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Health education and patient satisfaction

IN a study carried out by the division of Health Policy and Administration at Berkeley School of Health, University of California and the Pacific Business Group on Health, San Francisco, the relationship between health education and patient satisfaction was studied. Views were sought from patients attending health plan value checks conducted by the Pacific Business Group.

Three basic questions were asked of the patients:

'Overall, how satisfied are you with the doctor you have seen most frequently?'

'How satisfied are you with the doctor's attention to what you have to say?' — presumably looking at communication skills.

'Has your physician or other health professional discussed any of these health education topics with you in the last three years:

Exercise	Motor vehicle safety
Nutrition	Alcohol
Smoking	Substance abuse
Injury prevention	STD?'

Seventy-one per cent felt that they were happy with their physician's attention; 62% had had one or more health education topics discussed with them in the previous three years.

The conclusion was that patients were more likely to be satisfied with their physician if health education topics had been discussed with them in the previous three years. However, it was not clear who initiated the subject nor was the quality or depth of the health education initiative apparent. Furthermore there was no mention of follow-up.

The content of the health education was analysed. Exercise was discussed in 49% of cases, nutrition in 43% and smoking in only 21%. In only 9–11% was alcohol or STD discussed. These particular behavioural risk factors are recommended by the US Preventive Services Task Force for discussion in adult counselling at least every three years, as part of a comprehensive clinical prevention plan.

It is clear from the study that patient satisfaction is enhanced when health professionals raise the subject of health education. However, the quality of the health education advice does not appear to match what is considered appropriate by the US Preventive Services Task Force. The patient may be satisfied with the doctor, but is the profession satisfied with the advice it gives? Perhaps this in unfair to the authors, but it is a logical next question.

J E NOAKES
General practitioner, Harrow, Middlesex.
Non-Executive Director of Health Education Authority, England

Source: Schauffler HH, Rodriguez T, Milstein A. Health education and patient satisfaction. *J Fam Pract* 1996; **42:** 62-68.

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Ectopic pregnancy

THIS is a retrospective survey carried out by residents (equivalents of registrars) on a family physician's training programme based at the Mayo Clinic in Minnesota.

The two authors reviewed all the records of women (126) with proven ectopic pregnancies (135) who were admitted between 1986 and 1992. The population was largely rural, and it appears that the authors had been spurred into undertaking the study because previous studies of urban populations had shown that a high percentage of women with ectopic pregnancy had a history of prior pelvic infection. It is not possible to say much about the quality of the study as one cannot know the thoroughness with which notes were extracted. However, I note that the first-named author won the 1994 award for research from the American Academy of Family Physicians as a resident.

In this study, almost one half (47%) of the women with an ectopic pregnancy had no risk factors at all. Thirty-eight per cent had had tubal surgery and 35% had a history of infertility, and in the majority of cases this was not related to tubal disease. Only 17% had a history of pelvic inflammatory disease, and even this is almost certainly an overestimate as laparoscopy has shown that PID is a much overused diagnosis. I suspect this is because both gynaecologists and family physicians (GPs) make a presumptive diagnosis of pelvic infection whenever women present with pelvic pain. Only one woman in the study had an intra-uterine contraceptive device, but one cannot deduce much from this as the authors do not give the background prevalence of IUCD use in the USA. Given the litigious atmosphere, my guess is that the rate of use is lower than it is in the UK. The authors suggest that IUCDs do not cause ectopic pregnancies but that they do not prevent them as well as they prevent intra-uterine pregnancies.

The association of ectopic pregnancy with a history of infertility merits further research. The authors suggest possible use of drugs altering tubal function or indeed a primary problem with egg transfer down the tube.

In summary, this paper shows that past data based on urban women may be somewhat misleading in more rural areas, in that almost half the women who had an ectopic pregnancy had no risk factor whatsoever.

The message is clear: ectopic pregnancy is an easy diagnosis to miss, and assuming that a woman must have a risk factor is a good way of ensuring that one does miss the diagnosis. A high index of suspicion is needed, which is not easy when the average GP in the UK will only see one case every two years. Pregnancy tests can easily be carried in a doctor's bag and have a reasonable shelf life; I commend them.

GAVIN YOUNG
General practitioner, Temple Sowerby

Source: Garrett AM, Vukov LF. Risk factors for ectopic pregnancy in a rural population. *Fam Med* 1996; **28:** 111-113.

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Treatment of migraine

MIGRAINE is a very common condition that affects some 5% of the British population. It is more common in females. Data from the National Health Interview Survey shows that in 1989 10 million migraine sufferers in the United States (USA) spent over 3 million days per month bedridden owing to migraine. The condition was also responsible for substantial loss of work days or restricted activity during migraine attacks. Moreover, patients also suffered from impaired health between attacks, thereby substantially reducing their quality of life. This leads to underachievement and has economic consequences.

Clearly, any treatment which can prevent acute attacks, and is considered to be effective at the onset of the attack, is going to be of substantial benefit. This paper looks at the role of Sumatriptan in the treatment of acute migraine.

This study from the USA, lasting for 24 months, was conducted on long-term migraine sufferers who had already used a variety of medications during their illness. It recruited 344 patients suffering with migraine. The patients were treated with subcutaneous Sumatriptan 100 mg, which could be used between 1 hour and 24 hours after initial injection for recurrent or persistent headache. The patients completed a short form — 36 Health Questionnaire — on four occasions.

The results show an improvement in health-related quality of life, better social functioning, an increase in the confidence of the patients to tackle their headaches, and an increase in productivity. This paper shows that it is cost-effective to treat these patients with expensive Sumatriptan injections and tablets. Clearly, the findings could be translated to the treatment of patients in this country.

The study suffers from two major defects:

- It was an open-label, single-group design study, which was not placebo-controlled.
- In this country, we treat patients suffering from recurrent migraine with prophylactic Pizotifen. It appears to be effective in preventing migraine in most patients. This preventive measure will relieve the anxiety of suffering from break-through acute attacks of migraine. Moreover, most United Kingdom patients do not like to inject themselves.

Nevertheless, the paper is well written and is an important addition to the management of migraine.

K K AGARWAL
General practitioner, Newcastle Under Lyme

Source: Jhingran P *et al.* Improvements in health-related quality of life with Sumatriptan treatment for migraine. *J Fam Pract* 1996; **42:** 36-42.

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Asthma and chronic bronchitis

THE peak flow meter has become a standard tool in general practice. It is now widely used by general practitioners, practice nurses and indeed patients in the management of asthma. The care of asthma has received a lot of interest compared with chronic obstructive pulmonary disease, even though the latter causes a significantly greater number of deaths each year in England and Wales. The next development in the care of chronic respiratory illness within general practice will be the publication of national guidelines in the management of chronic obstructive pulmonary disease. This paper illustrates one of the reasons why spirometry will become a routine test for the primary health care team.

The authors measured several clinical parameters involving symptoms, physical signs, peak flow rate and diurnal peak flow rate in 160 patients with asthma or chronic bronchitis. They determined whether these simple clinical features were predictors of decline in respiratory function over two years. Unfortunately, they concluded that it was almost impossible to predict the rate of deterioration of asthma or chronic bronchitis on the basis of these parameters.

The paper agrees with the forthcoming national guidelines on chronic obstructive pulmonary disease in that the measurement of FEV_1 is necessary in the effective management of these respiratory diseases.

The lonely practice peak flow meter will have a companion in the spirometer.

MARK SHAPLEY
General practitioner, Newcastle Under Lyme

Source: Van Schayck CP et al. Asthma and chronic bronchitis. Can family physicians predict rates of progression? *Can Fam Physician* 1995; **41:** 1868-1876.

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