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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.

Glaucosa screening

Sir,

I read with great interest the paper by Sheldrick and Sharp on glaucoma screening that showed the value of non-specialist screening of a whole practice population aged 55 years and over.1

In our large study we also found that the rule of halves apply — only half of the true glaucoma cases are currently diagnosed. We also found that field testing could not be selectively performed on only those with high intraocular pressures (>22 mmHg) without unacceptable loss of sensitivity.

Unlike Sheldrick and Sharp, we found Damato oculokinetic perimetry (OKP) useful and reliable. We were able to perform OKP testing in nearly 1700 patients aged 55 years and over with only 83 patients (approximately 5%) unable to complete the test. This compares with 10% who were unable to complete the test in Sheldrick and Sharp's study.1 More importantly, only 12% of our patients completing the OKP and Pulsair (air puff tonometry) screening needed further assessment, compared with 25% in the OKP phase of the study by Sheldrick and Sharp.1

Sheldrick and Sharp referred all 115 patients, falling into categories defined by Vernon and colleagues2 for hospital assessment but 65 of these were found to be normal. In addition, only two cases of cataract were found. Of our 80 referrals to hospital, only six were normal. Their high false positive rate may reflect the very high sensitivity of the Humphrey visual field analyser, and the learning curve patients show on testing.3 With adequate explanation, good illumination and attention to patient eye movements, the OKP chart has shown its value in screening in other settings.4,5 A visual field defect identified by OKP is less likely to disappear on retesting or to be trivial. Although less sensitive, OKP had advantages in our study of being quicker and cheaper and of having a lower false positive rate (and to date no false negatives).

Oculokinetic perimetry enabled full screening involving relevant history, Snellen acuities, Pulsair tonometry and OKP testing of both eyes to be done in 6–12 minutes (mean 8.8 minutes) by a non-specialist practice nurse. The increased speed of testing and the reduced capital costs involved in using OKP rather than Humphrey visual field testing makes this type of screening more feasible and less costly than the method used by Sheldrick and Sharp. Our finding of 19 new cases of glaucoma added to the 17 known before the screening programme compares with Sheldrick and Sharp’s 14 new cases added to 11 previously known. We also found 12 cases of ocular hypertension and 24 cases of cataracts causing visual field loss.

The need for cost effectiveness is heightened by the ending of funding of health promotion clinics. Practices may be unable to justify the capital investment required for glaucoma screening suggested by Sheldrick and Sharp or the time spent by nurses in screening. Our work suggests that comparable results can be obtained more cheaply and quickly using OKP field testing combined with Pulsair tonometry.

The more fundamental question of how whole populations can be actively screened for glaucoma by optometrists who have the skills and the equipment but no age-sex registers remains unanswered. Cooperation between family health services authorities, optometrists and hospitals could improve the chances of early diagnosis for this blinding condition. Until this happens, our patients are fortunate in benefiting from low cost general practitioner based screening using OKP.

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References


Differentiating minor from serious illness in infants

Sir,

The study by Holme (February Journal, p.65), reports that between 67% and 99% of infants’ health problems were managed by parents without health visitor or general practitioner consultation. In assessing the severity of illness in infants there could therefore be value in using a tool that incorporates physical signs as well as symptoms. ‘Baby check’ devised by Morley and colleagues1 is such a tool and has been reported to help identify serious illness before sudden infant death.2 Acceptability of its use was demonstrated among a sample of parents biased towards the higher socioeconomic groups.3

We have recently carried out a study (supported by a grant from the Clare Wand Fund of the British Medical Association) in our own practice, which is located in a deprived area of west Belfast. We identified 55 mothers of babies aged under six months. Two mothers declined to participate and 19 could not be contacted; the remaining 34 mothers agreed to participate. They received an information booklet and agreed to complete the baby check card for symptoms and physical signs in their babies once a week for four weeks and were subsequently interviewed. No difficulties were reported in observing
Drug abuse and homelessness

Sir,

Patients with problems of drug abuse or homelessness are an everyday part of urban primary care but little has been written in the United Kingdom about the association between the two.

In the United States of America Herman and colleagues found that 46% of substance-addicted patients with mental illness in New York were homeless,1 and Spinner and Leaf found that 45% of a sample of homeless people in Connecticut were abusing drugs.2 In my practice in East London I have been treating 44 patients, mostly heroin users, on a long-term drug abuse management programme over the last four years. Of these patients, 17 (39%) are or have been homeless, which is in line with the work from the USA.1,2 Social chaos, that is, the presence of two or more out of the following three factors: long-term unemployment, lack of a relationship with a non drug abusing person or erratic outbursts towards self or others, is a marker of problems relating to other people. Social chaos was present in 26 of the 44 drug abuse patients in my practice (59%).

It was considered that a clinical outcome had been reached where a patient had stopped using opiates completely, had reached a maintenance dose of methadone with no further reductions in a 12-month period, or had left the prescribing programme before reaching one of these points. Patients were not included in the outcome data when, for example, they had only attended one appointment in the drug abuse management programme.

Thirty-five patients have reached an outcome, 23 using the programme for positive change and 12 being unable to use the programme for positive change. There was a significant association between presence of social chaos and outcome. Of the 23 patients with a positive outcome, social chaos was present in eight, and of the 12 patients with a negative outcome, social chaos was present in 11 (Yates variant of the chi square test, P<0.01). No trend or association was found between homelessness and outcome. This runs counter to the conclusions of McCarthy and colleagues who consider housing provision to be essential in order to support and maintain recovery.3

Outcomes are hard to interpret, and the numbers reported here are small. However, these data may suggest that for drug abusers who are socially and psychologically damaged the need to form meaningful human interactions is even more fundamental than the need for a permanent address. If this is so, primary care methadone programmes should focus on the doctor–patient relationship as a key therapeutic tool.

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References

GPs and anaesthetists: do we ‘gas’ enough?

Sir,

I was a general practitioner before I became an anaesthetist. The jobs are not too different. In the community, general practitioners are the first to be contacted when there is a crisis. In the hospital this is the anaesthetist’s role and not just when there is airway compromise or respiratory failure but whenever a patient is critically ill. We both put the presenting complaint into context and take account of all contributing factors. We both are required to make prompt diagnoses, to start immediate treatment and then to arrange definitive management and care. Our knowledge and expertise extends into the medical, surgical, paediatric and obstetric fields.

It is often said that doctors who dislike talking to their patients and colleagues train to be anaesthetists, but I write because I am concerned that we do not ‘gas’ (talk to each other) enough. Patients with anaesthetic risk factors known to their general practitioners sometimes present for anaesthesia and surgery without this information being communicated to the anaesthetist. During the six years that I have been a full-time anaesthetist I can recall only one occasion when I received a letter for a general practitioner: he warned me that his patient had developed hyperpyrexia following a previous anaesthetic, and I was grateful to have this information. Conversely, patients may be discharged from hospital with no mention in the discharge letter of an anaesthetic complication. This is probably because these letters are written by non-anaesthetists. Some of my anaesthetist colleagues have written to general practitioners when there have been specific problems (for example, hypersensitivity reactions, malignant