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Bee stings

The usual advice given for bee stings is: remove the remnant of the dead bee carefully, so as not to squeeze more venom from the bee into the wound. This advice is a fallacy.

American entomologists report a study of bee stings on their own forearms. They were brave men!

When a honey bee (Apis mellifera) stings it loses the lower part of its abdomen containing the venom sac. The sting has barbs with ducts from the venom sac. The moribund detached abdomen pulsates and pumps venom onto the sting, rather like a piston in a syringe. If the sac is squeezed the amount of venom expelled is not increased.

It follows that the correct treatment is to remove the visible remnant of the bee as quickly as possible, without wasting time about the method of removal. The authors advise using a credit card. It is also important to run away from other bees! A moribund bee emits an alarm pheromone which attracts other bees to avenge their colleague, although at the cost of their own lives.

Allergies to bee stings are greatly feared, though they are uncommon. Less than one in a million stings have been fatal. Desensitisation is not without risk. It is better to carry an emergency supply of adrenaline, either a *Minijet Adrenaline Syringe,* or a *Medihalor-Epi* (twenty puffs of the latter have to be taken).

Wasps and hornets are different, their sting is not barbed, and they fly away undamaged after stinging. A sting in the mouth is dangerous as oedema may cause obstruction to the airway.

GUS PLAUT
Retired general practitioner, Halstead

Source: Visscher PK, Vetter RS, Camazine S. Removing bee stings. *Lancet* 1996; **348:** 301-302.

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Falls in the elderly

Most Western societies are faced with the dilemma of diminishing resources and the provision of an ever increasing number of services to an ageing population. The maintenance of independence in the community is the goal of most welfare systems, and this if often severely compromised by decreasing mobility in the very elderly.

This paper from the University of Oulu in Finland, attempts to identify risk factors in those prone to recurrent falls.

In the two year study period, 788 elderly people (over the age of seventy) were included and were subject to a detailed questionnaire and physical examination.

A fall was defined as an unexpected event when the person fell to the ground on the same or from an upper level, taking a fall on stairs and those onto a piece of furniture into account. Recurrent falls were defined as at least two falls within 365 days after the day of examination.

Diminution of sensory function, mainly vibration sense and pain appreciation, along with lack of balance, diminished walking speed and reduced power of knee extension were identified as important.

Psychotropic medication, in particular tricyclic antidepressants, contributed significantly to the pattern of recurrent falling, as did the continuing use of short acting benzodiazepines.

Twice as many elderly women as men were identified as recurrent fallers. Predictors for recurrent falls which were thought to be significant, include psychotropic medication, signs of peripheral neuropathy and slow walking speed. An awareness of these predictors should lead to the introduction of early preventive measures.

Whilst most general practitioners in the United Kingdom will be bemused by the statistical analysis of the results in this paper, the conclusions are pertinent and an important contribution to preventive care for the vulnerable elderly in our communities.

NORMAN JARVIE
General practitioner, Crieff

Source: Luukinen H, Koski, K, Laippala P, Kivelä S-L. Predictors for recurrent falls among the home-dwelling elderly. *Scand J Prim Health Care* 1995; **13:** 294-299.

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Smoking behaviour

This study of smoking in the families of over 1,000 infants and children, aged under 5 years, is based on a questionnaire survey by health visitors of the parents of those attending a 6 week, 2 year, and 4 year routine child health clinic in Norway. About half the families had one child and the remainder two or more, and about half the children belonged to families with at least one smoker. Smoking was more likely in single and younger parents, and those of lower educational attainment; it was less likely in families with an infant under one year. About two-thirds of smokers with infants claimed not to smoke indoors

Given the evidence of the harmful effects of 'passive smoking' on infants and small children, these findings are depressing. What is more, the picture is likely to be worse than it first appears because parents of children are likely to have some knowledge of, and concerns about, the effects of their smoking on their children, and are therefore likely to under-report their smoking behaviour. That this should be so in a country such as Norway, with a generally high educational level and where tobacco advertising has been banned for 20 years, is extraordinary. But perhaps it would be even worse in the absence of an advertising ban!

GODFREY FOWLER
Reader in General Practice, University of Oxford

Source: Eriksen W, Bruusgaard D. Smoking behaviour in young families: do parents take practical measures to prevent passive smoking by the children? *Scand J Prim Health Care* 1995; **13:** 275-280.

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Sleep apnea

There is a growing awareness of morbidity and even mortality associated with sleep apnea, which is defined as period of sleep during which airflow stops for ten seconds or more. The apnea index, which refers to the number of these episodes per hour of sleep, is usually greater than ten in persons with sleep apnea syndromes. Apnea may be obstructive, central or mixed. Most patients have a combination of types.

A characteristic presentation of obstructive sleep apnea is an obese, middle aged man who has daytime hypersomnolence and fatigue, morning headaches, social conflicts, sexual difficulties and a partner who complains about his horrible snoring, lapses in breathing and changed personality. The patient with central sleep apnea most often complains of insomnia or frequent awakenings, mild to moderate snoring rather than daytime sleepiness, and may present with symptoms of decreased libido, morning headaches and frequent depression. More serious problems are possible if apnea goes untreated.

A thorough physical examination is appropriate. The gold standard diagnostic evaluation is the overnight 'polysonmogram'. By morning 200-400 or more apnea episodes may have been recorded.

In obstructive sleep apnea, a primary treatment strategy involves emphasizing that the patient should decrease alcohol and sedative consumption, lose weight, and sleep in the lateral or prone position. Nasal continuous airways pressure (CPAP) is offered to patients with severe obstructive sleep apnea. An obvious anatomical defect may qualify the patient for a surgical procedure. Patients with central sleep apnea may benefit from appropriate drug therapy. Family physicians can and should play an active role in detection, diagnosis and management of sleep apnea.

DAVID MURFIN
General practitioner, Ammanford, Dyfed

Source: Odens ML, Fox CH. Adult Sleep Apnea Syndromes. *Am Fam Physician* 1995; **52:** 859-866.

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Very low calorie diets

This American study assesses the results of a six month very low calorie diet (VLCD) programme 4 years after its completion.

Three hundred and six individuals entered the Sandoz OPTIFAST programme, which cost about £2000 each. The programme started with a 420 or 800 calorie high protein diet for 12 weeks, gradually increasing to a 1200 – 1400 calorie regular diet. Included were weekly medical checks and emotional support, with behavioural modification, nutritional education and exercise instruction.

Two hundred and fifty-five people were assessed at 2 years and 145 at 4 years. Two-thirds of these were severely overweight, the average entry weight for 45 men being 19st. 7lbs and for 100 women, 15st. 11 lbs. The average weight loss at programme end was over 20% of original weight, but after 4 years was less than 5%. However, 26% maintained a weight loss of over 10%. Most of these individuals exercised regularly, averaging three strenuous sessions of 30 minutes weekly.

Seriously overweight individuals usually have the genetic tendency to obesity associated with a broad body build (endomorphic) and most of them are under constant stress. They require an initial rapid wight loss as an incentive to keep to a diet. This study shows that a supervised programme starting with a strict but safe low calorie diet can lead to significant long term weight loss in motivated patients.

DENIS CRADDOCK
Retired general practitioner, Surrey

Source: Walsh MF, Flynn TJ. A 54-month evaluation of a popular very low calorie diet program. *J Fam Practice* 1995; **41:** 231-236.

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Its good to talk!

This paper from Texas describes research into factors contributing to patients' willingness to talk about quality of life issues with their doctor; quality of life encompassing those physical, psychological and social factors which contribute to health. There are some important messages in this research for British general practitioners.

The doctor–patient relationship, cornerstone of general practice, is shown to be vital in the willingness of patients to talk about quality of life issues. A longer relationship is more likely to lead to more effective communication and generally increased patient satisfaction. Willingness to talk also correlated to patients' understanding of the doctor's role. However, many patients did not perceive this to include psychological well-being. Clearly, continuing patients education about what is and is not a general practitioner's role is necessary. Patient satisfaction is also greater when doctors discuss physical health and overall well-being, but not psychological factors.

The study also indicates the willingness of patients to discuss areas of their health even when they do not perceive any limitation in these areas. This means doctors should not be afraid of promoting and discussing health lifestyle with their patients.

In conclusion, there are three lessons to be learnt by British general practitioners. First, to preserve and protect the continuity of the doctor–patient relationship. Secondly, to educate patients with regards to our role and responsibilities. Thirdly, to take the opportunity to discuss lifestyle and quality of life issues with our patients.

DAVID KNAPPER
General practitioner, Morecambe

Source: Street RL, Cauthen D, Buchwald E, Wiprud R. Patients' predisposition to discuss health issues affecting qualify of life. *Fam Med* 1995; **27:** 663-670.

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