Commentaries on selected articles from overseas journals of general practice.

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Independence in the elderly

THIS is a Canadian study identifying barriers and facilitators to independence as perceived by older people with chronic health problems and their care-givers. The method was quantitative using locus groups. Each of these consisted of seniors, informal health care givers, and professional care givers. Four major themes were identified: attitudes and attributes, service accessibility, communication and cooperation, and continuity of care. An underlying theme was the preservation of independence and autonomy, a now well-understood requirement for successful living in old age. Ageism was seen to be a serious threat to autonomy, together with the ease with which older people allow themselves to become patients, a relationship which lowers their self-esteem and confidence.

Taking into account the large numbers of older people who have chronic health problems, family physicians were seen to both impede and facilitate seniors' independence. Fostering positive attitudes was seen as the role of family physicians, using counselling skills where appropriate. Similarly, a family physician's availability was seen as important in increasing seniors' confidence to remain independent.

The study concluded that the importance of the role of family physicians in facilitating coordination and comprehensiveness of health care services could not be overstated. Family physicians are seen as taking the lead in refining services, easing access, better coordination, and provision of programmes geared to seniors' needs. All this is familiar to those working in primary care in the United Kingdom. It reinforces once again the pivotal role of the GP/family physician in caring for older people.

IDRIS WILLIAMS
Emeritus professor of general practice, University of Nottingham

Source: Brown JB, McWilliam CL, Mai V. Barriers and facilitators to seniors independence. Perception of seniors, caregivers, and health care providers. *Can Fam Physician* 1997; **43:** 469-470.

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Dampness in the home

THERE is fierce debate over the link between respiratory symptoms and reported home dampness and mould growth. This Canadian study informs the debate by testing the validity of questionnaire reports as an indicator of the burden of indoor fungi.

The study found that reported mould, water damage, and mouldy odours were associated with elevated levels of indoor fungi; however, inaccuracy was high and there was evidence of a systematic reporting bias. In the presence of low concentrations of viable fungi in dust, responders reporting allergies were more likely to report visible mould growth ($P = 0.10$). The study concludes that systematic overreporting could create a false positive association between fungi and health.

Great care appears to have been taken over the measurement of fungal biomass; however, only 403 of the original 1438 eligible families were studied, and there is insufficient information in the paper to assess how representative this sample is of the total population.

The results of this paper have important implications for primary and secondary health care and housing policy. There are currently over 1.4 million unfit dwellings in England, including many where dampness is a major problem. The prevalence of respiratory disease shows a clear social class gradient with hospital admissions for asthma higher in areas of poverty. However, the causality between indoor fungi and health is not yet fully understood. This paper's conclusion that there is a need to develop accurate objective measures of exposure to clarify the health effects of fungi is a small yet important contribution to the debate.

HELEN LESTER
GP and research fellow, Birmingham

Source: Dales RE, Miller D, McMullen E. Indoor air quality and health: validity and determinants of reported home dampness and moulds. *Int J Epidemiol* 1997; **26:** 120-125.

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Osteoporosis in males

AWARENESS and understanding of osteoporosis has increased greatly over the past few years and continues to do so in respect of both patients and their doctors. Some of this increase has been associated with the availability of hormone replacement therapy for the management of osteoporosis in women. More recently, the introduction of the bisphosphonate group of drugs has widened the scope for the prevention and treatment of the condition, and has raised possibilities for the availability of a treatment for male osteoporosis.

Professor Seeman's paper is a helpful review of osteoporosis in men, which puts the problem in perspective by pointing out that about 30% of hip fractures occur in men (there were 1.7 million hip fractures worldwide in 1990), and the morbidity and mortality of hip fractures is higher in men than women. This clearly represents a public health problem.

Hypogonadism is highlighted as an important factor to be considered in male osteoporosis. Excessive alcohol intake heads a list of risk factors which also includes tobacco use, inactivity, leanness, low calcium intake, reduced strength, corticosteroids, anticonvulsants, heparin, and excessive thyroid hormone replacement. Professor Seeman also reminds us to be aware of secondary osteoporosis with conditions such as multiple nyeloma coming high on that list.

Our attention is drawn to the interesting difference in the mechanism of osteoporosis in men compared with women. Trabecular thinning occurs in men because reduced bone formation is the main mechanism responsible for bone loss. Trabecular perforation occurs in women because of the increased bone turnover associated with the menopause. The rather limited choice of treatment options for osteoporosis in men underlines the need for added therapeutic possibilities, e.g. the bisphosphonates.

STUART F WOOD
Senior lecturer in general practice, general practitioner, Glasgow

Source: Seeman E, Do men suffer with osteoporosis? *Aust Fam Physician* 1997; **26:** 135-141.

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Electronic medical records

THE electronic or computer-held record is very much a topical subject. Despite the enthusiasm of some practitioners and some encouragement from the government there has yet been little progress with the computer-only record.

In his article, Dr Cheong describes the rise of computers in clinical practice in Australia and, in particular, their legal acceptability. Oral testimony is still the preferred method of giving evidence in court in both Australia and the United Kingdom. Therefore, one can understand the difficulties that courts may have with all-paper records, and all the more with electronic records.

The article describes some of the problems that may arise: who wrote the record, when was it written, and has it been altered? The uses to which computers may be put in general practice, such as automating many routine functions, makes it inevitable that a fully computerized record will arrive. It is to be hoped that there will be enough computer-literate staff to use them properly.

JIM RODGER
Medical adviser, Medical and Dental Defence , Union of Scotland

Source: Cheong I. The legal acceptability of an electronic medical record. *Aust Fam Physician* 1997; **26:** 37-41.

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Familial breast cancer

WITH an increase in the public awareness that breast cancer may be genetically determined, the demand for genetic risk counselling will increase. This paper set out to ascertain whether those patients who perceived themselves as being at increased risk in fact were, and what strategies could be evolved to assess genetic risk in general practice.

Patients who had consulted their general practitioners in a health centre in The Netherlands about a familial risk of breast cancer were identified and asked to agree to an interview with a clinical geneticist to establish their exact family history. Sixty-seven out of 81 patients agreed to this. Seventeen (25%) were, after interview, considered to have a high risk, 18 (27%) a moderate risk, and 32 (48%) a low familial risk of breast cancer. To establish these risk levels, the geneticist studied the family trees and then compared his opinion with that obtained from two sets of guidelines already published. The guidelines were those published in the *BMJ* in 1994 and those produced by the Dutch West Cancer Centre.

All the patients assessed as having a high risk were identified by the Dutch guidelines, but only 14 out of the 17 were picked up by the *BMJ* guidelines. Both these guidelines are quite complicated and would not be easily used in general practice.

It seems that if the limited genetic counselling available in most areas is to be rationally used, then clear guidelines and clear recommendations should be drawn up that are easily applicable to general practice.

ANN DUNBAR
General practitioner, Dundee

Source: de Bock GH, Perk DC, Oosterwijk JC, *et al.* Women worried about their familial breast cancer risk - a study on genetic advice in general practice.

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Acute sinusitis in adults

Acute sinusitis in adults is a frequently diagnosed condition in general practice. In European morbidity studies, the incidence varies from 15–43 episodes per 1000 patients per year. In the United States, 14% of the population self-reported a diagnosis of sinusitis, making it one of the most common health complaints. In the United Kingdom (UK), an average consultation rate for acute sinusitis is 20 per 100 patients.

Diagnosis depends on the symptoms, although various tests used for confirmation of the diagnosis include X-ray sinuses, CT scan of sinuses, and antral washouts. Treatment of acute sinusitis mostly consists of the relief of symptoms and antibiotic therapy, although, in some cases, functional endoscopic sinonasal surgery (FESS) is contemplated. Although sinusitis in general practice is usually a self-limiting condition, it has a significant effect on the working time lost. Management of sinusitis in general practice in the UK depends mainly on the clinical presentation, owing to lack of direct access to investigations (X-rays and CT scans) and results.

Norway

Linbaeck *et al* looked at the incidence, complications, referral to ear-nose-throat (ENT) specialist, and economic costs during a one-year period. In 1993, computer tomography (CT) was used as a reference standard to divide patients into two groups: with or without confirmed sinusitis.

During 1993, 1053 patients with 1138 episodes of acute sinusitis were clinically diagnosed: 69% women and 31% men. Eighty-seven of the 138 patients (63%) had their clinical diagnosis confirmed by CT scan. The incidence of acute sinusitis was 21.7 episodes per 1000 adults per year. Two per cent of the patients needed proof puncture. Acute sinusitis generated an estimated cost of 192 million NOK (about £196) per year; 75% of this was due to sick leave taken from work.

In conclusion, this study showed a yearly incidence of acute sinusitis in Norway similar to other countries. Two thirds of the patients were women. Not many were referred to an ENT specialist. The disease has few complications and generates considerable expense, sick leave being a major part of these expenses.

Source: Linbaeck M, Hjortdahl P, Holth V. Acute sinusitis in adults in Norwegian general practice. *Eur J Gen Pract* 1997; **3:** 7-11.

The Netherlands

This study aimed to determine the evidence for effectiveness of antibiotic treatment in acute maxillary sinusitis in adults by assessing the methodological quality of placebo controlled double-blind randomized trials between January 1996 and July 1996.

Eighty-eight clinical trials of antibiotic treatment of sinusitis were identified, only three of which were placebo-controlled double-blind randomized trials in adults with acute maxillary sinusitis. All other trials were excluded because of exclusion criteria.

Most of the studies scored poorly, because of poor internal or external validity and lack of placebo-controlled double-blind randomized trials. Only one study claimed superiority of antibiotic treatment in acute maxillary sinusitis, showing a significant difference in recovery between the treatment groups. In conclusion, there is no evidence-based advice available to GPs regarding antibiotic treatment in acute maxillary sinusitis.

Source: Stalman W, van Essen GA, van der Graaf Y, de Melker RA. Maxillary sinusitis in adults: an evaluation of placebo-controlled double-blind trials. *Fam Pract* 1997; **14:** 124-129.

This cross-sectional pilot study was undertaken among patients on the list of a Dutch group practice (six GPs) in cooperation with ENT and radiography departments of a local hospital. Patients aged between 16 and 65 years with one or more of the following symptoms were included: purulent nasal discharge, pain in the sinuses on bending forwards, predominantly unilateral maxillary pain and pain in teeth or on mastication, and above symptoms after a common cold or influenza.

Of the 60 evaluated patients, acute sinusitis was diagnosed from the history in 80% of cases. Diagnosis was confirmed in 13% and 18% by two assessors reading the ultrasound scan, and in 55% and 60% by two radiographers reading the X-rays. The group practice decided that, in this pilot study, agreement between clinical history and ultrasound scan and radiography was too poor for these two investigations to add greater diagnostic certainty to their situations.

Source: Difficulties in diagnosing acute sinusitis in a Dutch group practice. Stalman W, van Essen GA, Gubbels JW, de Melker RA. *Eur J Gen Pract* 1997; **3:** 12-15.

Overall comments

- Diagnosis of acute maxillary sinusitis in adults can be made with reasonable accuracy by clinical history and findings.
- Confirmation by radiography can be helpful in 50-60% of the patients.
- There was no significant difference in the outcome between GP and specialist treatment.
- The role of antibiotics could not be proven as effective in these studies but remains the mainstay of treatment in this country, along with symptomatic treatment.
- Antibiotic therapy would definitely help in reducing the time taken off work.

AVINASH KHUNGER
General practitioner and clinical assistant ENT, Stafford District Hospital