

Succeeding days saw a huge variety of unfamiliar tropical diseases including bilharzia, malaria, typhoid, kwashiorkor, TB and snake bites — I was saved only by the *Oxford Handbook of Clinical Practice*, a textbook on tropical diseases, and some super WHO publications on Third World medicine. Obstetrics played a large part in the daily routine as well, and an early emergency was a twin pregnancy at 34 weeks with a cord prolapse. However, my week's study leave learning how to do Caesarean sections served me well, and a further week's crash course in spinal anaesthesia also proved a Godsend — on one occasion I did the anaesthetic, the operation and resuscitated the baby — a far cry from daily life in Trowbridge!

There were six full time doctors and two part-timers. We managed 300 beds, and because some had to share, sometimes 400 patients. Each doctor ran a ward — mine was paediatrics. Kwashiorkor, snake bites and burns were all common, and the stoicism and acceptance of suffering meant that nurses often needed persuading that pain relief was a worthwhile treatment — they thought I was pretty namby-pamby — I wished they could meet some of my British patients! It certainly felt like proper doctoring and the rewards were enormous. In this doctor-centred environment, the patients were undemanding, always grateful and often would sleep overnight in the outpatient department until we were able to see them. No Patient's Charter here!

The lows were keenly felt too: HIV prevalence is 20% and we saw many young people die. What an enormous problem is now in store for Africa as AIDS starts taking its toll.

Another part of the job was to visit outlying clinics, on wheels or in the air. These clinics were right out in the bush, and there would be a queue of people in a field, nowhere to examine anyone and no confidentiality whatever. I ended up managing 3-min consultations, but then expectations were not high and counselling was pretty low on the list.

After a brief but welcome holiday in Zanzibar, it was time to return home, and once again, I'm plunged into a world of fundholding, computers and appointments which never seem long enough. But curiously I do feel refreshed and more able to cope with it — I can only hope the feeling will see me through this latest 'flu epidemic! So my advice to anyone thinking about a sabbatical is — just do it!

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## Direct access to CT screening

Sir,

Both the Royal College of General Practitioners and the Royal College of Radiologists recommend that GPs and hospital clinicians should, where possible, have equivalent access to radiological services.<sup>1</sup> Our district general hospital offers GPs direct access to CT scanning. We recently made a 6-month retrospective study of the initial use of the service, reviewing CT request and scan result for each patient, and sending a questionnaire to the referring GP; a comparative population of hospital outpatients was also assessed.

A total of 95 GP patients were referred, with almost half of the practices in the area using the service at least once (22/45). Sixty-three per cent of the patients were referred for brain scan, 32% for lumbar spine scan and 5% for abdominal scan. With regard to the spine scans, the clinical indications used and the proportion of abnormalities found compared favourably with the hospital group (Table 1). However, with regard to the brain scans, only 10% of the GP group have an abnormal finding, compared to 25% in the hospital group (Table 1).

Questionnaire responses indicated that almost all referring GPs found the service helpful (98%). In particular, the scan result allowed a change in the proposed management in 90% of cases. Fifty-nine CT scans were performed instead of immediate hospital referral and only 22 of these patients were subsequently referred.

The use of spinal CT by GPs demonstrates the effectiveness of open access; results were similar to reported series<sup>2</sup> and satisfaction was high. The relatively low rate of positive brain scans probably reflects the high proportion of scans performed for the investigation of headache

alone (Table 1).<sup>3</sup> Although there are no specific guidelines for CT brain scan, such investigations clearly involve significant cost and radiation exposure, and the use of scanning in the absence of clear neurological symptoms or signs may be criticized. We have now established local guidelines for direct access CT.

Overall, we believe that direct access to CT benefits patient care. In our study, hospital referral was avoided in a substantial proportion of patients, thereby reducing burden on hard-pressed outpatient departments. Furthermore, since many direct access patients would eventually have been scanned from hospital, overall costs may have been reduced. Finally, in those patients in whom subsequent hospital referral was necessary, the GP was able to refer appropriately, thereby avoiding delay in treatment. In conclusion, therefore, we hope that our favourable experience with direct access CT will encourage such provision by other hospitals.

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**Table 1.** Spine and brain CT scans performed during the study period. The main data set refers to those scans requested by GPs. Figures in brackets represent all patients referred from hospital OPD during the same period.

Spine			Brain		
Reason for referral	Total	Abnormal	Reason for referral	Total	Abnormal
Pain	8 (10)	1 (3)	Headache	27 (4)	1 (0)
Pain and neuro	22 (42)	9 (17)	Neuro±headache	33 (57)	5 (15)
Total	30 (52)	10 (33%) [20 (38%)]	Total	60 (61)	6 (10%) [15 (25%)]