LETTERS

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Perceived underprescription of topical therapy

Sir,

Patients with eczema may require treatment with emollients and topical steroids. In our experience many patients with chronic eczema who attend hospital dermatology outpatient clinics complain of underprescription of topical therapy by their general practitioners. This perceived underprescription may be because the doctor has difficulty in assessing or is unfamiliar with the amounts of topical therapy required to treat the affected areas, it may be due to the doctor's concern over the potential side effects of topical steroids, or it may relate to a misunderstanding by the patient of how much treatment should be applied.

In order to assess the extent of any underprescription we surveyed consecutive patients aged over 16 years attending our dermatology department throughout 1992. Adult patients with chronic eczema of greater than one year's duration, which affected an area of greater than the equivalent of the flat of four hands (approximately 4% of total body surface area) were asked to complete a questionnaire.

Eighty three patients (39 men, mean age 44 years; 44 women, mean age 35.5 years) completed the questionnaire. The mean duration of their eczema was 17.8 years. Of the 83 patients, 21 (25%) felt that their general practitioner prescribed insufficient quantities of topical steroids, while 24 (29%) felt that insufficient quantities of at least one form of emollient (moisturizer, bath oil, soap substitute) were prescribed. Thirteen of the 21 patients (62%) who received insufficient quantities of topical steroids also received inadequate amounts of emollients. Only 43 of the 83 patients (52%) claimed to have ever received advice on how much topical therapy they should use. Sixteen of the 21 patients who received insufficient amounts of topical steroids (76%), and 21 of the 24 who received inadequate amounts of at least one form of emollient (88%) felt that their general practitioners did not realize how much treatment they needed. The majority of those who felt they were not prescribed sufficient topical steroids or emollients were reluctant to attend for a further prescription — 15/21 (71%) and 18/24 (75%), respectively. Most of the patients in these two groups felt that their eczema suffered because of underprescription — 19/21 (90%) and 21/24 (88%), respectively.

The results of this survey suggest that while the majority of patients with chronic widespread eczema are supplied with adequate amounts of topical therapy more than one in four are not. Underprescription can have several disadvantages: patients may be unable to treat their eczema long enough for the treatment to be effective; treatment may be discontinued and the condition deteriorate when supplies run out; and patients may feel that treatments (and particularly topical steroids) are ineffective if their eczema has failed to respond.

We would urge all doctors to become familiar with the amounts of topical therapy that patients require,[1,2] so that the problems of underprescription can be avoided.

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2. Long CC, Averill RW, Finlay AY. The rule of hand: 4 hand areas = 2 FTU = 1 gram. *Arch Dermatol* 1992; **128:** 1130.

GPs as participants in scientific research

Sir,

One of the conclusions of Murphy and colleagues in their article on gaining access to primary care settings and subjects was that if inadequate information is given by the researcher to general practitioners before the study the project may get underway, but participants may well withdraw once the implications of the project become clear.[1]

The department of general practice at the University of Limburg in the Netherlands is steadily increasing its research activities, and the success of this research programme depends on the cooperation between the department and general practitioners. In order to obtain more insight into this collaboration a study was carried out in May 1989.

A self-administered questionnaire was posted to 150 general practitioners familiar with scientific research and 200 general practitioners who had never participated in one of our research projects. With a total response rate of 60% we came to the following conclusions. The most important factors for general practitioners in deciding whether or not to participate in research were an interest in the topic concerned and the burden for patients and for the general practitioners themselves. Like Murphy and colleagues we found that the provision of information was an important factor influencing general practitioners' participation in research. The information provided in advance was often considered insufficient. Sixty per cent of the general practitioners considered it very important that they receive the final results of the study in which they had participated, while 37% felt the final results should be presented at a meeting. Approximately half of the general practitioners (46%) thought that reasonable remuneration for the extra work involved would be £15.00–30.00 per hour.

In conclusion, we agreed with Murphy and colleagues that more attention should be paid to communication between the researcher and the general practitioner involved in the study. Cooperation between research institutes and general practitioners demands a professional approach.

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Reference

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Working with social services departments

Sir,

We are concerned that poorly developed inter-agency cooperation may be hampering the implementation of the children act 1989. The document *Working together under the children act 1989* states that the protection of children requires a close working relationship between social services departments, the police service, medical practitioners, community health workers, schools, voluntary agencies and others.[1] As general practitioners and health visitors in a primary health care team we do not have a balanced working relationship with our local social services child and family team. We have a considerable workload with children on the protection register, and the geographical proximity of the health centre to the social services office allows the general practitioners to attend case conferences more frequently than doctors in many other localities.

The following is a description of some of the problems we have encountered. Our concerns about individual family situations seldom influence the decisions that are made, and we have detected little willingness on the part of the social services department to integrate other professionals' opinions into their decision making. Our referrals of families for preventive work are rarely acted on convincingly, lack of resources being cited as the predominant reason. We are concerned by the many dysfunctional case conferences we have attended: there is too great a focus on whether to place a child on the protection register, so inhibiting the drawing up of a wider child protection plan. Decisions at case conferences are made on insufficient information, while at other times indiscriminate or inappropriate information is provided. An insistence on voting for decision making is often divisive and inappropriate, as 'one person one vote' leads to the view of the social services department predominating. Case conferences become confrontational if opinions other than the prevailing view of social services are expressed, with chairpersons failing to facilitate the working together of different professions. There is scanty implementation of policies or procedures for working with parents in case conferences. We are also concerned that core groups (for example, a social worker, a health visitor and a general practitioner) can fail to work, with patchy and incomplete follow up of children.

While we have made representations at a local level to try to improve working relations with social services we do not feel this has been successful. Our approaches at a county level initially led to us being able to express our concerns but this, several months on, has not yet led to anything concrete. We therefore wish to ascertain whether other primary health care teams are experiencing similar problems in their working relationships with social services. If this is so we would welcome suggestions on how to progress towards a generalizable solution.

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Reference

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Aspirin and myocardial infarction

Sir,

The discussion paper by Dr Rawles presents a well argued discussion on the acute management of patients with myocardial infarction, with particular emphasis on recent advances relevant to general practice.[1]

Our only concern about this paper is the absence of reference to aspirin. The ISIS-2 trial demonstrated a 25% reduction in mortality when 160 mg aspirin was given within the first four hours of the onset of chest pain.[2] Birkhead demonstrated that for patients admitted with chest pain by their general practitioner the median time by which they received thrombolytic treatment was over four hours.[3] The ISIS-2 results demonstrate that the effect of aspirin is somewhat less when it is given more than four hours after the onset of chest pain.

It would therefore seem reasonable for all patients with suspected myocardial infarction to be given 150 mg of aspirin immediately when first seen by the general practitioner. This treatment is more likely to be acceptable to general practitioners than the administration of thrombolytics at this time. Further, the finding that patients are admitted substantially quicker if they call the ambulance themselves, suggests that the time may be right to consider whether aspirin should in fact be carried and given by ambulance crews.

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References

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James Mackenzie

Sir,

James McCormick (letters, June *Journal*, p.262) challenges the assertion in my Mackenzie lecture (February *Journal*, p.78) that coronary thrombosis, or myocardial infarction, was rare at the beginning of the century and was not described by James Mackenzie. This challenge is a repetition of that[1] issued to a previous Mackenzie lecturer, Walter Yellowlees, 14 years ago.[2]

Yellowlees' detailed response[3] provided much of the evidence supporting our contention (and that of Mackenzie's biographer, Professor Alex Mair[4] that myocardial infarction was only just becoming recognized at the time. It may be true that, as McCormick suggests, 'angina' included some cases of 'infarction'. However, the fact that Mackenzie, writing about angina, stated that 'there are cases in which angina pectoris develops with great severity and ends speedily in death. On the whole these cases are rare'[5] and 'great as the distress is which the pain produces, pain itself is in no sense a dangerous symptom'[6] suggests that, even if 'angina' included 'infarction', the latter was not common. Review of pathology reports for autopsies carried out at the London Hospital during the period 1908–13 (when Mackenzie was cardiologist there) indicated that, al-