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Apparent food allergy

Sir,

The occurrence of chronic ill health as a result of food allergy is probably rare. More often, persistent debilitating symptoms owing to non-allergic causes are falsely attributed to food allergy leading to failure to reach correct diagnosis, or, as in the three cases reported here, result in unnecessary dietary restrictions and expenditure on diagnostic tests.

A 52-year-old man presented to the Hitchin hospital chest clinic with a persistent cough and an irritant widespread rash, thought to be due to urticaria. He was diagnosed as having a food allergy and given an exclusion diet. He was free of symptoms for nine months while on a milk-free diet. Subsequent inpatient investigation at a hospital for diseases of the skin, including oral challenge testing, by drinking 500 ml of milk, failed to reveal any evidence of food allergy and the lesions, originally thought to be urticarial, turned out to be classical cutaneous lipomas.

A 25-year-old woman, with loose stools and acute skin swellings attributed by her general practitioner to food allergy and particularly allergy to milk, wheat and fruit was referred to Hitchin hospital dietetic department by her general practitioner. She had already excluded these items from her diet when she attended and had lost 6.3 kg in weight over three months. As an inpatient she was reintroduced to cereal foods, milk and fruit. This did not result in any symptoms, and her stools remained normal. Psychiatric assessment revealed that her apparent food intolerance was an expression of an emotional defensive response to what she perceived to be a hostile environment. Although the patient refused long term psychotherapy, she now accepts that food is unlikely to be the major cause of her symptoms.

A 66-year-old woman presented at the dietetic clinic at Hitchin hospital with one year's history of headaches, soreness of

the mouth, difficulty in swallowing and red discoloration of the legs. These symptoms were attributed by her general practitioner to food intolerance. Sialography revealed a tight stenosis of the right parotid duct which was later surgically dilated resulting in restoration of normal function. However, her general practitioner subsequently referred her to a consultant allergist who could find no evidence of food allergy and recommended reversion to a full diet which the patient has taken without adverse consequences.

In all three patients mistaken attribution of symptoms to food allergy resulted in a prolonged period of inconvenient dieting and, in at least one case in considerable ill health, and in two cases in costly inpatient admission. In all three cases, the spurious diagnosis of food allergy, which was reinforced by medical advice, resulted in delay in achieving a correct diagnosis which was organic in two cases and psychiatric in one.

This unfortunate sequence of events would be avoidable in many cases if a diagnosis of food allergy was conditional upon obtaining positive evidence from controlled food challenge testing. The value of placebo controlled studies in the identification of patients with true food hypersensitivity has recently been reviewed by Metcalfe.¹

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Reference

1. Metcalfe DD, Sampson HA. Workshop on experimental methodology for clinical studies of adverse reactions to foods and food additives. *J Allergy Clin Immunol* 1990; **86**: 421-422.

The General Practitioner Writers Association

Sir,

The General Practitioner Writers Association was formed in 1985 with the aim of improving standards of writing from general practice and to help authors to get their work published. The association holds two workshop meetings a year, sends a detailed register of members' writing interests to editors and publishes its own journal, *The GP Writer*, twice a year.

In an attempt to quantify the activities of the membership a questionnaire comprising both closed and open questions was sent in February 1992 to 216 association members (paid up members in February 1992). Questionnaires were returned by 192 (89%). The membership is predominantly male (163 respondents, 85%), with only 42 respondents (22%) aged less than 40 years and 96 (50%) over the age of 50 years. Most (163, 85%) are, or have been, general practitioners, 15 (8%) are doctors but not in general practice and the remaining 14 come from other professions allied to medicine. The majority (117, 61%) are, or have been, associates, members or fellows of the Royal College of General Practitioners and 126 (66%) are actively involved in teaching undergraduate, postgraduate or professional or lay groups.

The membership is represented on the editorial boards of 43 different journals and 49 respondents (26%) edit or publish 51 journals and 13 books. These 13 books include some of the standard texts of general practice and also books for lay and general readership.

Respondents were asked to classify their writing into categories in which they had published or hoped to publish (respondents produced their own categories which were subsequently grouped by the author). Of 65 different categories of medical and non-medical writing the 14 most frequently mentioned are shown in Table 1. Fiction is the aim of many with 22 having

published in this field but with 53 hoping to do so. Writing of books was also common with 109 of the 192 respondents writing or contributing to 53 books in sole authorship and 60 in joint authorship, and with 73 contributions of chapters. Altogether the respondents had published many thousands of articles and papers in a total of 69 medical journals and in 79 lay periodicals including many national and local newspapers, where several members have regular columns.

Table 1. Respondents classification of their writing.

Category/subject of writing	No. of respondents (n = 192)	
	Have published	Hope to publish
Review articles	109	7
Book reviews	92	10
Case reports	75	8
Scientific research	74	13
Practice organization	66	5
Writing for patients	59	17
Philosophy and ethics	41	15
Practice finance	30	3
For television and radio	28	6
Travel	24	8
Fiction	22	53
History	20	6
Poetry	17	12
Nursing topics	13	1

n = total number of respondents.

This survey of the writing and editorial activities of the members of The General Practitioner Writers Association reveals a thriving and productive group of individuals with wide interests. Certainly the lively atmosphere of association meetings and workshops is extremely stimulating and it is usually possible to meet someone with greater expertise than oneself in any field of writing. Thus, the association exerts a considerable educational effect, a function recognized by the acceptance of its meetings on the list of those which qualify for the postgraduate education allowance.

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Ambulatory blood pressure measurement

Sir,
We were interested to read the editorial by Dr Cox and colleagues on ambulatory blood pressure measurement (October *Journal*, p.402) and agree that the time has come for pilot studies of the use of this technique in general practice.

During the last 12 months we have used a Spacelab 90207[®] monitor in the assessment of hypertensive patients in our practice (list size 9500). During this period 99 patients were monitored. Sixty seven of these patients had diastolic pressures measured in the surgery of 94–110 mmHg (phase five) and were being considered for treatment. Of these, 37 had a mean diastolic pressure over a 24 hour period of less than 90 mmHg and were therefore listed for follow up in three to 12 months. For 11 of these 37 patients, the difference between the measurement in the surgery and over 24 hours was greater than 20 mmHg, and these patients may have been suffering from 'white coat hypertension'. Thirty patients had mean ambulatory diastolic pressures of 90 mmHg or above and were prescribed treatment. In addition 32 hypertensive patients were monitored while receiving treatment, to assess the need for a change in therapy.

About an hour of nurse time is required for each patient who receives ambulatory monitoring: 20–30 minutes counselling the patient before monitoring, 15 minutes at the end of the monitoring period to print out the result and discuss the findings and any difficulties that have been encountered with the patient, and 15 minutes of administrative time. It was not considered safe to allow the patients to have their blood pressure taken when driving a car and they were taught how to switch the apparatus off or to time their journey so that a measurement would not be made while they were driving. Eight patients did not satisfactorily complete the monitoring and are not included in the above analysis. Four of these patients had high systolic pressures and experienced considerable pain on inflation of the cuff. Furthermore, in those patients who were judged to have completed the monitoring, examination of the print out showed that, owing to technical reasons, such as kinked tubing and movement of the arm, only about 80% of the expected readings were recovered.

A questionnaire was given to each patient at the start of the monitoring period and he or she was requested to complete it at the conclusion and return it to the nurse. A total of 107 questionnaires were handed out and 84 (79%) were returned. These showed that 41 patients (49%) had experienced some interference with normal activities and for two manual workers this interference was considerable. Sixty four patients (76%) reported some disturbance of sleep, which raises the question of whether the pressures recorded at night are representative. Sixteen patients (19%) felt moderately anxious during the measurement and two very anxious.

A theoretical problem with the technique is that it assumes that the day on which the measurements are made is representative of the patient's usual lifestyle. However, despite this and the problems experienced by the patients in this study, we are convinced that ambulatory blood pressure monitoring is a valuable method for assessing hypertension and more reliable than the isolated measurements made in the practice. Both clinicians and manufacturers are still, however, on a steep learning curve. The apparatus currently used in our practice is already outdated and the normal values of blood pressure are still in dispute. The message concerning ambulatory monitoring should therefore perhaps be 'watch this space' rather than 'go and do likewise'.

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Community care of patients receiving antipsychotic medication by depot injection

Sir,

We were pleased to read Amanda Kirby's letter emphasizing the importance of good communication between general practitioners and psychiatric services.¹ This is particularly relevant to patients receiving long term antipsychotic medication by depot injection.

The results of our survey completed in March 1992 of all adult male patients receiving such medication in the London borough of Sutton serve to illustrate the need for continuing close liaison between hospital-based and community-based services. Of 119 male patients (age range 21–71 years), the majority (81, 68%) received their depot medication from one of the community psychiatric services but 14 (12%) received it from their general practitioner (remaining 24 patients were mainly hospital inpatients). Compared with the group attending the community psychiatric clinic general practice patients were older (mean age 49 years versus 46 years) and had received depot injections for longer (mean 13 years versus seven years). Although the mean dose of antipsychotic medication was lower among the general practice group (458 mg chlorpromazine equivalents per day versus 661 mg), a greater percentage of the group (14% versus 5%) were taking doses in excess of 1000 mg chlorpromazine equiv-