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Practice nurse telephone triage

Sir,

The paper by Gallagher *et al* (April *Journal*)¹ on telephone triage of acute illnesses by a practice nurse is a useful contribution to the means of managing this aspect of primary care workload. It is one that we are contemplating in our own, equally busy, practice. However, I am astonished about the statement in the discussion that 'a large proportion of patients seeing the nurse require prescriptions'.

General experience and workload reports from out-of-hours cooperatives suggest that the majority of 'acute' illnesses, for which urgent advice is sought, include coughs, colds, 'flu-like illnesses, earaches, vomiting, diarrhoea, and minor allergic conditions. Very few of these are likely to be helped significantly by medical actions, and symptomatic remedies are easily available from pharmacy outlets.

I would be concerned that a high rate of prescribing will compound surgery attendance for these conditions, and that opportunities to inform and educate patients towards a greater degree of self-reliance is being lost.

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Prevalence and treatment of dizziness

Sir,

The editorial studying the prevalence and treatment of dizziness (April *Journal*)¹ was a fascinating read. It certainly is the case that 'undifferentiated illness' such as dizziness forms a substantial part of our workload in general practice. How disappointing then, that the aetiology of dizziness described in standard textbooks is written by ENT specialists rather than general practitioners.

Yardley *et al* state that the aetiology might be vestibular, cardiovascular, iatrogenic, psychiatric, neurological, or 'multi-sensory' in origin. Another possible source of dizziness, not mentioned in standard textbooks, is the neck. Proprioceptors in the neck enable us to sense the position of our head in relation to the rest of our body. Might such disturbed proprioception be an important cause of dizziness? In my experience, assessing and treating patients' necks with osteopathic methods within my own general practice, I have been struck by the number of patients who complain of dizziness along with their neck pain. Sometimes this dizziness improves dramatically with osteopathic manipulation.

I hasten to add that I am not advocating neck manipulation for all dizzy patients, but that osteopathy provides new insights into possible alternative aetiologies. Interestingly, Yardley *et al* state that chronic dizziness is associated with neck pain, but claim that this is a secondary phenomenon consequent to adopting a rigid head position. Perhaps the neck symptoms are the primary problem and the dizziness is a secondary phenomenon?

The description of 'vestibular rehabilitation'² includes a programme of graded exercises consisting of eye, head, and body movements that are designed to stimulate the vestibular system. Surely they will also stimulate proprioceptors in the musculo-skeletal system? Normal balance involves a complex interplay between numerous interacting systems, vestibular, neurological, proprioceptive, and visual. Dizziness results when this fails.

Professor Bain³ asks how 'vestibular rehabilitation' can be provided within general practice. This question also applies to the provision of other physical therapies including spinal manipulation. Providing such assessment and treatment within general practice not only broadens our therapeutic choice away from the narrow, unsatisfying, and unproven confines of pharmacology, but also provides us with insight into alternative aetiologies for

these common but neglected disorders.

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Group D streptococcal throat infection

Sir,

The brief report by Sanders (February *Journal*)¹ suggests an unusually high incidence of isolation of Lancefield group D β -haemolytic streptococci in patients with pharyngitis or tonsillitis in a London general practice. Moreover, he attributes this organism as the likely source of infection. We feel that this is giving a false impression of the pathogenicity of group D streptococci, and goes contrary to the current and long-standing opinion that groups A, C, and G are responsible for throat infections.²

Lancefield group D streptococci are almost all enterococci (the majority being *E. Faecalis*), which are normal gastrointestinal commensals. They may be a cause of urinary tract infections, post-operative sepsis, septicaemia, and endocarditis. They are generally less sensitive to penicillin than the other haemolytic streptococci.

Dr Sanders quite rightly diagnoses the infection on clinical grounds, but wrongly attributes isolated bacteria, not recognized pathogens in that site, as being the causal organism. He makes no mention of whether the patients had been previously treated with an antibiotic. Antibiotic therapy would select out resistant organisms, such as enterococci, and give the impression of a higher than usual carriage rate. We suspect, however, that most of these infections are viral. Dr Sanders makes no reference to any attempt to investigate a viral cause for these infections.

We also wish to make the point that he uses 'near patient testing' in the wrong context. Near patient testing is widely