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Reference

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Aspirin in acute myocardial infarction

Sir,

We would endorse the statements by both Michael Moher (August *Journal*, p.444) and John Rawles (September *Journal*, p.504) about the importance of the involvement of the general practitioners in pre-admission aspirin treatment in acute myocardial infarction. Most studies have shown that few patients arriving at hospital with a suspected myocardial infarction have received aspirin,^{1,2} despite the recognition by many authorities about the benefits of this.

In South Tyneside, the Medical Audit Advisory Group, in conjunction with the physicians, undertook a guidelines dissemination and implementation exercise involving general practitioners, doctors in accident and emergency and medical departments, doctors in deputising services, and ambulance paramedics, using a variety of strategies.³

The guideline stated that all patients diagnosed as having a suspected myocardial infarction should be given 300 mg of aspirin to chew and hold in their mouth as soon as was possible, unless there was a recognized contraindication. Of 164 patients that received aspirin as per the guideline, 43 were given it by their general practitioner, 31 by doctors in the accident and emergency department, five by ambulance paramedics, three self-administered and a further 82 were given it by a junior hospital physician. A further 123 did not receive 300 mg of aspirin. Whilst a proportion of these would have had the diagnosis of suspected myocardial infarction overturned when they were seen in hospital, and thus, not require aspirin, the majority should have received aspirin if they had been treated as per the guideline.

By making the provision of aspirin to patients suffering from a suspected acute myocardial infarction the responsibility of all clinicians involved in their care, we feel that a higher proportion receive this optimal care, and that despite arguments to the contrary,⁴ we should continue to recommend that it should also be the responsibility of general practitioners and

ambulance paramedics to give aspirin, and not just abdicate this responsibility to hospital doctors.

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References

1. Moher M, Johnson N. Use of aspirin by general practitioners in suspected myocardial infarction. *BMJ* 1994; **308**: 760.
2. Wylie HR, Dunn FG. Pre-hospital opiate and aspirin administration in patients with suspected myocardial infarction. *BMJ* 1994; **308**: 760-761.
3. Eccles MP. RCGP Guidelines Skills Course Material. London: RCGP, 1995.
4. Shetty BKK. Aspirin and suspected myocardial infarction [letter]. *BMJ* 1994; **308**: 1713-1714.

Register inaccuracy

Sir,

Harris and colleagues commented on list inflation, which was raised in our article (September *Journal*, p.463).

There are two separate but inter-related aspects to register inaccuracy. Most importantly, there are the clinical implications of inaccurate registers for screening, recall systems, morbidity recording and documentation of performance by primary care teams. Even in more affluent areas, inflation calculated by methods similar to our own was around 15%, and the interquartile range for our 16 (not three) practices was 21-27%. Deflation, where patients reside in a new area but delay in registering, is poorly researched, but is also likely to be a feature of deprived areas.

The administrators of both the cervical and breast screening programmes are well aware of register inaccuracy and have sought to define 'active patient denominators' using Prior Notification Lists. This has been successful for cervical screening, which receives active support by recruitment from the primary care team (resourced by target payments), and less successful for breast screening, where there are no additional resources for local recruitment programmes.

The principle of validation of regis-

ters/denominators needs to be incorporated into quality assurance programmes for clinical data, such as preventive care, disease registers and associated variables, if meaningful comparisons are to be made between practices and areas, and registers of real people are to be clinically useful.

In our subsequent 1994 audit, we stopped writing to patients for validation purposes as it was too complex for routine use. We have also found that computer usage has been considerably more rapid than we thought and future audits/registers will be based on computer searches (though reference to paper records may need to be made as part of quality assurance). Some simple method of validation is still required and a consensus on this remains to be established. In the meantime, unexpurgated registers will continue to underestimate performance and need, particularly in areas of deprivation and high turnover.

Payment based on capitation is a related but separate issue. Harris and colleagues are quite right, this is unlikely to be addressed through the 'back door' of clinical registers and preventive activity. It is more effectively addressed through administrative improvements such as GP-links. This is a model of good practice and democracy of data handling!

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Chlamydial infection in women

Sir,

In their editorial on management of chlamydial infection in women (November *Journal*, p.615), Pippa Oakeshott and Phillip Hay state that the failure rate of erythromycin treatment is 37%. The source of this figure was not clear, but I believe that it originates from a Canadian study in which 35 male patients with urethral chlamydia infection were treated with low-dose erythromycin, namely 250 mg qds for 7 days.¹ Historically, many studies of erythromycin therapy for genital chlamydial infection have suffered from inadequate dosage or patient numbers; indeed, one frequently cited study included a series of only five women.²