Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Sleep and health

Sir,

The relationship between sleep and health should be of interest to general practitioners and is worthy of study within the general practice setting.

A study was undertaken in a three-partner urban general practice of 5000 patients. During one week in December 1991, a questionnaire about sleep patterns was handed out to 200 consecutive patients aged 16 years and over attending the surgery for any reason.

A total of 136 patients completed the questionnaire. Four potentially adverse features were identified from their responses: a reported sleep duration of ≥1 standard deviation above or below the mean; an above mean number of awakenings at night; a below mean reported sleep quality during the week of the survey; and reported proneness to sleep problems in general. Respondents' medical records for the previous 10 months were then inspected to identify those with any of the following three features: an above mean consulting rate; a tendency to musculoskeletal pain, as shown by a consultation for musculoskeletal pain without injury, or a prescription for oral non-steroidal anti-inflammatory drugs; and a tendency to psychological problems, as shown by a history of any psychological problem except insomnia, or a prescription for a psychotropic drug. Relationships between features of sleep and medical features were investigated using the chi square test.

Clear and significant associations between the four sleep items, and the three medical record items were found (Table 1). Although only 5% of the subjects had sought advice for insomnia, 43% admitted that they were sometimes prone to sleep problems.

Poor sleep is related to poor health,[1,2] and there is evidence of a triangle of three inter-related problems: poor sleep, depression and musculoskeletal pain.[3,4] Poor sleep may sometimes be the feature most easily accessible to treatment. If poor sleep is related to poor health, does poor sleep as a primary (and potentially treatable) problem cause poor health? Can general practitioners improve their patients' general health by helping them to sleep better? At what age do poor sleep patterns become established? Can a brief intervention by the general practitioner in a young patient lead to better life-long health?

Patients' subjective opinions of their sleep patterns are not always reliable, but they do have value and interest.[5] Doctors should not be afraid to ask about their patients' sleep habits, and should take a complaint of poor sleep seriously. Satisfactory sleep may be one of the major factors determining the quality of patients' lives.

V P SMITH

Lyngford Park Surgery
Fletcher Close
Taunton
Somerset TA2 8SQ

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Referred pain in pelvic metastatic disease presentation

Sir,

In rheumatological practice it is recognized that knee pain may reflect locomotor disease in the hip, pelvis or lumbar spine.[1-3] However, review of the literature suggests that such a presentation in malignant disease is not well documented. We present three cases.

In the first case, a 65-year-old woman with bronchial carcinoma was referred to the hospice having become bed-bound in the previous four weeks owing to knee pain. A knee x-ray arranged by her general practitioner was normal. There was

Table 1. Relationship between features of sleep and medical features.

	% of patients who were		
	High consulters	Prone to musculo-skeletal pain	Prone to psychological problems
Mean duration of sleep			
<1 SD (*n* = 99)	*29*	*35*	*13*
≥1 SD (*n* = 37)	*51**	*43*	*32***
No. of night awakenings			
Below mean (*n* = 67)	*27*	*19*	*16*
Above mean (*n* = 69)	*43**	*32**	*20*
Sleep quality			
Above mean (*n* = 65)	*28*	*25*	*8*
Below mean (*n* = 71)	*42*	*49***	*28***
General sleep problems			
Not prone (*n* = 78)	*33*	*26*	*9*
Prone (*n* = 58)	*38*	*53****	*31***

n = number of patients in group. **P*<0.05, ***P*<0.01, ****P*<0.001. SD = standard deviation.

slight tenderness over the right hip, but no abnormality of the back was detected. Pelvic pathology was suspected and radiology of the pelvis confirmed this, showing a large lytic area extending from the ilium through the acetabulum into the upper posterior part of the ischium. She received palliative radiotherapy to the right acetabulum for pain relief and was discharged home a few days later free of pain and mobile. She died six weeks later at home having had no recurrence of this problem.

In the second case a 70-year-old woman with bronchial carcinoma was referred to the hospice for assessment. Shortly after admission she developed left thigh pain associated with a deterioration in mobility. Pelvic disease was suspected and radiology of the pelvis showed extensive erosion of the medial aspect of the left ilium and a lytic area within the inferior pubic rami, consistent with metastatic disease. She received palliative radiotherapy to the left side of the pelvis with marked symptomatic improvement and was discharged home where she lived independently until shortly before her death one month later.

In the third case a 71-year-old man with bladder carcinoma was admitted to the hospice with rapidly deteriorating mobility owing to pain in his right knee and lower medial thigh. The pain was precipitated by movement. Prior to admission he had been able to walk and dance despite a mild right hemiparesis following a stroke 18 years previously. Examination of the knee, hip and back revealed no obvious abnormality. General examination revealed a mild residual right hemiparesis. Radiology of the knee and femur was normal; however pelvic x-ray showed bony destruction of the right acetabulum consistent with metastatic disease. Palliative radiotherapy to the metastases was planned with the aim of pain relief and restoration of mobility. However, his general condition deteriorated and he died before this could be carried out.

In these cases, pelvic metastatic disease presented as referred pain to the knee in two patients and to the thigh in one patient. Recognition of this promoted palliative radiotherapy which was effective in alleviating pain and restoring mobility to two of the patients, allowing them to return home. This was clearly worthwhile, producing improvement in their quality of life even though their prognosis was limited.

It is essential to consider the possibility of more distant disease and to examine and x-ray the hip and lower spine when patients present with knee or thigh pain, especially if they have no obvious local abnormality. As we have shown, this has important therapeutic implications.

KATHLEEN L SHERRY
ELAINE MORRISON
JAMES S ADAM
JOHN WELSH

Hunters Hill Marie Curie Centre
Belmont Road
Springburn
Glasgow G21 3AY

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Reaccreditation

Sir,

Reaccreditation is being considered by general practice leaders at present, but may not be popular among trainees. These motivated young professionals, coming to the end of formative and summative assessment programmes are preparing to enter general practice at a time where change and uncertainty are the only certainties. Could reaccreditation be made more acceptable to them by employing the Leicester assessment package (March *Journal,* p.109), thereby building on their newly acquired (and all too well tested) skills?

Stanley and Al-Shehri highlight the difficulties encountered in the 'how' question of reaccreditation.[1] They are rightly uncertain about measuring competence; measurement of performance against a guideline comprising the 39 separate competences of the Leicester assessment package would be reassuring and would form a suitable benchmark, especially as its face validity has been established. If utilized with video recordings of doctors' consultations in a surgery, such a package would blend seamlessly into Stanley and colleagues' model of experiential learning.[2]

England's chief medical officer is keen for the profession to take responsibility for its self regulation.[3] I hope someone will direct the chief medical officer towards the Leicester assessment package which offers great potential as a tool which will be acceptable to, and feasible for the reaccreditation of, all general practitioners, but especially to the decreasing numbers of trainee general practitioners when upgrading to principal status.

DAMIAN MCHUGH

Market Street Surgery
40 Market Street
Heywood
Lancashire OL10 4LY

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Counselling in general practice

Sir,

I was interested in the comments expressed in the editorial by Salinsky and Jenkins (May *Journal*, p.194) and in the work of King and colleagues (p.229).

It is good practice to refer to counsellors those patients who may have, for example, marriage difficulties or drug-related problems, because they will receive both specialized and well-informed help and advice. However, my work on the 'heartsink' issue in general practice suggests that general practitioners may often use counsellors for the wrong reasons, and that the issues associated with the difficulties in providing health care have not been confronted. For many reasons heartsink relates to a relationship problem between a general practitioner and a patient, and the patients involved do not necessarily have psychiatric morbidity, social problems or a family or life crisis.[1,2] General practitioners, particularly those new to practice, have accepted that limitations in their medical training, their own stress and tiredness, and clinical uncertainty are an important part of the problem.[3,4]

These findings have important implications for the future of counselling in general practice. First, the problems associated with heartsink cannot be passed to a third party. Balint's concept of the 'collusion of anonymity' would once again raise its ugly head,[5] and furthermore, more questions than answers would arise. Is it correct to assume that counsellors will not face the same problems? What happens when counselling fails? Would some