References

1. Young E, Stoneham MD, Petruckevitch 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.

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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.

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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