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General practitioners' prescribing data for multiple sclerosis patients indicates a link with asthma

Sir,

The General Practice Morbidity Database Project (GPMDP) collates data routinely entered into GPs' computer systems for a representative sample of at least 10% of the resident population of Wales.¹ Anonymised data for 1996 was obtained for all patients from 24 GP practices in the database ($n = 234\ 961$ for 1996) who had a Read code of multiple sclerosis (MS) at some point from 1993 to 1996 as well as a randomly selected age-sex matched control group. Some 216 MS patients were identified, giving a prevalence of 91.9 per 105 (within the 24 GP practices' population in 1996). Their mean age was 46.7 years (range 17–84) and 67% were female. MS patients were found to have been prescribed significantly more (different) drugs (BNF categories 1–15) compared with controls (mean of 15.0 versus 8.0 respectively; $P < 0.0005$) (Table 1). They were prescribed significantly more laxatives, diuretics, hypnotics and anxiolytics, antidepressants, antiepileptics

(including carbamazepine), corticosteroids, drugs for genitourinary disorders (predominately oxybutynin), nutrition and blood (mainly vitamin B₁₂ and vitamin B compound), and neuromuscular disorders (primarily baclofen) ($P < 0.05$). There were no significant differences between MS and control patients for analgesics and non-steroidal anti-inflammatory drugs ($P > 0.05$). In contrast, significantly fewer bronchodilators and inhaled corticosteroids were prescribed ($P = 0.008$ and $P = 0.03$ respectively). Patients with MS were also less likely to have a Read code for asthma (from 1993 to 1996) compared with controls (six versus 30 patients respectively; $\chi^2 = 16.03$; $P = 0.00006$; odds ratio = 0.18; 95% CI = 0.47–0.67).

Underdiagnosis and underprescribing for co-morbidities in patients with chronic diseases is well recognised.² However, this does not explain the low prescribing of drugs and low recording of Read codes for asthma in our MS population, since no underprescribing was found in other diseases, such as cardiovascular disease. MS patients may be less likely to develop asthma for several reasons. First, they may have less exposure to environmental aller-

gens, particularly if housebound, although this could increase exposure to other allergens (e.g. house-dust mites). Secondly, reduced exercise owing to disability may limit exercise-induced bronchospasm, although intrinsic asthma only accounts for a minority of asthma cases. Thirdly, greater use of immunomodulatory drugs in MS patients may have alleviated asthma symptoms; for example, two patients had cytotoxic immunosuppressants in 1996 and 22 (10.2%) had at least one course of corticosteroids, although only one person had received a Read code for asthma. One intriguing explanation for our finding is the possible existence of a protective mechanism linked to MS. Certainly, MS has been associated with a reduced risk of IgE-mediated allergy,^{3,4} something which supports our finding. It is unfortunate that drugs for allergic disorders could not be analysed in our dataset owing to their widespread availability without prescription.

J EVANS
C ROGERS
C M WILES

University of Wales College of Medicine
Cardiff

Table 1. Prescribing of selected drugs by GPs in 1996, by BNF chapter, for MS and control patients.

Drug group (BNF chapter) ⁵	MS patients		Control patients		Odds ratio (95% CI) ^a	P value ^b
	Prescriptions (n)	Patients (n)	Prescriptions (n)	Patients (n)		
Laxatives (1.6)	255	37	17	9	4.75 (2.23–10.12) ^f	<0.0005
Diuretics (2.2)	107	19	41	6	3.38 (1.32–8.62) ^e	0.007
Hypnotics and anxiolytics (4.1)	146	23	116	10	2.33 (1.08–5.06) ^e	0.03
Antidepressants (4.3) ^c	261	43	62	14	3.58 (1.90–6.78) ^f	<0.0005
Antiepileptics (4.8) ^d	98	14	43	5	2.92 (1.03–8.27)	0.04
Analgesics (4.7)	263	57	116	43	1.44 (0.92–2.26)	0.09
NSAIDs (excluding aspirin) (10.1.1)	98	42	100	29	1.56 (0.93–2.61)	0.1
Corticosteroids (6.3)	54	24	23	8	3.25 (1.43–7.4) ^f	0.004
Genito-urinary disorders (7.4)	156	30	0	0	- ^f	<0.0005
Nutrition and blood (9)	205	37	22	8	5.37 (2.44–11.84) ^f	<0.0005
Neuromuscular (10.2)	272	39	33	8	5.91 (2.69–13.0) ^f	<0.0005
Bronchodilators (3.1)	9	7	108	20	0.33 (0.14–0.79) ^e	0.008
Inhaled corticosteroids (3.2)	12	3	55	11	0.26 (0.07–0.95)	0.03
Total	3231	216	1713	216	-	<0.0005

^aOdds ratio for the number of MS/control patients prescribed at least one drug from the specified chapter; ^bMann-Whitney U test comparing the number of prescriptions for MS patients versus controls; ^cincludes all prescriptions for amitriptyline; ^dincludes all prescriptions for carbamazepine; ^e $P < 0.05$; ^f $P < 0.01$ (2/22 with continuity correction, $df = 1$).

D K LUSCOMBE
H L TREMLETT

Welsh School of Pharmacy
Cardiff University
Cardiff
CF1 3XF

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Incidence and management of hypoglycaemia in children

Sir,

Between September 1998 and April 1999 we carried out a survey in our clinic population to determine the incidence and management of hypoglycaemia in children under 16 years of age who had type 1 diabetes mellitus for more than one year.

At routine clinic visits parents were asked to complete a questionnaire giving information about hypoglycaemic episodes over the preceding year. Hypoglycaemia was defined as 'mild' when symptoms responded to oral glucose or glucose polymer gel and 'severe' when glucagon or intravenous glucose was required or if seizure, coma, or marked impairment of consciousness was present.

One hundred and seventy-one children fulfilled the criteria for inclusion in the survey and 129 questionnaires were completed (75% response rate). Overall, there were 28 severe hypoglycaemic episodes (seizure in 14, coma in six, reduced level of consciousness in seven, uncertain symptoms in one) reported by 24 of the children over one year (21.7%). Two children had two episodes of severe hypoglycaemia over one year and one had three episodes. Mild hypoglycaemia was reported in all but eight patients (93.2%),

although 11 parents did not complete this section.

Eleven children (8.5%) reported the use of glucose polymer gel to manage hypoglycaemia. Four children had self-administered it for mild autonomic symptoms, one teacher had used it (symptoms unreported) but, of note, six parents had used it in preference to glucagon to manage seizure (five) and coma (one). One had subsequently given glucagon at home and two others then attended the accident and emergency department. Sixteen children (12.4%) had been given glucagon appropriately at home by an assisting adult.

The absence of accepted criteria for the definition of severe hypoglycaemia in children makes it difficult to compare the results of this survey with other studies.¹⁻³ However, it is noted that, in 21% of the severe hypoglycaemic episodes, glucose polymer gel was the firstline therapy chosen by parents. This would have been in accordance with the British Diabetic Association (BDA) guidance at the time. In January 1999, during the survey, the BDA revised its recommendations on the use of glucose polymer gel, stating: 'Hypostop should not be used on people who are unconscious and unable to swallow, unless by a trained healthcare professional such as a paramedic'. We would like to highlight to all diabetes educators that there is a need to actively update carers on the new recommendations.

D CARSON

Institute of Clinical Science
Belfast

M C MCGOVERN

Paediatric Department
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
Co Armagh
BT63 5QQ

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General practice computing

Sir,

The recent review of general practice computing in the January *Journal*¹ once again flags up the disquiet over the legal status of general practitioner electronic records. However, this worry is now unnecessary because of recent events.

As I recently pointed out in an editorial in *Update*,² the Shipman case has solidified the legal status of such records in English courts. By being used as a major plank in the prosecution, and not being challenged by the defence, records without a designed-in audit trail have been shown to be acceptable to the court. Before this case there was always the possibility that computerised records would be challenged as not being reliable. Dr Shipman's downfall due to the alterations being out of sequence in the database is significant. More should be made of this change in status.

TREFOR ROSCOE

Informatics Tutor — North Trent
Institute of General Practice
University of Sheffield

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Sir,

I read with interest Dr Waring's results on his questionnaire¹ regarding the extent to which practices now regard themselves as 'paperless'. I note that he quotes cost as a major obstacle to further computerisation, with other concerns involving the legality of such records and standardisation of data. The paper, *Information for Health*,³ is quoted, which we are led to believe elsewhere² suggests that we should all be computerised by the year 2005. I would like to suggest that this may not be possible, not for the reasons stated by Dr Waring but due to a hidden fear of computers hinted at by Dr Waring and certainly very prevalent among many of our colleagues. I fear that computerisation will not take significant steps forward until many of those who do not wish to become computer-literate have hung up their stethoscopes for good. I feel the goal of computerisation by 2005 is not realistic, although perhaps a more attainable target would be 2015. A study into GP attitudes towards computerisation might be helpful.

TONI NACZK

Cumnock Health Centre
Cumnock
KA18 1BF

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Snake wars

Sir,

The symbol of a snake on a pole to represent healing pre-dates Greek mythology.¹

About 1300 BC an unlikely, large rabble of refugees crossed a desert under the leadership of one man. Their aim was to find the land promised to them by God. The eventual achievement of that aim resonates down through history to present day Middle East politics.

At one point the people were disobedient and suffered from snake bites. As instructed by God, Moses made a bronze snake, put it up a pole, and anyone who looked at it was healed (Numbers 21: 8-9). This foretold the manner of Jesus' death and resurrection, which is the central means of the Christian's healing from sin. 'Just as Moses lifted up the snake in the desert, so the Son of Man must be lifted up, that everyone who believes in him may have eternal life' (John 3: 14-15).

Please let us acknowledge the true origin of this remarkable medical symbol.

PETER DAVIS

63 Golf Lane
Whitnash
Leamington Spa
Warwickshire
CV31 2QB

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Muddling through in a parallel track universe

Sir,

Murie's paper in the January *Journal*¹ concludes that GPs' motivation and attitude presents a barrier to needs assessment in primary care — a fundamental part of the

evolving NHS framework. This study builds on a number of others that expose life in the NHS as a parallel track universe.

The high level track is a world of virtual politics, where belief in the difficulties of change are suspended and all becomes possible as the symbolism of the policy illusion becomes paramount rather than the practicality of the content.² From this universe emerges a continuum of organisations, edicts, and documents underpinned by the directives of evidence-based medicine and health economics; a linear world understandable by a reduction into its component parts and the application of inferential statistics.

The low level track is a world of practitioners who are pragmatic, adverse to innovation, and already feel overwhelmed with information.³ Where, even after the implementation of intensive, in-practice programmes designed to convey the best practice for clinical care, improvements are not found.⁴ Working within a framework that qualitative research exposes as an organisation under siege — barely coping with the lack of skills to fulfil current agenda, apathy among the majority, and a capacity to present glossy corporate images that belie the problems of working in a complex organisation.⁵

Unfortunately, the real universe is not always about cosy certainties like guidelines, needs-based planning, and easy solutions, but is a chaotic, complex, non-linear system where human frailties and feeling, complex social rituals, and expectations direct many interventions.

In reality — it's all a bit of a muddle.

D P KERNICK

St Thomas Medical Group Research Unit
Cowick Street
EX4 1HJ

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Communicating for better health

Sir,

This year a key feature of the NHS changes saw primary care groups (PCGs) given greater responsibility for improving the health of resident populations. With this responsibility comes accountability, making it more important for clinicians to communicate with their local community about not only their own health needs but also broader health issues.

For example, in implementing a Health Improvement Programme in mental health we could find ourselves needing to tackle quite complex issues, such as perceptions of schizophrenia as the 'lion's den' image that currently prevails within the tabloid media, or how to increase understanding of other mental health disorders, such as Alzheimer's Disease.

Clearly, improving the health of whole populations is part of a long-term agenda. In their recent editorial, Fisher and Gillam¹ ask: how well equipped are GPs and PCGs to further the public health agenda? We entirely agree with their focus on needing to engage the local community.

In addition, clinical governance will entail a raft of education meetings, implementation initiatives, and team-building exercises to encourage and facilitate quality health care to all patients.

Until recently, we have only had to focus on imparting information in a one-on-one situation with our patients. Now a new communication skill must be developed: that of communicating quickly and effectively to a wider audience in a subject area that is easily prone to hype and manipulation.

Much communication needs to be done and the mantle now seems to fall on us in primary care. Hype has so far tended to fill the vacuum that a lack of open debate leaves. Raising awareness and managing expectation is a great challenge. As clinicians we must be prepared to become involved in the debate about the use of new interventions and how they may affect individual patients and local health service provision. Quick and simple solutions to the issue are just not possible. But we can make a start by beginning the dialogue we are going to need with our communities, such as how the rationing decisions will be made as to which treatments will be available to all and which will not.

Knowing where to start is perhaps the biggest challenge. Novartis, in consultation with the NHS Executive, have developed a tool to support the engagement of others with primary care through their communication programme, *Engaging the*

Public. Tools such as these can help us set up some of the practical mechanics for a dialogue and teach us some of the new skills we now need in communication.

Success depends on developing two-way communication with target audiences and requires analysis, planning and implementation, follow-up, and evaluation. The expectations, concerns, and opinions of local people are the currency of this debate. The findings will allow an interpretation of people's likely response to our proposals and will be an important element in service planning and gaining support for our decisions.

It will not be long before those decisions will be about the impact and implications of new technologies in medicine. A prime example of these emerging technologies is functional genomics. The future of pharmaceutical healthcare could be revolutionised by the mapping of the human genome and the resulting possibility of identifying, through single-nucleotide polymorphisms (SNPs), disease-associated genes. Therapeutic interventions could then be targeted to specific individuals.

Yet however good the potential benefits, we cannot embrace new technologies unquestioningly. In the main we tend to be distrustful of change, particularly where new innovations impact, not just on society or the environment in which we live, but on ourselves, our families, and our future generations. This general distrust of change is particularly unfortunate in health care, as it is here that we could have the most to gain from embracing new innovations and technologies.

Fear of new technologies often arises through a lack of understanding and public debate can be used as an opportunity to inform the public about the emerging technologies. It is important, however, that such debates cover not just the benefits of the emerging technologies but discuss their associated risks to humans, society, and the environment. It is about assessing risk against benefits and therefore putting them into context. It is through this openness and the presentation of the full picture, of both advantages and risks, that the public will begin to trust, not just the new technologies, but the organisations responsible for developing them. Moreover, just as important as debating what impact an emerging technology might have is considering the implications of it not being introduced or researched.

We have some work to do before we, and our communities, are able even to engage in the debate on a sensible footing. But we cannot avoid being in it. We

should start getting some of the basics in place now. The work Surrey Health has been doing in developing *Engaging the Public* is proving to be a useful platform from which to begin.

GEOFF ROBERTS

Upper Gordon Road Surgery
37 Upper Gordon Road
Camberley
Surrey
GU15 2HJ

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Randomised controlled trials in general practice

Sir,

Paterson's description of a successfully completed RCT in general practice¹ ascribed the success to the use of nurses explaining the reasons why the trial was being performed and to allowing discussion of patients' concerns.

I suspect that the intervention of the nurses is likely to have affected the outcome of the RCT. For this reason, other researchers should be wary of using such a 'facilitation' exercise to aid recruitment and to ensure follow-up of patients taking part in RCTs for fear of 'contamination'. Failure to allow for the effects of such facilitation can, in some instances, so materially affect patient response that the outcome is likely to produce spurious, although seemingly valid, outcomes.

A further problem should be mentioned. The inability to create 'active' placebos in antidepressant and in psychological therapy RCTs is also likely to have equally confounding effects when patients spot the differences between the 'active' treatment and the 'control' one. Regrettably, all too few researchers in these areas of inquiry fully understand the implications of this.

Cochrane himself warned researchers of the difficulty in performing useful RCTs in 'care' conditions as opposed to 'cure' conditions, making the still valid point that cure is still relatively rare but the need for care is widespread. He even went further, claiming that the pursuit of cure at all costs may restrict the supply of care.²

Prophetic words indeed; it would be wise if we listened carefully to them.

GRAHAM CURTIS JENKINS

Counselling in Primary Care Trust
First Floor
Majestic House
High Street
Staines
TW18 4DG

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