

stressful at first but in fact seemed to focus better on problems when they arose although the population profile did not allow a controlled trial.

Responsibility for routine care and assessment of risk status is now jointly shared between the general practitioner and midwife. The protocols are continuously updated and the main principles of this project, now taking the Winterton report⁶ into account, are to be introduced into practices in Crawley and Horsham next year.

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'Mobile' patients

Sir,
The new contract for general practitioners included among its requirements that all new patients accepted or assigned to a list after 1 April 1990 should be offered a consultation to render personal medical services to the patient. Furthermore, specific details were required concerning past and present medical history, social and lifestyle factors, and health screening tests. In order to facilitate this process a revised 'new patient questionnaire' was developed for use in my practice of five partners, serving a population of 9950 patients.

A total of 103 new patients joined and left my practice in the first three years of this scheme. The information these clients provided on their questionnaire was analysed to assess the characteristics of this group of 'mobile' patients and their specific health needs.

Of the 103 'mobile' patients 50% were aged 16-25 years, 55% were women, 65% of 94 respondents were single, divorced, separated or widowed, and 45% of 94 respondents were unemployed. Almost half of these patients (43) smoked tobacco, one fifth (20) were obese,¹ and approximately one third (30) took no form of

exercise. Six patients admitted to excess alcohol consumption (more than 14 units per week for women and more than 21 per week for men) and two reported having abused drugs at some time. Twenty four had some degree of significant past medical history and over one third (38) were currently taking prescribed medication, most commonly the oral contraceptive pill.

One third of the patients (33) did not know if they required a tetanus immunization booster and over one half (58) were unaware of their poliomyelitis immunization status. One third of the women (19) did not know the date of their last cervical smear. Other important details such as rubella and rhesus status are not requested on the questionnaire.

It is possible to obtain useful information from this type of questionnaire. However, these patients represent a significant recurring workload within general practice, both administratively in assessing their current medical needs, and clinically to provide appropriate preventive and ongoing medical care. Their mobility may prevent them obtaining optimal care and make it difficult to achieve both practice based and *Health of the nation* targets. Additional administrative and clinical facilities may be needed for this small but important group, possibly including alternative medical records for which the client is responsible.

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Reference

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Treating nocturnal enuresis

Sir,
O'Dowd makes an admirable attempt to review the management of urinary incontinence in women (*October Journal*, p.426). However, he has not referred to the role of vasopressin analogues in the management of primary nocturnal enuresis. In patients for whom other causes of nocturnal enuresis have been excluded, the use of desmopressin via nasal spray or intranasal solution can prove to be revolutionary. The treatment must be used in accordance with data sheet instructions, and regular review with attempted withdrawal after three months is essential.

Within the boundaries described, the use of desmopressin has made a considerable improvement in the quality of life of

a number of my patients and should be mentioned in a review of urinary incontinence in women.

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Who will guard the guards themselves?

Sir,
I feel that Adrian Elliot-Smith (letters, November *Journal*, p.485) would be more usefully occupied if he complained about the parlous state of the National Health Service rather than grumbling about whether the president of the Royal College of General Practitioners should, in this learned journal, give the title his editorial in Latin.¹ The translation of this is already well known as it is a phrase of some note.

He grumbles about Latin being used as a 'secret code' between health professionals that alienates patients. Has he, for example, tried translating polymyalgia rheumatica into English?

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Fears of HRT

Sir,
The paper by Sinclair and colleagues (*September Journal*, p.365) debates the question of why more women who would benefit from hormone replacement therapy do not take up the offer of treatment.

From my experience the fear of breast cancer, not mentioned in this paper, is still the main cause of worry in a world where postmenopausal women all have friends and relations among the one in 12 who suffer from this disease. Reassurance that the incidence does not increase until at least five if not 10 years of treatment with hormone replacement therapy does not fully dispel the fear of increasing the risk of such a problem. Only continuing publicity from all sources will change this attitude.

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