The incidence and causes of rectal bleeding

Sir,

The conclusion of JV Metcalf and colleagues,[1] that all patients over the age of 40 presenting in general practice with rectal bleeding should be referred for flexible sigmoidoscopy or colonoscopy, needs further scrutiny before it becomes part of 'routine good practice', or before dissemination to the public by the popular media occurs.

Metcalf *et al,* in their study, observed the incidence of consultations for rectal bleeding to be approximately half the expected rate.[1] The authors suggest reasons why they did not feel that substantial selection bias had occurred, but we believe that there will inevitably have been a degree of selection bias. This would be likely only to increase the predictive value of rectal bleeding for serious pathology. We are concerned that the general practitioners' diagnostic processes were not described.

Jones and Lydeard[2] found that 20% of the total population had noticed rectal bleeding in the preceding year, but other data suggest that the presentation rate in general practice is substantially lower — perhaps only 8 per 1000 per year.[3] Approximately one patient in 25 with the symptom of rectal bleeding consults a doctor, and this is followed by a second filtration process in the general practice. Not only is this a classical 'iceberg phenomenon' of symptom presentation,[4] but the predictive value of rectal bleeding for colorectal cancer also rises from 1 in 1000 in the general population, to 2 in 100 in general practice and up to 36 in 100 referred patients.[3] It is not fully understood how this filtration process takes place, but the general practitioner and the patient are operating a remarkable process of selection.

Metcalf *et al* have identified certain symptoms (blood mixed with stool, change in bowel habit, and abdominal pain) which appear to be useful clinical discriminators between those with serious underlying diagnoses and those with benign causes of rectal bleeding.[1] Although the sensitivity and specificity of these symptoms are not impressive, these concepts are more useful for the screening scenario. When managing an individual patient, it is the predictive values of these symptoms which are more useful to practitioners.

The conclusion that all patients aged over 40 with rectal bleeding should be referred is surely premature. The iceberg phenomenon is present here and with some evidence of efficiency; similarly, the cost effectiveness of the general practitioner's 'gatekeeper role' is a relevant point in the debate and has not been included in the analysis. Media coverage of a message suggesting such a high predictive value of rectal bleeding for serious pathology could dramatically increase the presentation of this symptom in general practice. For patients of all ages, the number of consultations for rectal bleeding is potentially 470 per general practitioner per year.[3] Although the study of Metcalf *et al* concerned only patients aged over 40, recommendations for referral of all such patients presenting with this symptom requires stronger evidence.

Metcalf *et al* were able to identify the prevalence of serious pathology in those referred to the study, but the study could not and was probably not designed to accurately assess the incidence of rectal bleeding. What is required is a prospective study which addresses more fully both the significance *and* incidence of rectal blood loss in the general practice setting in order to identify the signs, symptoms, and risk factors that my contribute to effective and efficient diagnosis.[3] Only then can valid conclusions be drawn about the appropriateness of a mandatory referral of patients aged over 40 with rectal bleeding.

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Complementary medicine — doing more good than harm?

Sir,

Professor Ernst's article on complementary medicine[1] (February *Journal*) reignites the debate on several important issues regarding the practice of complementary medicine. Can we orthodox doctors accept complementary medicine in its literal sense?

As a British trained general practitioner working in Hong Kong, I have had the opportunity to gain experience in serving both the British population and the Chinese population in Hong Kong now. Although Hong Kong has been following the British health care model, the proportion of health care providers are much more substantially represented by the private sector. Among these private health care providers are those so-called complementary medicine practitioners. These practitioners include traditional Chinese herbalists, bonesetters, acupuncturists, Chi practitioners, and so on. One recent survey in Hong Kong revealed that nearly 20% of the respondents consulted a complementary medicine practitioner for their most recent illnesses.[2] The practice of these branches of complementary medicine are so widely accepted among the local population that the term 'complementary medicine' is not literally meaningful. There is a local belief that, in general, orthodox medicine is better for the treatment of acute symptoms whereas traditional Chinese medicine is preferred for chronic conditions. Patients are known to use both streams of treatment, be it orthodox or complementary, at the same time for the same condition, most behind their therapist's backs. My gut feeling (probably many others' as well) is that if these practices of complementary medicine did not work, they would not be able to survive for centuries. I would agree entirely with Professor Ernst's point that we would need to prove that they do work, find out how they work and the related safety issues. Only randomized controlled trials can provide the answers and the cost of complementary medicine can only be evaluated after these answer have been found.

When doctors were asked in a survey about whether they believed that they should be encouraged to learn more about complementary therapy techniques,[3] it was not surprising that the majority responded positively to the question, as they have probably come across or had some experience of complementary medicine in one way or another in their professional life. This is especially true in Hong Kong where most of our local patients would have had contact with complementary medicine.

Due to our training in orthodox medicine, most of us cannot answer questions relating to complementary medicine. This probably applies to doctors in both Hong Kong and Britain, and even worldwide to

a certain extent. Therefore, we can no longer ignore the issues relating to alternative medicine, and research in these areas should be given greater emphasis.

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Clinical guidelines in primary care: a survey of general practitioners' attitudes and behaviour

Sir,

In his 1994 survey, Siriwardena found that GPs were generally in favour of clinical guidelines and thought they improved patient care (December *Journal* p.643). Our recent experience produced similar results.

We developed guidelines for the management of cervical chlamydia infection based on recommendations from the Communicable Disease Surveillance Centre.[1] In 1994 and early 1995 we gave these guidelines to GPs and practices nurses in the 14 general practices near St George's Hospital that took part in a project to screen women for chlamydia infection. In January 1996 we sent a confidential questionnaire to all 53 GPs and 11 practice nurses in those practices, asking their opinion of these guidelines. If there was no response, we sent the follow-up questionnaire via the practice manager, who was asked to encourage the relevant GP or practice nurse to complete it.[2]

Eighty-three percent of the GPs and 72% of the nurses returned completed questionnaires. Seventy-six percent of respondents had received the guidelines and claimed to have read them, 14% could not remember and 10% had not received them (we omitted to ask if this was because they had only recently joined the practice). Eighty-four percent of respondents found the guidelines easy to use and 81% said the guidelines had altered their clinical practice.

In addition, we asked whether practices would continue to screen women for chlamydia. The guidelines suggested that this should be considered for women aged under 35 years attending for speculum examination. Ninety-four percent of respondents said they would continue testing women for chlamydia. Indications included: vaginal discharge (94%); suspected pelvic inflammatory disease (92%); before IUCD insertion (46%); aged under 25 years and sexually active (35%); and before termination of pregnancy (20%).

Siriwardena observed that GPs often fail to follow systematic guidelines even when they are evidence-based. Moreover, responses to questionnaires may not accurately reflect what is carried out in practice. We are now analysing patients' records to see if our guidelines did lead to appropriate patient management.

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GPs' views of a new counselling service

Sir,

GP Care is a service being offered throughout five FHSAs to general practitioners (GPs) and their families, and involves both telephone and face-to-face counselling. The aim of this exploratory interim study was to assess GPs' beliefs about such a service and whether or not they would consider using it. This is part of a larger study, the results of which are yet to be published.

Fifty-seven GPs from five FHSAs were randomly selected using a quota sampling strategy and interviewed on the telephone about their beliefs concerning the GP Care service just prior to its commencement (Bedfordshire, n=11; Buckinghamshire, n=11; Lambeth, Southwark and Lewisham, n=11; Hertfordshire, n=13; Berkshire, n=11). The sample was composed as follows: 70.2% male (n=40), 29.8% female (n=17), 91.2% full time (n=52), 8.8% part time (n=5), 93% in a group practice (n=53), 7% single handed (n=4) practitioners, 1.8% aged 20-29 (n=1), 44.6% aged 30-39 (n=25), 42.9% aged 40-49 (n=24), and 10.7% aged 50

Table 1. Beliefs about the new counselling service (numbers in parentheses)

Would GPs find a counselling service helpful?	No	Possibly	Yes	Don't know
In general?	0 % (0)	29.8% (17)	66.7% (38)	3.5% (2)
For work related problems?	12.3% (7)	36.8% (21)	49.1% (28)	1.8% (1)
For personal problems?	3.5% (2)	10.5% (6)	86 % (49)	0 % (0)

What factors would deter GPs from using the service?

1/ Confidentiality	52.6% (30)
2/ Professional pride	40.4% (23)
3/ Not admitting that there's a problem	24.6% (14)
4/ Not having faith in a counsellor	19.3% (11)
5/ Not having the time	19.3% (11)
6/ Embarrassment	15.8% (9)

Would GPs prefer to talk to some on the telephone or face-to-face?

Telephone	Face-to-face	Both
22.8% (13)	61.4% (35)	14% (8)

How would you feel about using the service?

Would use	Might use	Would not use
52.5% (30)	38.6% (22)	8.8% (5)