Commentaries on selected articles from overseas journals of general practice.

● digest ● digest ● digest ● digest ● digest ●

Children's injuries in Iceland

THE basic principles of child accident prevention (i.e. the 'three Es') have been described as the education of both professionals and the public, the enforcement of injury prevention strategies, and the use of engineering initiatives that aim to ensure a safer environment. To these 'three Es' could be added to a fourth one: the use of epidemiological studies that are capable of indicating, at a local level, trends in the occurrence of childhood injuries.

While it is recognized that the collation of local accident statistics represents a fundamental step in the initiation of accident prevention strategies, most work in this area has been impaired as a result of lack of access to accurate data of local relevance. The authors of this paper had two advantages in this respect. The population of Iceland is stable and homogeneous, and all of the accident and emergency attendances of children aged 0–14 years were captured onto a computerized information system. Hence, the researchers were able to obtain an overall picture of childhood injuries in Reykjavik that was similar in some respects to previously published studies in this country, but which, nevertheless, highlighted some interesting local variations. For example, the proportion of girls who sustained accidents was higher than expected.

While the childhood injury rate in Iceland is significantly higher than that recorded in other Nordic countries, at least the authorities in that country now possess a greater insight into the nature of the problem and are in a better position to deal with it. One significant limitation of the study was that no information was available regarding the injuries that were treated at primary care level. Further prospective studies with respect to the epidemiology of children's accidents as they present to primary care is therefore needed.

YVONNE H CARTER
Professor of General Practice and Primary Care, London

Source: Stefánsdóttir A, Mogensen B. Epidemiology of Childhood injuries in Reykjavik 1974-1991. *Scand J Prim Health Care* 1997; **15:** 30-34.

● digest ● digest ● digest ● digest ● digest ●

Magic boxes

COMPUTERS are universal. They have imbued every aspect of our living. Therefore, it would seem inevitable that they should be used when we consult with our patients. This paper, from Aarhus in Denmark, looks at the influence of the computer in daily practice, with a selected group of doctors' and patients' consultations analysed afterwards (by using video) with both groups individually. Are they neutral objects, like a pen or a clock, or are they integral to the consultation?

This elegant study, which was very easy to read, comes to the conclusion that the computer is a significant part of the consultation. Ms Als identifies five categories of behaviour in relation to the computer: 'time-out' to think about problems being presented, 'magic box' to act as a resource to back up assertions, 'conversational changes' when the patient stopped talking when the doctor explained what they were doing with the computer. Some doctors were surprised at how the computer intruded into their consultations, and felt they needed to review their behaviour.

The analysis of the study was thorough with relevant quotes, and is clearly work we should be aware of. I was fascinated by a software tool that they used, called NUDIST — there is no explanation of this acronym!

The final analysis is that patients need more information about the use of computers; magic box or no, they are here to stay.

DOMINIC FAUX
Senior lecturer in Medical Education, University of Wolverhampton

Source: Als AB. The desk-top computer as a magic box: patterns of behaviour connected with the desk-top computer: GPs' and patients' perceptions. *Fam Pract* 1997; **14:** 17-23.

● digest ● digest ● digest ● digest ● digest ●

Irritable bowel syndrome

THERE are few conditions that cause as much anxiety for the patient and take up as much time for the doctors as irritable bowel disease. Over-investigation often serves only to reinforce in the patient's mind that there must be something sinister behind the symptoms. It is therefore very helpful when a paper can neatly and concisely give guidance on how to make the diagnosis on clinical grounds with the minimum of investigation and set out helpful guidelines on how to approach treatment. This is, in my opinion, just such a paper.

The Rome Diagnostic Criteria have been developed by an international group of investigators to describe the symptom patterns, diagnostic criteria, and clinical features of 24 functional gastrointestinal conditions, one of which is irritable bowel syndrome. A careful history using these criteria, along with an assessment of the patients psychosocial situation and an understanding of his or her illness, leads to the diagnosis with the minimum of investigation. The paper also points out the differential diagnoses and the way in which the signs and symptoms differ with these other possibilities.

The authors set out a therapeutic approach to the treatment of the condition, pointing out how the symptom severity and degree of disability modify the treatment. They emphasize just how important the doctor–patient relationship is in getting a successful outcome, and that this outcome is not necessarily an abolition of all the symptoms. Successful treatment depends on setting reasonable goals, patient education and negotiating treatment. They also point out that, as in all things, it is important to recognize our own limitations, and that management may require a multidisciplinary approach.

I believe that this article is essential reading for anyone who sees patients with irritable bowel syndrome, and should therefore be in every GP's library.

RICHARD J PAGE
General practitioner, Audley, Staffordshire

Source: Dalton CB, Drossman DA. Diagnosis and treatment of irritable Bowel syndrome. *Am Fam Physician* 1997; **55:** 875-880.

● digest ● digest ● digest ● digest ● digest ●

Oral contraceptives and back pain

FROM official health statistics in Sweden, the prevalence of low back pain in women (16–84 years) over the period 1975 to 1989 was shown to have increased from 6.1% to 8.1% while no corresponding increase was seen in men. Earlier studies have linked low back pain (LBP) to heavy physical work, multiparity,

● digest ● digest ● digest ● digest ● digest ●

and smoking. The authors of this paper were seeking to establish a link between oral contraceptive (OC) use and LBP.

In some districts of Sweden, the use of pharmaceutical agents has been registered for many years. By using this register, past users of OC were identified and matched with non-user controls, and a history of LBP was established from primary health care records. Statistical analysis was carried out for the age range 14-44 years. It was found that LBP occurred more commonly in those using OC than in non-users, but this difference only reached statistical significance in the first year of use ($P<0.01$) and the fourth year of use ($P<0.05$). The authors make the suggestion that this difference may be related to the hormone relaxin. Earlier thought only to be a hormone of pregnancy, recent, more sensitive measurements have detected it in the normal menstrual cycle and in higher concentrations during OC use.

In this study, LBP was recorded as a diagnosis and did not subdivide sufferers into any causal sub-groups, nor were lifestyle factors, such as obesity or occupation, considered. There was no differentiation between high- and low-oestrogen OC and no distinction made between a single episode of LBP and continuing problems. The concept of late complications of OC use is interesting but this paper does not make a convincing case for a link with LBP.

ANN DUNBAR
General practitioner, Dundee

Source: Wreje U, Isacsson D, Åberg H. Oral contraceptives and back pain in women in a Swedish community. *Int J Epidem* 1997; **26:** 71-84.

● digest ● digest ● digest ● digest ● digest ●

Community-based continuing care

THIS Canadian study compares the relative power of functional assessment, nurses' clinical judgement, and demographic variables to predict death and drop-out from a continuing-care community programme. The organization of such care in Canada has parallels with the GP and district nurse services in the UK, although the structure of it is different.

The study was a prospective cohort study of clients of the programme and lasted for four years. Each client entering into the study was assessed for cognitive function, affective state, and physical ability to perform activities of daily living (ADL), using standard instruments. Before testing, demographic information was collected and the assessing nurse was asked to predict whether the client would be dead or alive in one year, and whether, if alive, the client would still be in continuing care. The mean age of the subjects was 78.3 years.

The results were predictable. Cognitive function and ADL function tests were significant predictors of both death and drop-out from the programme; they were better than the nurse's clinical judgement. Rate of cognitive and ADL function were as expected, but the rate of affective impairment (53.6%) was much higher than expected. At the end of the four years, just less than a quarter of the cohort were still receiving continuing care.

What does this tell us that is helpful to UK practice? The sample was of all clients entering into the scheme, and they may have had different levels of dependency and disability for acceptance into a continuing programme than would be the case in the UK, but I doubt it. The practical lessons for primary care physicians was the high rate of dysphoria. The authors suggest scope for therapeutic intervention. I have no doubt that there would be similar findings in the UK.

IDRIS WILLIAMS
Emeritus professor of General Practice, University of Nottingham

Source: Worrall G, Chaulk P, Briffett E. Predicting outcomes of community-based continuing care. *Can Fam Physician* 1996; **42:** 2360-2367.

● digest ● digest ● digest ● digest ● digest ●

Euthanasia

THE Netherlands is the only developed country where euthanasia and assisted suicide are permissible provided that certain medico-legal requirements are met. The two terms are legally defined, but a moral distinction between them is not usually made.

This paper reports the results of a cross-sectional survey of 1042 Dutch family physicians in which doctors were asked about their practice and beliefs about euthanasia and assisted suicide (EAS). It was published in Canada to inform debate in that country. It helps us here in Britain to understand what is happening in the Netherlands.

The survey seems to have been carried out with the scientific rigour that we have come to expect from Dutch general practice research. The response rate was 67% and doctors could indicate that they had sent in an anonymous questionnaire by returning a reply card separately. Contact was made with 86% of non-responders. The main reason for non-response was 'lack of time'.

The survey asked about experience of EAS in the four-year period 1986 to 1990. In any given year, 24% of responding doctors had practised EAS, but only 1% had done so more than twice. In total, 48% of responders had never practised EAS. In most cases EAS took place at home (96%), outside business hours (73%), and in the presence of others (99%). In 74% of cases, the doctor was present during the process of dying.

The shortening of a patient's life by EAS was estimated as less than 1 week in 42% of cases, and less than 1 month in 79%. In 5% of cases, the estimated time was more than 6 months. The main reported reasons for the request of EAS were futile suffering (56%), fear or avoidance of loss of dignity (42%), unbearable suffering (42%), and pain (35%).

The main condition that patients requesting EAS were suffering from was cancer (85%). Other conditions included cardiovascular disease (3%), multiple sclerosis and amyotrophic lateral sclerosis (3%), and others including AIDS (9%). The average age for patients dying by EAS was 63.5 years for men and 66 years for women.

Physicians who practised EAS were more likely to work in urban areas and to have no religious affiliation. Physicians were more opposed to EAS if they had a religious affiliation or were older.

There are many similarities between general practice in the Netherlands and in the UK. It might well be thought that if the UK ever came to permit EAS, our experience as GPs would mirror that of our Dutch colleagues. Would we want this? I, as someone who has firm Christian religious beliefs, would sincerely hope that we do not go down that road.

ROGER GADSBY
General practitioner, Nuneaton, Warwickshire

Source: Verhoef MJ, van der Wal G. Euthanasia in family practice in the

● digest ● digest ● digest ● digest ● digest ●