LETTERS

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Cisapride to relieve dysphagia

Sir,

A case is reported of dysphagia in a patient suffering from a stroke which was greatly helped by cisapride.

An 81 year old man suffered a severe stroke associated with marked left sided facial paralysis, dysarthria and dysphasia. His condition progressed over one week to become a complete left sided paralysis. Initially his blood pressure was raised (220/120 mmHg), but settled without treatment to 140/75 mmHg. He is managed at home with the help of his family and medical support services.

After about four months he began to experience difficulty in swallowing which at that time apparently improved with a short course of metoclopramide syrup. His condition remained unchanged for about four years, when he again complained of difficulty in swallowing, with the sensation of food sticking in his oesophagus. His symptoms were quite marked and it was understood that they had essentially been present since his original stoke, although probably less severely. He was commenced on cisapride 10 mg three times daily before meals and at night. At review after four weeks' treatment he was much improved and according to the speech therapist he reported no swallowing difficulties. The patient has continued to receive regular cisapride for the last two years without recurrence of his symptoms.

Dysphagia is a common sequel to stroke particularly where there is a pseudobulbar palsy,[1] and it is often a difficult symptom to relieve. Although cisapride is most commonly used for disordered upper intestinal motility (for example dyspepsia and oesophageal reflux) it might well have a place in relieving symptoms referable to disordered pharyngeal motility, and thus perhaps reducing the risk of aspiration pneumonia.

I am aware of only one reference to the use of cisapride in patients with dysphagia (Awad R, abstract of the Dysphagia Research Society inaugural meeting, Milwaukee, United States of America, 1992). Three patients (two after proven stroke) who were receiving nutrition via a gastrostomy tube were given careful and full explanation of the principles of swallowing (biofeedback) together with cisapride 2.5 mg via the gastrostomy before breakfast. All three patients recovered their ability to swallow after a mean time of 56.6 days and continued to eat and drink normally for up to 33 months. It is difficult to know whether the biofeedback or the cisapride was the prime mover in these cases, but the cases highlight the need for further investigation.

Dysphagia is a common and unpleasant sequel to a stroke, and anything that helps to alleviate it is welcome.

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Reference

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Repeat prescribing for cystic fibrosis patients

Sir,

The National Audit Office report on National Health Service repeat prescribing expressed concerns that repeat prescribing, by its nature, carries a higher risk of drug wastage than acute prescribing.[1] It cited the statistic that 60% of prescriptions were repeat prescriptions. We are led to believe that tight controls over prescribing will reduce the drug budget without reducing the quality of patient care. Patients with cystic fibrosis have a continuous need for prescribed therapy.

A random sample of the 119 attenders at a Southampton cystic fibrosis clinic were sent a postal questionnaire asking how, when and where they obtained their pancreatic enzyme replacement therapy, how much they used, how much was prescribed, and how long it took them to obtain it. Eight out of 10 questionnaires were returned.

All patients routinely received their pancreatic enzyme therapy from their general practitioner rather than the hospital: two made their requests by telephone, five by repeat prescribing cards and one when consulting the general practitioner. It was found that a box of 50 capsules lasted a mean five days. Prescriptions were repeated a mean of 16 times per year. Six patients reported that repeat prescriptions were requested when stocks were reduced to one week's supply. Seven patients reported having been given insufficient quantities to cover their use on at least one occasion. Half of the patients had run out of medication on at least one occasion. At the time of the survey, patients reported having between nine and 52 days' supply of treatment. Two patients relied on their community pharmacist to dispense enzymes in advance of receipt of the prescription. Three patients also reported having to justify their need for a repeat prescription, and two had to account for every capsule taken. This was distressing for them since all patients are actively encouraged to alter their dose of enzymes depending upon their stool output and consistency.

Pancreatic insufficiency in cystic fibrosis results in a lifelong requirement for pancreatic enzyme replacement therapy. Modern enzymes have a shelf life of about two years, and cystic fibrosis patients were not found to hoard enzymes. The National Audit Office report recommends that drugs without side effects that require minimal observation during administration should be prescribed in larger quantities in the face of continuing patient need.[1] Prescribing a year's supply in 16 instalments cannot be justified on the basis of side effects or drug stability. Frequent dispensing would only be necessary if a patient's home had insufficient storage capacity. Pancreatic enzyme replacement therapy is therefore an ideal candidate for repeat dispensing, where the prescriber writes one prescription which is dispensed in instalments by the pharmacist.

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Research activity in general practice

Sir,

The Department of Health report *Research for health* states that 'the content and delivery of care in the National Health Service should be based on high quality research relevant to improving the health of the nation'.[1] General practice should be a logical place for such research to be carried out, since 90% of NHS health activity occurs exclusively within it.[2] However, little is known about the number of service general practitioners taking part in research. The Royal College of General Practitioners has suggested that both the quantity and quality of research in general practice should be improved[3] and evidence from the numbers of publications by service practitioners suggests that their involvement is limited.[4] Possible barriers to research have been identified as lack of time, patient cooperation and staff support.[5] With the increasing employment of practice nurses by general practitioners could a solution be to involve nurses in research?

In March 1991, a questionnaire sent to all senior partners in 259 practices in Birmingham Family Health Services Authority explored the amount of research being undertaken in general practice by asking whether practices take part in personal research, national studies, clinical therapeutic trials or any other types of research. They were also asked if they employed a nurse, if the nurse was involved in research, and what their attitude was to a research role for the nurse.

After a single reminder 219 practices (84.6%) responded. Of these, 136 (62.1%) stated that their practice took part in some form of research. Of those practices taking part in research (57.4%) were involved in a single area of research (Table 1). The clinical therapeutic trial was the type of research reported most frequently by practices (32.4% of practices were only doing these trials and 69.9% of practices were carrying out trials among other research activities).

Involvement in research did not differ significantly with size of practice, but practices with four or more partners were more likely than those with three or fewer partners to carry out personal research (68.4% of 19 versus 34.9% of 109; $\chi^2 = 6.27$, $P<0.05$).

Table 1. Type of research undertaken by practices.

Type of research	% of practices (n = 136)
CTT only	*32.4*
Personal/national/CTT	*15.4*
National surveys only	*13.2*
National/CTT	*13.2*
Personal research only	*9.6*
Personal/CTT	*8.1*
Personal/national	*4.4*
With other groups only	*2.2*
Personal/national/other	*0.7*
Personal/national/CTT/other	*0.7*

n = number of practices. CTT = clinical therapeutic trial.

The majority of the 219 responding practices (79.9%) employed at least one practice nurse and 79.5% of general practitioners thought that there was a research role for the nurse. For the 30 general practitioners who thought there was no role, the main reason given was that the nurse was already too busy. Although only 29.1% were already aided by the nurse in research, the more types of research undertaken by a practice the greater likelihood that the nurse was participating. In practices pursuing only one type of research 27% of 78 nurses assisted compared with 61% of 23 nurses in practices pursuing three or more types of research ($P<0.01$). Nurse participation was most common in practices conducting personal research (53% of 53) followed by clinical therapeutic trials (46% of 95) and national surveys (34% of 65). Of the 51 practices where a nurse assisted, the nurse's most common research involvement was in patient care (49%), performing diagnostic tests (37%) and general administration (26%).

Research among service general practices in Birmingham appeared to be extensive. However, much of the research activity was in clinical therapeutic trials or national surveys, which involve an essentially passive role in servicing other peoples' protocols and ideas. Personal research involves identifying the problem area, initiating the protocol design, organizing the project, involving and motivating other members of the practice team, and analysing and reporting the results. Nevertheless, 53 of the 219 practices responding (24.2%) were engaged in personal research projects. These results suggest that the number of publications by general practitioner authors does not reflect the true extent of general practice research. The extent of research activity compared with the low rate of publication points to the need for greater investment in research training for doctors and nurses in general practice.

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Telephone access in general practice

Sir,

Before we can assess the use and usefulness of the telephone in primary health care provision, the first issue to address is whether patients can make initial contact with the practice. If the telephone is often engaged, or the answering time unduly long, the public is likely to have a poor perception of the service, whatever the quality of health care subsequently provided. I was therefore pleased to see that Lesley Hallam made reference to this (August *Journal*, p.331) but surprised that a more objective method of assessing telephone access was not used.

A simple audit was devised to assess the telephone answering time for my practice of 8500 patients based in a health centre with three telephone lines. The advertised appointment number was called by someone with an unrecognizable voice three times each day at 08.30, 11.30 and 15.30 hours for a four week period. If the line was engaged, the number was redialled at five minute intervals until the ringing tone was obtained. The number of rings before the telephone was answered was recorded and the caller then asked a simple question which would not arouse suspicion among the reception staff. We were pleased to find that the line was answered within seven rings on 81% of occasions but were disappointed to discover that the line was engaged for 57% of first calls.

Following discussion with the staff, a number of changes were made, such as limiting the use of the telephone for outgoing calls at busy times of the day and training receptionists to deal with calls