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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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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 registers/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]

In Bolton, we retrospectively reviewed the casenotes of 239 non-pregnant women with cervical chlamydia infection who had been treated with a standard regimen of erythormycin 500 mg bd for 10 days. Treatment failure occurred in only 14 (5.9%) cases; of these failures, 11 women discontinued treatment because of gastric upset and three were re-infected by their sexual partners.[3]

We have shown that erythromycin is an effective, well-tolerated treatment for genital chlamydial infection in women. In addition, its lack of fetotoxicity makes it particularly useful for patients who are either pregnant or not using reliable methods of contraception.

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Effect of leaflets on contraception

Sir,

Smith and Whitfield (August *Journal,* p. 409) conclude that providing information leaflets appears to significantly improve knowledge about contraception. Uncritical readers of the abstract may conclude that the value of such leaflets has been proved. Unfortunately, the study provides only limited evidence to support this.

I assume that the first questionnaire was complete *after* the consultation, thus controlling for information provided during the index consultation, though this is not entirely clear from the paper. There remain other possible explanations for the improvement in knowledge. Thus, the pack insert may have contributed to the improvement, especially in new users, who would not have had the chance to read this previously. Of more importance is the fact that completing the questionnaire will in itself have made this group more likely to seek information, either from the inserts, pharmacist or the leaflets themselves. The improvement in aspects of knowledge not mentioned in the leaflet supports the involvement of other factors. The percentage of women knowing that emergency contraception could be obtained from a casualty department, information not given in the leaflet, increased from 12 to 17.6%, this change just failing to reach statistical significance (Yates corrected chi-square = 3.52, $P<0.06$). At best, this study illustrated the advantage of handing out a questionnaire followed by the FPA leaflet.

The only satisfactory way to demonstrate the true effect of providing information leaflets would be through a randomized controlled trial. More urgently, the deficits in knowledge highlighted by this paper (e.g. even after receiving leaflets on contraception, three-quarters of respondents did not know the 'seven-day rule') should prompt attention to the whole area of providing information to contraceptive users.

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Cold chain storage

Sir,

Professor Grob highlights the ineffectiveness of the cold chain in vaccine storage in physicians' offices in the USA (International Digest, January *Journal,* 53). He then wonders whether the UK experience is similar to the poor results found in this American study. In fact, two recent UK general practice studies have indeed shown a defective cold chain storage programme.

A questionnaire survey of 40 general practices and child health clinics revealed that only 16 were aware of the appropriate vaccine storage conditions.[1] Only eight centres had a maximum–minimum thermometer, with only one centre monitoring it daily. Of the eight practices selected for detailed monitoring of refrigeration temperatures, the vaccines were exposed to either subzero temperatures (three fridges) or temperatures up to 16°C (three).

In a study of 29 general practices, compliance with six key requirements for storage of vaccines varied from 70 to 0%.[2] Only 16 out of the 29 practices had a named person responsible for vaccine storage, only 15% of the refrigerators had a maximum–minimum thermometer, 27% of the refrigerators also had food and drink stored in them, and in 10 of the practices, the potency of some vaccines became suspect after use.

It would appear that the suggested nine-point protocol for the storage of vaccines does need to be implemented in the UK.

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MRCGP examination 1996

Sir,

If any process can be guaranteed to deter the already dwindling number of medical graduates from entering into general practice as a career, it must be the suggested changes for the 1996 examination for membership of the Royal College of General Practitioners and summative assessment proposals, details of which were distributed in an insert in the July issue of the *Journal.* A more daunting and confusing set of proposals I have yet to read. No one would dispute the ideology of improving the professional quality of tomorrow's general practitioners, but if there has to be an entry qualification to family practice, let it be the MRCGP examination and be done with it. The examination should be able to encompass all of the requirements of summative assessment and so rid us of the ever increasing obstacles placed in the path of aspiring general practitioners.

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