

Acute sinusitis and antibiotic treatment <i>Morton Lindbæk, Per Hjortdahl and Ulf L-H Johnson</i>	1341	Telling the truth <i>Michael Kirby, Conor Maguire</i>	1343	Screening for abdominal aortic aneurysms in general practice <i>Stephen Moore</i>	1345
Counselling in primary care <i>Michael Moore</i>	1341	Practice nurse telephone triage <i>John Pitts</i>	1344	Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use <i>double spacing</i> and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk ; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.	
<i>Max Kammerling</i>	1342	Prevalence and treatment of dizziness <i>Nefyn H Williams</i>	1344		
Cluster randomization <i>Sally Kerry, Martin Bland</i>	1342	Group D streptococcal throat infection <i>Ian McKay and Tom Gillespie</i>	1344		
Urine sample collection <i>Sue Vernon, CK Foo and ND Plant</i>	1342	Screening: the inadequacy of population registers <i>RJ Lowry</i>	1345		
Community hospitals <i>Mari Lloyd-Williams</i>	1343				

Acute sinusitis and antibiotic treatment

Sir,
Stalman *et al* presented an interesting study (December *Journal*)¹ that found no significant differences between 10 days' treatment of doxycycline and placebo in adults with acute sinusitis-like complaints.

We performed a similar trial comparing penicillin V and amoxycillin treatment in patients with acute sinusitis.² Our reference standard was computed tomography (CT), with fluid level or total opacification as criteria of acute sinusitis. In this study, 10 days' antibiotic treatment gave significantly faster response than placebo, evaluated by four outcome measures.

In addition, we performed a study on 63 patients with mucosal thickening of 5 mm or more without fluid level or total opacification. We found no significant differences between the antibiotic group and the placebo group with regard to subjective status, clinical status, and duration of illness (to be published elsewhere).

Our study also included a group of 40 patients with no CT findings who did not get any medication. To compare our studies with that of Stalman, the results in the sinusitis group was summated with those with only mucosal thickening or no CT findings, comprising a total of 230 patients. The difference in proportion of patients feeling restored after 10 days diminished between the antibiotic groups (88/151; 58%) and the placebo group (32/79; 41%), the difference still being significant ($P = 0.01$).

In our BMJ study we had a high probability of bacterial sinusitis.³ In the Stalman study, only clinical symptoms and signs without any objective visualization were used to include patients. This is the main difference between the two studies and can explain the different results. As the authors state, virus may be the causing agent of many of their patients' illnesses. Thus, we do not agree with the authors that supportive treatment could explain

the different results, as our patients also got decongestants.

The authors do not raise the question whether subgroups among patients with a clinical diagnosis of acute sinusitis benefit from antibiotic treatment. Our study has demonstrated that patients with a CT-confirmed acute sinusitis, as a group, benefit from antibiotics. All patients in general practice cannot and should not be investigated by CT or X-ray. The real challenge is clinically to single out patients with a bacterial sinusitis. In another article we demonstrated that patients with at least three out of four clinical symptoms and signs (purulent rhinorrhoea, two phases in the disease history, purulent nasal secretion, and erythrocyte sedimentation rate >10 mm) had a positive predictive value of 0.86 of having a CT-confirmed acute sinusitis.⁴ In addition, Gwaltney has underlined the importance of at least seven days' duration before diagnosing bacterial sinusitis.⁵

MORTON LINDBÆK
PER HJORTDAHL

Department of General Practice
University of Oslo, Norway

ULF L-H JOHNSON

Department of Neuroradiology
Ullevål Hospital
University of Oslo, Norway

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Counselling in primary care

Sir,
The two recent studies concerning counselling in primary care (March *Journal*)^{1,2} add valuable information to the debate about the effectiveness of counselling in this setting. Unfortunately, their results appear conflicting and the debate unresolved.

Counsellors are new to primary care, and how patients of GPs have become clients of counsellors has not been described. In the study by Harvey *et al*, any adult with emotional or relationship problems was eligible for inclusion.¹ The authors were unable to determine the number of potential recruits and, unfortunately, we are not told the practice populations or consultation rates. From the information given, the population from which the study group was drawn was probably in excess of 50 000, so, over the two years of the project, 100 000 adult consultations would have taken place, of whom 30 000 would be expected to have some degree of psychosocial distress. How then were the 162 recruits selected?

Baker *et al* specified more stringent referral criteria but even less information about the population from which they were drawn.² There are worries also about their attrition rate, as only 117 clients were included in the analysis from the 583 referred to the service. We are unable to determine whether the different outcomes of the two studies were the result of bias arising from the absence of a control group or arising from patient selection. To make sense of the results, we need to know much more about the process of patient selection and recruitment.