

LETTERS

Shared care of patients with a neuropathic bladder <i>P Sett, et al</i>	532	Diabetic patients' recommendations for better care <i>Trevor Guppy and Michael Hall</i>	534	Prescribing antidepressants <i>David C Lloyd</i>	536
Food intolerance and baby food <i>F B Coward and R M Quinlivan</i>	532	Community pharmacy <i>Steven Ford</i>	534	Assessing inhaler fullness <i>Michael Wilcock</i>	536
Helping asthma patients to stop smoking <i>D A Fitzmaurice and C P Bradley</i>	533	Leicester assessment package <i>G A Rutt; L M Campbell and T Stuart Murray</i>	535	Part-time training in general practice <i>Denis Pereira Gray</i>	536
Trainees' out of hours work <i>Elizabeth Goyder and Barbara Kneale</i>	533	Treatment of drug misusers <i>John Strang, et al</i>	535		
Stinging nettles for osteoarthritis pain of the hip <i>C F Randall</i>	533			Note to authors of letters: Please note that all letters submitted for publication should be typed with <i>double spacing</i> . Failure to comply with this may lead to delay in publication.	

Shared care of patients with a neuropathic bladder

Sir,
Even though the prognosis of traumatic cord injury continues to improve, the prevalence of the condition is rare and any one general practitioner is only ever likely to care for one or two such patients during his or her career. However, the management of the urinary tract after traumatic cord injury has many features in common with that of other neurological or disabling diseases. There is no single correct way of managing the bladder in these patients. The bladder management on discharge from hospital may be found subsequently to be inappropriate. The general practitioner should be aware of the principles of management of the neuropathic bladder and the reasons for change in management.

Between January 1989 and December 1990, 141 adult patients were discharged from the National Spinal Injuries Centre at Stoke Mandeville Hospital after their first admission following spinal injury. Twenty were excluded from the study (13 were lost to follow up, two died and five had no neurological deficit). The remaining 121 patients were reviewed 14 to 37 months (mean 27 months) after discharge.

Their bladder management on discharge from hospital fell into five categories. The 40 patients with neither appliance nor catheter had incomplete cord injuries with some preservation of motor or sensory function below the lesion. None of this group changed their management during the follow-up period. The other four categories of management were: penile sheath (39 patients), indwelling suprapubic catheter (28), indwelling urethral catheter (four) and intermittent catheterization (10) (usually by the patient).

Of the 121 patients reviewed, 16 changed their bladder management. Five using penile sheath drainage and one with a suprapubic catheter regained continence and dispensed with catheters and appliances altogether. Two using penile sheath

drainage, two with indwelling urethral catheters and one using intermittent catheters changed to suprapubic drainage for reasons of retention, incontinence or recurrent infections. Five other patients with suprapubic catheters changed to penile sheath drainage (three) or indwelling urethral catheters (two) because of problems with blockage or leaking around catheters.

The message for the general practitioner is that whatever method of bladder management is prescribed it may need to be altered for a variety of reasons which includes improvement in bladder function. Self intermittent catheterization is popular with many patients provided they have wheelchair access to a toilet or place of privacy.

Bladder management for people with motor and sensory disability lends itself to shared care between hospital and general practitioner and close cooperation between the two parties is essential.

P SETT
D WANG
G J FELLOWS
B P GARDNER

National Spinal Injuries Centre
Stoke Mandeville Hospital
Mandeville Road, Aylesbury
Buckinghamshire HP21 8AL

Food intolerance and baby food

Sir,
A recent paper has estimated that 1.4% of the adult population in the United Kingdom have clinically significant symptoms related to food intolerance.¹ Food intolerance is more common in young children and the early introduction of certain proteins can lead to the onset of allergy in susceptible individuals.²

For this reason the Health Education Authority information leaflet published for parents correctly advises starting

solids with single ingredients from four months of age. It advises that certain foods — cows' milk, wheat, eggs, citrus fruits and nuts — be withheld until at least six months of age because of their potential allergenic properties.³ No specific mention is made of soya, fish and tomatoes which also commonly cause problems.⁴

For use with our own children, we obtained ingredients lists of infant foods from the major manufacturers and examined content labels of other brands as available. Few single ingredient preparations, particularly of vegetables, were available.

Baby foods labelled as suitable 'from three months' contained up to seven ingredients, most commonly skimmed milk powder, soya, wheat, citrus juices and tomatoes. Such mixtures make it more difficult to determine the cause of any intolerance reaction provoked. As they may be bought even in pharmacies, many parents may not realize that they are often inappropriate for babies under six months of age.

In the United States of America and some parts of Europe, we found only single ingredient foods of low allergenicity marketed for young infants. This policy is accompanied by consistent weaning advice from both medical and lay sources; the products sell well.

We are concerned that susceptible babies are being placed at an unnecessarily early risk of developing unpleasant allergic symptoms and even anaphylaxis.² It is our responsibility, as health professionals, to provide weaning advice to parents and to encourage the manufacture of more suitable baby foods.

F B COWARD

The Oaks
16 Broadwater Close
Walton on Thames KT12 5DD

R M QUINLIVAN

Department of Paediatrics
Guy's Hospital
St Thomas Street
London SE1 9RT

References

1. Young E, Stoneham MD, Petrukevitch A, *et al.* A population study of food intolerance. *Lancet* 1994; **343**: 1127-1130.
2. Sampson HA, Scanlon SM. Natural history of food hypersensitivity in children with atopic dermatitis. *J Pediatr* 1989; **115**: 23-27.
3. Health Education Authority. *From milk to mixed feeding [information leaflet]*. London: HEA, 1993.
4. Lessof MH. Food reactions. In: Royal College of General Practitioners. *1992 members' reference book*. London: Sabrecrown, 1992.

Helping asthma patients to stop smoking

Sir,

The management of asthma has two basic components, pharmacological and educational.^{1,2} The pharmacological component comprises ensuring that patients receive appropriate medication, usually in the form of inhalation therapy, and ensuring that the most appropriate delivery system is used.¹ The educational aspect usually centres around ensuring correct and appropriate use of inhaler devices, with information also given regarding the pathophysiology of the disease, the therapeutic effects of any medication prescribed, and general advice regarding avoidance of trigger factors.²

Smoking is well recognized as a major cause of respiratory morbidity and mortality. While smoking undoubtedly plays a role in the pathophysiology of asthma, there has been surprisingly little work to measure this.³⁻⁶ There are no reliable figures for the number of asthma sufferers who smoke, and whether interventions aimed at decreasing smoking levels in this group can improve control of asthma.

Between June and August 1993, asthma sufferers in an inner city general practice were surveyed regarding their smoking habits. The practice is a five partner inner city practice which has an asthma clinic supervised by a practice nurse trained in asthma management. The list size is 6788 patients. Using the practice computer, 258 asthma sufferers between the ages of 16 and 65 years were identified. The notes of these patients were tagged and a simple questionnaire inserted. These questionnaires were completed opportunistically by the doctors or practice nurses. A total of 110 questionnaires were completed over a three-month period. Of the 110 respondents 35.5% admitted smoking while 71 (64.5%) said they did not smoke. Twenty five of the 39 smokers said they would like to give up (64.1%). As a result of this study, a stop smoking clinic was instituted specifically aimed at asthma sufferers. This was unsuccessful as only one person agreed to attend the clinic. This highlights the problems associated with attempting to educate patients with chronic respiratory disease to stop smoking.

If the number of asthma sufferers who smoke really is in the region of 30%, more education should be directed at getting people with asthma who smoke to stop; and if a reduction in the number of asthma sufferers who smoke could reduce the need for medication, this would have profound economic implications. Our study, however, suggests that persuading people with asthma to stop smoking will not be easy.

D A FITZMAURICE

C P BRADLEY

Department of General Practice
University of Birmingham
The Medical School, Edgbaston
Birmingham B15 2TT

References

1. Horn CR. Compliance by asthmatic patients — how much of a problem? *Res Clinical Forum* 1986; **8**: 47-48.
2. Charlton I, Charlton G, Broomfield J, Mullee MA. Audit of the effect of a nurse run asthma clinic on workload and morbidity in general practice. *Br J Gen Pract* 1991; **41**: 227-231.
3. Forero R, Bauman A, Young L, Larkin P. Asthma prevalence and management in Australian adolescents: results from three community surveys. *J Adolesc Health* 1992; **13**: 707-712.
4. Bakke PS. Course of obstructive lung disease. *Tidsskr Nor Laegeforen* 1993; **113**: 177-181.
5. Oosterhoff Y, de-Jong JW, Jansen MA, *et al.* Airway responsiveness to adenosine 5' monophosphate in chronic obstructive pulmonary disease is determined by smoking. *Am Rev Respir Dis* 1993; **147**: 553-558.
6. Murray AB, Morrison BJ. The decrease in severity of asthma in children of parents who smoke since the parents have been exposing them to less cigarette smoke. *J Allergy Clin Immunol* 1993; **91**: 102-110.

Trainees' out of hours work

Sir,

Out of hours work and night visits remain a major cause of concern among trainees as well as principals in general practice.¹ Informal discussion with trainees reveals wide variation between training practices in rotas and in support from trainers. In the hope of promoting further debate a postal survey was undertaken of Leicestershire vocational training scheme trainees in general practice in January 1994. The questionnaire comprised open and closed questions, which sought information on practice arrangements, and trainees' views and experiences. Of 25 trainees, 21 replied (84%).

Rotas ranged from being on call one night in three to one in 13, or not at all, with all but four trainees doing the same rota as trainers. Two trainees claimed to be doing more time and two trainees claimed to be doing less time on call than their trainers or practice partners. Twenty four per cent of trainees were in practices which used deputies to some extent, including one practice which used them for practice partners but not for the trainee.

Of 21 trainers, 57% had never accompanied their trainees on night visits; 29% had done so on the first night only. Of trainees 71% felt they had gained valuable experience and 76% were happy with their out of hours commitment. However, 86% felt they should receive some form of payment, as currently night visit fees earned by trainees are paid to their practices.

The main priorities identified from this survey are the need for standards to be set for the proportion of out of hours work done by trainees, and for the level of support trainees should be able to expect. There was agreement among trainees that this work represents valuable educational experience and it would be encouraging to see this acknowledged and developed by the Royal College of General Practitioners. We would welcome any further views from both trainees and trainers.

ELIZABETH GOYDER

BARBARA KNEALE

200 Fosse Road North
Leicester LE3 5ET

Reference

1. Hallam L. Primary medical care outside normal working hours: a review of published work. *BMJ* 1994; **308**: 249-253.

Stinging nettles for osteoarthritis pain of the hip

Sir,

I would like to report a case of a patient using stinging nettles (*Urtica dioica*) as a treatment for pain from osteoarthritis of the hip.

I saw the man at the end of April 1994 who had been complaining of pain over the left hip joint for the previous six months. This had made it difficult for him to walk up hills and he had been unable to ride a bicycle as previously. Apart from that, he was a fit man for his 81 years of age and still took part in local amateur dramatics. I referred him for an x-ray of his hip and prescribed ibuprofen tablets. The x-ray showed definite osteoarthritis and joint space narrowing. He returned to see me in mid-July to inform me that the prescribed tablets had been no help, but in recent weeks he had been applying stinging nettle leaves to the region of his left hip. It had produced a remarkable improvement. In fact, he had been almost free of pain for some weeks and now only had to apply the stinging nettles every few days. He was able to stand on either leg and was riding his bicycle up to 10 miles a day with no pain.

I have since spoken to an elderly woman who for years has successfully