describe the severity of epileptic seizures by using fuses of different strength to represent seizure threshold in mild, moderate and severe epilepsy. The role of medication in seizure disorders can then be explained in terms of strengthening the weaker fuses so that they approximate appropriate seizure thresholds more closely. However, increasing fuse resistance may impede other functions, which can be correlated with the potential side effects of anti-convulsant medication. The cause, severity and treatment of the patient's epilepsy can thus be demonstrated by selecting a fuse which best reflects their individual aetiology, seizure threshold and medication.

The comparison of an easily recognized household object with the often difficult to understand concept of seizure disorders, may help to defuse the explanation of epilepsy. This comparison may provide patients with a greater awareness of the need to find a suitable balance between adequate control of their seizures and the resultant side effects of medication. Analogies such as this may help to de-mystify epilepsy, and render seizure disorders more understandable to patients and their families.

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Nephrotoxicity with non-steroidal anti-inflammatory drugs

Sir,

A 65 year old man in my practice was diagnosed as having cervical spondylosis. Because of increasing pain he was prescribed a variety of non-steroidal anti-inflammatory and analgesic drugs, including naproxen, diclofenac sodium, mefenamic acid, ketoprofen, and also the compound analgesic Tylex® (Cilag). These drugs were prescribed separately, not in combination, and in the doses recommended by the *British national formulary*, over a period of several months. He was referred for a consultant orthopaedic opinion. X-rays of the cervical spine and routine blood tests, including erythrocyte sedimentation rate, urea and electrolyte levels, and liver function tests, were carried out.

At this time he was developing further symptoms including loss of weight, anorexia, dyspepsia, night sweats, tiredness and general malaise. He consulted several times at the surgery with these continuing symptoms. He was also attending the orthopaedic outpatient clinic. Because of progression of his symptoms the blood results were obtained by telephone from the hospital. These showed that he was suffering from renal failure and he was immediately admitted to hospital. Sadly, his condition continued to deteriorate and he died following a cerebral haemorrhage.

At autopsy interstitial nephritis was found which was compatible with a nephrotoxic drug reaction, presumably caused by the treatment he had been receiving for his cervical spondylosis.

The case has been reported to the Committee on Safety of Medicines, but I am also writing this letter at the specific request of his family, who wish general practitioners to be fully aware of the risk of a nephrotoxic drug reaction with these widely used drugs, and to consider this possibility in the event of their patient developing unexplained symptoms which may indicate renal failure. The possibility of such a reaction is already recognized and is mentioned in the relevant data sheets, but it seems that the gastrointestinal side effects are more regularly considered.

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Disease register for patients with asthma

Sir,

With the current interest in asthma as a subject for disease management in general practice, it is becoming necessary for practices to maintain reliable registers of affected patients.

In my practice of 7672 patients, the computer listed 211 patients as having 'asthma' in 1992. In November 1992 a search for patients receiving repeat prescriptions for beta$_2$-agonist drugs or inhaled steroids in the past year produced 311 patients, 146 of whom were not recorded as having asthma. This latter group included nine patients who had repeat prescriptions for inhaled steroids only, and 71 who had received beta$_2$-agonists only. The remaining 66 patients had prescriptions for both types of drug.

Thus, 46 patients listed as having asthma did not receive repeat prescriptions for either class of asthma drugs during the year. Of these patients, 31 had these drugs prescribed acutely, and two had received repeat prescriptions for sodium cromoglycate. Thirteen of these patients had received no treatment for asthma at all: nine patients had received asthma treatment in the year before that studied, but one had not been prescribed asthma treatment for four years.

It would appear that a register of patients having asthma needs constant updating. Carrying out searches for patients receiving repeat prescriptions for beta$_2$-agonist and prophylactic drugs seems to be a reasonable way of identifying patients who are currently affected, but the period over which prescribing data should be collected must be specified. Many more patients would be identified if acute prescribing were also considered, but this could be associated with a risk of false diagnosis. There is also a need for policies to be made regarding patients listed as having asthma who are no longer receiving treatment. For example, if a patient, once diagnosed as having asthma, subsequently does not appear to be in need of treatment, should he or she be removed from the disease register?

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Audit and morbidity registers

Sir,

Liam Donaldson in his editorial in the *British Medical Journal* has drawn attention to the importance of morbidity registers for the assessment of resources.[1] He states that 'Disease registers restricted to general practice lists are more limited in their applicability in not having a natural population base'. Surely if such a base is to be found anywhere it is in a general practice population.

Morbidity registers have long been advocated for general practice,[2] primarily as a tool for research and teaching. Now an important new use has arisen, namely audit.[3] In the past it has been difficult to ensure that morbidity registers are complete and there have been problems in keeping them up to date.[4] This is usually because they have been too comprehensive, and it has been difficult to agree on definitions for some conditions.

As the implementation of the audit process gathers pace, it is becoming clear that certain chronic conditions are the most frequent subjects of clinical audit. The Isle of Wight medical audit advisory group has encouraged practices to establish

limited morbidity registers for the purposes of audit, indeed it has made this an acceptable audit project for the first year or two of audit, and has provided finance accordingly. It is suggested by the Isle of Wight medical audit advisory group that the following conditions should be included in a morbidity register: hypertension, ischaemic heart disease, asthma, chronic obstructive airways disease, gastric and duodenal ulcer, migraine, epilepsy, parkinsons disease, cerebrovascular accident, non-insulin dependent diabetes, hypothyroidism, hyperthyroidism, gout, rheumatoid arthritis and osteoarthritis.

A limited register of this size should not be difficult to compile or keep up to date. Conditions that are mostly monitored in hospital clinics, such as insulin dependent diabetes, are purposely omitted from the recommended list. Of course, practices will expand this list for their own purposes, but no practice however small or understaffed should have difficulty maintaining such a morbidity register, and it will provide audit projects for many years to come.

Another use of such a register is as an indicator of resource needs. If each practice in a district or region kept a morbidity register of the common conditions listed above, it would not be difficult to establish resource needs for that area, and these are conditions which need resources, as opposed to most acute conditions.

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Intermittent self catheterization

Sir,

After our paper on intermittent self catheterization appeared in the *Journal*[1] we received correspondence from a retired general practitioner who stated that we should not hesitate to quote from his letter.

'Referring to your article I thought you might care to hear of my experiences, and benefits which have resulted therefrom. I am 87 years of age. Briefly my history is as follows: 1987 prostatectomy for chronic retention. Failed to regain control. Videocystogram showed a scar on the bladder neck. Further surgery in 1988... Thereafter incontinence at night. Cystoscopy showed no abnormality. Repeat urodynamics showed incomplete emptying of the bladder, but no advice or action from the hospital consultant.

On reading your article in the *British Journal of General Practice* I asked our GP to do something. I had a visit from a lady continence adviser. She advised self catheterization and supplied advice and equipment. This I was able to carry out morning and bedtime without any difficulty. The result was usually about 300 ml [of urine]. I have been on self catheterization for three months now. Nights are now dry which is a great improvement on having to change pyjamas and bedding most nights. I can now go to bed with prospects of a decent sleep. So all I can say is many thanks.'

General practitioners might consider whether any of their patients with urinary incontinence associated with atonic or neuropathic urinary retention might similarly be helped by learning intermittent self catheterization.

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Reference

1. Oakeshott P, Hunt GM. Intermittent self catheterization for patients with urinary incontinence or difficulty emptying the bladder. *Br J Gen Pract* 1992; **42:** 253-255.

Long term use of IUCDs

Sir,

I read with interest the paper from Israel by Dafni and colleagues (October *Journal,* p.423) as I am at present looking into the use of intrauterine contraceptive devices in general practice in the United Kingdom.

The authors of the paper appeared to be advocating the continued use of inert devices for indefinite periods. I am not sure of the position in Israel, but inert devices are no longer available in the UK, and in our practice the last one was inserted six years ago. Copper devices achieved popularity because in the early years after insertion they gave lower pregnancy rates than the inert devices.[1,2] In the women reported on in the study in Israel, the devices had all been present for five years or more. At this point one would have hoped that problems would have lessened. However, a third of the women had to have the device removed for intolerable side effects and a further third had the device removed for a variety of reasons including intrauterine pregnancy, menopause, patient request and for exchange. Again, this seems a high figure.

No copper device is licensed for use for more than eight years[3] so a direct comparison between inert and copper devices would be difficult. Many of the copper devices have been around for 15 years and many women will have used a succession of such devices, only breaking for the change of device advised by the manufacturers.

Dafni and colleagues also discuss the low rate of pelvic infammatory disease in their subjects. However, they did not look for actinomycoses. They also stated that they did not carry out cervical smears as there is a low rate of cervical cancer in Israel. Is the rate of pelvic inflammatory disease also low?

Although this is an interesting study I am not sure that the authors' conclusions can be justified. It would seem that the copper devices are here to stay and are being continually improved. It is to be questioned whether it is really time that inert intrauterine contraceptive devices were reintroduced.

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Effect of dietary advice on cholesterol levels

Sir,

Robertson and colleagues seem to be disappointed at the small overall effect of the dietary advice given to patients submitting to health checks in their survey of Buckinghamshire general practices (November *Journal,* p.469). But are they justified in expecting a greater change?

They give no details of the dietary advice given to patients by nurses but it may well have been in line with that advocated by the Committee on Medical Aspects of Food Policy (COMA), that is, total fat to