

up, and could be reproduced anywhere. Patients are recruited from three practices and the exercise sessions take place in the gymnasium of the local community college. Patients pay the cost of one prescription, which entitles them to 10 exercise sessions. Sessions are run on weekday evenings by a trained fitness adviser, who is advised by the referring general practitioner of the indication for exercise, and given any relevant medical information. No age limit is set on participation, and conditions referred range from patients with coronary heart disease and obesity to patients with anxiety and depression.

Two courses have now been completed and a third is oversubscribed. The drop-out rate so far is five out of 75 patients referred. Post-course questionnaires have shown high levels of satisfaction. For example, respondents highlighted areas in which the scheme had helped: weight loss, having been helped socially, stress relief, better awareness of body shape, improved strength, and reports that the course had been educational. Most encouraging is that a group of patients who have completed the course continue to meet for exercise, having hired the gymnasium and the fitness adviser themselves.

This scheme has aroused considerable interest in the community, and has been reported in the local media. We commend it to others.

RICHARD AYRES

South Molton Health Centre
East Street
South Molton
Devon EX36 3BZ

EMMA POCOCK

Sport and Recreation Department
North Devon District Council
Civic Centre
Barnstaple EX31 1EA

References

1. Wannamethee G, Shaper AG. Physical activity and stroke in British men. *BMJ* 1992; **304**: 597-601.
2. Kannel WB, Belange A, D'Agostinor R, Israel I. Physical activity and physical demand on the job and risk of cardiovascular disease and death. The Framingham study. *Am Heart J* 1986; **112**: 820-825.
3. Law MR, Wald NJ, Mead TW. Strategies for prevention of osteoporosis and hip fracture. *BMJ* 1982; **303**: 453-459.
4. Campbell MJ, Brown D, Waters W. Can general practitioners influence exercise habits? Controlled trial. *BMJ* 1985; **290**: 1044-1046.
5. Iliffe S, Tai SS, Gould G, *et al.* Prescribing exercise in general practice: look before you leap. *BMJ* 1994; **309**: 494-495.

Diagnostic delay in appendicitis

Sir,

Perforation of the appendix is common in young children, the main contributing factor being diagnostic delay owing to non-specificity of symptoms or signs.¹ A retrospective study was undertaken to determine how often general practitioners contribute to delayed diagnosis in young children with acute appendicitis, and the consequences of such delay.

The hospital records of all 100 cases of clinically suspected appendicitis in preschool children (aged five years or less) in the greater Belfast area from 1985 to 1992 were reviewed. Acute appendicitis was confirmed histologically in 81 children. Fifty eight patients were assessed by a general practitioner; appendicitis was suspected in 39 children at the first consultation and these children were referred for surgical opinion, the diagnosis being confirmed in 36 (92%). Of the 19 children not referred initially for a surgical opinion, five were reviewed by the general practitioner within 24 hours then sent for surgical opinion and appendicitis being correctly diagnosed in four. Five of the cases not referred initially were admitted to the regional infectious diseases unit with suspected gastroenteritis, of whom two had simple appendicitis and three had appendiceal perforation. All of the remaining nine children were 'self-referred' to hospital; three had appendicitis and one had appendiceal perforation.

Appendiceal perforation was found in 35 of the 100 cases. The greatest contributing factor was considered to be diagnostic delay as this was the only significant difference found between the groups with and without appendiceal perforation. The mean duration from onset of symptoms to surgery in the group with appendiceal perforation was 77 hours compared with 45 hours in the group of 46 children without appendiceal perforation (chi square = 4.3, 1 degree of freedom $P < 0.05$). In 19 cases where delay was attributable to the general practitioner, symptoms or signs were non-specific: diarrhoea (10 cases), dysuria (four), respiratory infection (two), constipation (two) and tonsillitis (one). In this group, four (21%) had perforated appendicitis compared with 49% of the 39 children referred following the initial consultation.

The population of greater Belfast is served by 314 general practitioner principals (Eastern Health and Social Services Board statistical data, 1990). Thus a general practitioner would expect to encounter a case of preschool appendicitis once in 27 years.

General practitioners do not contribute unnecessarily to the high rate of appendiceal perforation in young children and, indeed, given the low incidence of the condition in this age group, diagnostic accuracy was high. However, it should be noted that nine children were 'self-referred' to hospital after being assessed by a general practitioner and it seems that the traditional dictum of early reassessment of cases of abdominal pain in this age group not referred to hospital was not observed. We would reinforce the wisdom of the principle of reassessment.

D WILSON

W A MCCALLION

132 Upper Newtownards Road
Belfast BT4 3EQ

Reference

1. Rappaport WD, Peterson M, Stanton C. Factors responsible for the high perforation rate seen in early childhood appendicitis. *Am Surg* 1989; **55**: 602-605.

Urban community hospitals

Sir,

Acute medical admissions to hospital are increasing (by 13% per year in Exeter, unpublished data). Surveys suggest that up to 16% of these admissions do not require the additional resources available in a district general hospital.^{1,2} One proposed solution is to use community hospitals for this group of patients. The presence of a rural community hospital has been linked with decreased admissions to an acute hospital,³ but this may reflect the type of general practitioner who practises in such an area. Indeed, an experimental urban community hospital had little success in attracting general practitioners to use it.^{4,5} Therefore, before an urban community hospital is established in an area which has never before had such a hospital it is important to determine general practitioners' opinions.

All general practitioners practising in Exeter were surveyed to assess their views about an urban community hospital and to examine whether it was a realistic solution to relieving pressure on district general hospital beds. Questions were asked about interest in a community hospital and categories of patients suitable for the hospital.

In June 1994, 76 questionnaires were sent of which 72 were returned (95%). Of general practitioners, 49% were very or moderately interested in having a community hospital, 17% were neutral, and 35%

uninterested. However, 53% indicated they would use such a hospital if provided, 29% would probably or possibly use it and 18% would be unlikely or very unlikely to use it. No correlation was found between doctors' age, sex or practices fundholding status and level of interest. Use of community hospital as an out-of-hours centre attracted the support of 83% of doctors.

Of all 72 general practitioners, 78% indicated they would admit patients to an urban community hospital for respite care (82% of the 38 general practitioners who had reported they would use a community hospital); 75% of all doctors indicated they would admit patients for social reasons (74% of 38 doctors); 64% of all doctors would admit elderly acute medical patients (79% of 38 doctors); 60% would admit patients for observation, assessment and simple investigation (77% of 38 doctors); 50% would admit early hospital discharges following surgery (56% of 38 doctors); 50% would admit patients for terminal care (59% of 38 doctors); and 47% of all 72 doctors would admit early hospital medical discharges (56% of 38 doctors).

The high response rate reflects the relevance of the topic, although only half (49%) of general practitioners were in favour of a community hospital. They proposed positive primary health care reasons for their support, for example respite care. Therefore, such a hospital may attract different patients than are currently admitted to district general hospitals. The high proportions of general practitioners stating that they would use a community hospital for social and respite care suggest that these are not readily available at present, and indicate that community services are underused or perhaps underprovided. However, where a community hospital is to be built, a firm admission and discharge policy would need to be maintained to ensure appropriate bed usage.

An urban community hospital would provide services not now available, rather than being an alternative to district general hospital admission. This means that relatively small savings of bed days in a district general hospital could be anticipated.

WILLIAM HAMILTON

Barnfield Hill Surgery
12 Barnfield Hill
Exeter EX1 1SR

ALISON ROUND

Department of Public Health
Exeter and North Devon Health Authority
Exeter EX1 1PQ

References

1. Victor C, Nazareth B, Hudson M, Fulop N. The inappropriate use of acute hospital beds in an inner London district health authority. *Health Trends* 1993; **25**: 94-97.
2. Coast J, Inglis A, Morgan K, et al. *The hospital admissions study. Final report* Bristol: Health Care Evaluation Unit, University of Bristol, 1994.
3. Baker JE, Goldacre M, Gray JA. Community hospitals in Oxfordshire: their effect on the use of specialist inpatient services. *J Epidemiol Community Health* 1986; **40**: 117-120.
4. North N, Hall DJ, Kearns W. First year of an inner city general practitioner hospital. *BMJ* 1984; **288**: 1209-1211.
5. Victor CR. End of an experiment: report from an inner city community hospital. *J R Coll Gen Pract* 1988; **38**: 407-410.

Reducing benzodiazepine usage

Sir,

Having read the paper by Cormack and colleagues on reducing benzodiazepine use among patients by sending them a simple letter,¹ I performed the same exercise on my own list of patients who regularly used benzodiazepines, after first screening out those I considered to be unsuitable for the intervention.

I undertook this exercise in February 1994 and, on review in January 1995, I found that the number of regular users of benzodiazepines has been reduced from 108 to 94, some 13%, with very little extra work and mainly positive feedback from patients. This result is confirmed from prescribing analyses and cost (PACT) figures and repeat prescribing computer analysis. My practice partners' benzodiazepine prescriptions have been static over this time.

As a result, we are extending the letter to include all regular benzodiazepine users in the whole practice of 11 500 patients.

R M WYLIE

The Church Lane Surgery
24 Church Lane
Brighouse
West Yorkshire HD6 1AT

Reference

1. Cormack MA, Sweeney KG, Hughes-Jones H, Foot GA. Evaluation of an easy, cost-effective strategy for cutting benzodiazepine use in general practice. *Br J Gen Pract* 1994; **44**: 5-8.

Bereavement care

Sir,

Following the publication of the paper by Robinson and Stacy on setting guidelines

for palliative care,¹ the question of bereavement care was addressed at a primary care team meeting in the practice. Three areas of interest arose out of the discussion.

First, attention was focused on those who had recently been bereaved. Should they be offered a visit, and if so by which member of the team? After a death, when would be the best time to visit a bereaved person? Should such people receive a booklet with information on death and grief? This produced lively dialogue, but no consensus. Therefore, following the meeting, the number of deaths over the last year was extracted from the practice computer. In a practice population of 12 000 there were 95 deaths. In 40 cases there was no identifiable survivor. Of the remaining 45 cases, a doctor or nurse had made contact with 37 survivors since the patient's death, and knew of their progress, leaving eight whose progress was unknown. It was decided to repeat the exercise every six months in order to examine the care that was being offered, and to develop a protocol.

Secondly, it was sometimes found that a patient's current problem was related to past, unresolved grief. Such revelations usually came towards the end of a consultation, when there was little time to explore the issues adequately. There was a need for a counsellor to take quick referrals. Each patient could be limited to four one-hour sessions over four weeks. From special family health services authority funds a bereavement counsellor was employed, and saw five patients in the first month. All were seen within 10 days of referral, and each stated it was of great benefit.

Thirdly, it became obvious that we as health professionals were not at ease with death. Education and training in grief was considered to be the most effective way of improving the bereavement care of patients. This suggestion was warmly received by all staff, and dates were arranged for training sessions.

Where there is enthusiasm and goodwill in a primary health care team, improvements in bereavement care can be initiated, with the benefit of helping both patients and the team.

CRAIG K BROWN

West Court
12 The Street
Rustington
West Sussex BN16 3NX

Reference

1. Robinson L, Stacy R. Palliative care in the community: setting practice guidelines for primary care teams. *Br J Gen Pract* 1994; **44**: 461-464.