their second annual check, it seems likely that the scope for identifying problems will be diminished.

Of the 175 patients over 75 years old in a single handed practice who had an annual check in the first year of the new contract, 154 patients were reviewed in the second year, 21 patients having died or moved away. Table 1 shows the problems identified during the course of the year through normal, patient-initiated consultations, and at the time of the second annual check.

It would appear that patients in this age group are quite capable of presenting to the doctor with conditions requiring a new diagnosis (21 patients) but a small number of new diagnoses were also made at the second annual check (seven patients). In four of these seven cases the diagnosis was hypertension. Measuring blood pressure is not a requirement of the annual check for elderly people, but in view of the recent research on the benefit of treating hypertension in elderly people this may be a worthwhile exercise.³

Of the 154 patients having a second annual check, either in the surgery or at home, 63 had problems requiring action. It is difficult to equate this with benefit

Table 1. Problems requiring action identified among the 154 patients aged over 75 years.

	No. of patients with problem:	
	Identified during normal consultations	Identified at the second annual check
New diagnoses	21	7
Deteriorating mobility	4	0
Deteriorating mental function	5	0
Needed to be moved to residential home as unable to cope	2	1
Increased medication required	6	9
Treatment no longer needed	0	4
Needed to be registered blind	1	0
Needed to be registered partially sighted	1	1
Referral for hearing aid needed	1	5
Vaccination required	0	12
Referral to optician needed	0	4
Ear needed to be syringed	0	9
Referral to ophthalmologist needed	0	4
Referral to social services needed	0	2
Letter to other agencies required	0	2
Referral for surgery needed	0	3
Total	41	63

to patients, but it seems that problems with vision and hearing are more likely to be identified at the annual check than to be presented by patients during normal surgeries. Conversely, it seems that deteriorating mobility and mental function are more likely to be presented to the doctor during normal consultations.

These results indicate that a change in emphasis could be beneficial for the second and subsequent annual checks for those aged over 75 years.

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Treating candidiasis in community child health clinics

Sir,

Colonization with candida is common in infancy, one study reporting 82% of infants aged four weeks being colonized.¹ It is therefore not surprising that many babies require treatment for candida infections.

I would like to report a study of the in-

cidence and treatment of candidiasis in two community child health clinics in South Sefton, Merseyside. Both study clinics were in areas of high socio-economic deprivation (underprivileged area scores of 15, 23 and 45 for the wards covered).

Three clinics were held each week, two with the same doctor and one without a doctor. Treatment was prescribed and dispensed by the doctor when she was available, according to an agreed district policy. If a doctor was not available, the child was referred by the health visitor to the general practitioner for treatment. For this study, any child with clinical candidiasis not receiving appropriate treatment at the time of attendance was included. Children already receiving treatment were not included. Cases were collected prospectively for 13 weeks between September and November 1991.

There were 912 attendances during the study period and 399 were seen by the doctor. A total of 83 cases of candidiasis were seen in 73 children. All except two of the children were under one year old. Of the 83 cases, 42 (51%) were cases of perineal candidiasis only, nine (11%) were of oral candidiasis only and 32 (39%) were of both. Thus, there were 41 occurrences of oral candida infection and 74 occurrences of perineal infection. One child also had a facial infection.

Parents recognized candida infection in 33 of the 115 occurrences (29%). They recognized 16 occurrences of oral candidiasis (39%) compared with 17 occurrences of perineal candidiasis (23%). Reasons parents gave for attending the clinics were as follows: weighing (32), candidiasis (20), child health surveillance (16),

immunization (eight), minor ailments (four) and nappy rash (three). Six of those presenting their child for treatment of candidiasis had been referred by a health professional, such as a health visitor or midwife, visiting the home. In babies attending the clinic for reasons other than candidiasis, candida infection had been noticed by the health visitor while weighing the baby. Of the affected babies, 94% were bottle fed. Antibiotics had been taken by 28% of infants in the two weeks preceding the onset of candidiasis.

Of the 41 occurrences of oral candidiasis, 38 were treated with nystatin suspension, two with miconazole gel and one child was referred to the general practitioner. Of the 74 episodes of perineal infection, 34 were treated with Timodine[®] cream (Reckitt and Colman), 33 with nystatin cream, three with miconazole cream, and four children were referred to their general practitioner. The facial infection was also treated with nystatin cream.

This study shows that 9% of child health clinic attendances had clinical candidiasis requiring treatment. No comparable community studies could be found but a Liverpool study of hospital admissions showed an incidence of 7%.² Extensive use of dummies^{2,3} and usage of antibiotic may be associated with candidiasis.

The high incidence of candidiasis justifies a policy of having treatment available at child health clinics, as described by Polnay.⁴ Community child health clinics are likely to continue in deprived areas for the foreseeable future, as Hart's inverse care law is likely to apply to health promotion activity as in other areas of work.⁵ Informal discussion with local general practitioners confirm their support for this service as they have no desire to increase their inevitably high consultation rates any further. Travel costs and inconvenience to parents would also increase if they had to attend their general practitioner for a prescription. Pharmacy dispensing fees would add to National Health Service costs.

The potentially divisive nature of the new contract for general practitioners and the reforms in the NHS should not be allowed to interfere with the current cooperation between general practitioners and community doctors in providing an effective service to disadvantaged parents and children.

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Diverticular disease

Sir,

Diverticular disease is a common condition and occurs in 50% of patients aged over 50 years.¹ The disease is often discovered incidentally as it remains asymptomatic in around 90% of the population.¹ However, its symptoms of abdominal pain with or without change in bowel habit are not pathognomonic and can be ascribed to other more serious diseases of the distal large bowel. Similarly, both diverticular disease and colonic neoplasms have an average age of diagnosis that is in the seventh decade.

In my general practice two patients with recently diagnosed descending and sigmoid colonic carcinoma had undergone a barium enema examination within the previous eight years which had demonstrated diverticular disease. In July 1992, the records of all patients with a current diagnosis of diverticular disease were, therefore, examined to determine the clinical management of patients with this condition and to identify other pathologies occurring within this group. The total practice population is 9974 and of these 3097 (31%) are aged 50 years or over.

Sixty three patients with diverticular disease were identified (2% of total practice population aged 50 years or over). The mean age of these patients was 71 years (range 48-95 years), only one patient being under 50 years of age, and the male:female ratio was 1:2.7. Forty seven patients (75%) had undergone barium enema investigation of which four had been normal (these four patients were diagnosed clinically), 37 had shown diverticular disease and six had revealed diverticular disease and colonic polyps. Eleven patients (17%) had been diagnosed purely on clinical grounds, no radiology or other investigation having been performed. In five patients other investigations revealed coexisting colonic carcinoma (two patients), ulcerative colitis (one), irritable bowel (two) and gallstones plus peptic ulcer (one).

Thus, 11 of the 63 patients had a coexisting pathology, the most common being adenomatous polyps (six patients). Four patients had later suffered a serious complication of diverticular disease — haemorrhage (one patient), peritonitis (two) and perforation (one). Fifteen patients (24%) had been referred for secondary care.

Diverticular disease is a condition most commonly found in the distal colon of elderly women. However, it is not a disease without serious complications. Nor can the diagnosis be made purely on clinical findings — 17.5% of patients with diverticular disease may have a coexisting condition, not always diagnosed on barium enema alone.

It is too simplistic to expect to investigate a patient's symptoms appropriately, reveal a condition which may be the cause of those symptoms and then to ascribe all future symptoms to the condition diagnosed. When diseases can occur coincidentally, with similar symptoms and signs, we should always be prepared to review a diagnosis critically and reinvestigate to discover the true cause.

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Reference

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Chronic mental illness in general practice

Sir,

Goldberg and Jackson's attention to improving liaison between primary care and the specialist in the context of mental illness is very welcome (editorial, July *Journal*, p.267). They contrast the widespread use of protocols and shared care plans for patients with chronic physical illnesses with the lack of proactive approaches to patients with long term mental illnesses in the community.

In planning a strategy of care for patients with chronic mental illness an essential first step is to define the scale of the problem. In our practice a medical student (S H) carried out a study in October and November 1991 scrutinizing the notes of all the practice patients (3986 at the time of the study) and identifying those patients aged over 16 years with chronic mental illness. The following categories of patients were used, that seemed to generate the principal burden of work for