All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Risks and benefits of MMR

The study by Evans *et al*[1] highlights the need for the Child Health Service to create a forum for open discussion about the risks, benefits and options available for immunisations.

The immunisation Hotline Service at the Royal United Hospital in Bath, run by the Community Child Health Department, has to some extent, bridged this gap by providing such a service. The paediatricians and specialist registrars (under supervision) take part in a weekly rota, which conveniently fits in with the child protection rota to answer, discuss or investigate any immunisation queries that are made by professionals, such as health visitors, practise nurses, GPs, or by parents themselves. These queries are received via an immunisation answerphone service that is managed by named administration staff during the morning and which is then reviewed by the on-call doctor and answered on the same afternoon. We provide up-to-date information on any immunisation issues, including the immunisation schedule, Department of Health guidelines, dealing with adverse reactions, contraindications to vaccinations, and so on.

Since the recent controversy regarding the MMR vaccine, we have had a huge increase in numbers of parents wanting to discuss these issues. Between February and October in 2001 the hotline service received 368 calls, of which 145 (40%) dealt with issues involving the MMR vaccine. Many of these queries involved discussions regarding use of the single vaccines, MMR and autism, MMR and Crohn's disease, and MMR and egg allergy, among others.

While most child health departments will be involved with dealing with immunisation queries as part of their daily work, by formalising this process into a dedicated service we have created a forum for parents to enable them to be more actively involved in the decision-making process. They can access information and also use this as an opportunity to discuss their concerns regarding immunsations.

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Use of aural speculum in epistaxis

Epistaxis is a one of the most common problems encountered by ENT surgeons as well as GPs. The usual site of bleeding is the Little's area (the anterior inferior aspect of the septum). Cauterisation of the localised area of bleeding using trichloroacetic acid or silver nitrate sticks is our usual choice of treatment. However, problems with accidental cauterisation of the surrounding area — for example, the medial aspect of the inferior turbinate, the floor of the nasal cavity, and the nasal vestibule itself — can occur.

We wish to describe a method of overcoming this problem by using the aural speculum in the nose. The speculum is placed in such a way that only the localised area that requires cautery is directly visualised. Thus overspillage is prevented.

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Learning disability and homelessness

We welcome the editorial[1] showing the importance of general practitioners recognising learning disability as a significant risk factor for illness: it may also be a risk factor for homelessness, a point overlooked by Martin. He makes reference to 'social deprivation' as an association of learning disability, but without any evidence. In the case of homelessness and learning disability, there is in fact very little evidence, as our recent literature search showed.

We agree that 'the policy of taking people out of institutions and placing them into community care may have meant that some adults with learning disability have disappeared into the community with little structured follow-up'. Ken Simons' report, *Life on the edge*,[2] described the experiences of learning-disabled people in Bristol who were not in contact with specialist services. He found that two-thirds of the 28 people he interviewed described a history of one or more of transience, shared or temporary accommodation, and homelessness. He suggests that lack of access to employment, low income, difficulty in managing money, and limited social networks, are factors

contributing to these vulnerable people becoming homeless.

He observed that, in official United Kingdom homelessness statistics, learning-disabled people are effectively 'invisible'. Indeed, in a recent major review of research into single homelessness,[3] learning disability did not appear at all. Simons' work also points to the only other significant research we could find in this area: in Sydney, Australia. Here, Hill[4] has reviewed a number of studies that suggest that learning-disabled people are 'over-represented' among the homeless population.

In Hull we are starting a controlled prevalence study of learning disability among the homeless (and transient) population, compared with a comparable non-homeless population, centred on a new primary care service for socially excluded groups, which we believe will help to fill this gap in the evidence-base for learning disabilities.

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Funding the NHS

I must congratulate Professor Stange for having the perception to be able to see the wood rather than the trees with respect to British general practice. Many in primary care feel that the contagion of disillusion is very unbalanced.

One small point is, however, worthy of mention. In the final paragraph he talks of 'inadequate resources amid growing need'. The need has surely always existed; we are merely now more aware than ever that it is not being met. The major problem is therefore increasing patient (as well as clinician) awareness and expectation. This is fuelled by a government that promises the world in order to be elected but which cannot possibly be delivered, as the fiscal measures required would render them unelectable in future. The theory seems to be that the public will not elect anybody who will raise taxes in an open manner.

I can see only two possible solutions. First, the costs of providing the National Health Service could be devolved to a non-political commission that would decide on the fiscal requirements, regardless of who was in power, to let the government of the day off the hook with respect to tax ramifications.

Secondly, the NHS could choose to try to contain costs by defining a scope of service. This would undoubtedly be unpopular, as certain things would by definition be outwith the NHS scope of service (perhaps removal of tattoos and cosmetic procedures, perhaps IVF for those with one child already, perhaps certain expensive medications).

Unless somebody is prepared to grasp the nettle, primary care will increasingly be a site where unmet medical need (hence patient expectation) is elicited and subsequently intolerably delayed, or indeed shelved, through lack of resources.

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Author's response

I agree with Dr Simpson that GPs have always responded to a great need. Although panel sizes are smaller now than in Collings' day, I wonder if the perceived need is greater because, with so many advances in biomedicine, there is so much more we can do. And, in part, for the reasons cited by Dr Simpson, much more is expected. My impression — from a very limited time in England and from some reading — is that there is a relative shortage of GPs, but I claim no particular expertise on this impression. Regarding Dr Simpson's second proposed solution, the state of Oregon in the United States has had a very interesting experience with a public process for deciding on health care priorities.[1-8] It is a very good idea to develop community consensus regarding what should be paid for. The process of engaging in priority setting is at least as important as the outcome. Like many good ideas, the devil is in the detail.

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Rhabdomyolysis associated with cerivastatin plus gemfibrozil combined regimen

We report a case of a 60-year-old man with hypertension, hyperlipidaemia, non-insulin-dependent diabetes mellitus, ischaemic heart and cerebral disease, who required a visit for presenting progressive and painful proximal muscular weakness (Gowers' sign), and inability to walk. He had taken simvastatin, atenolol, enalapril, and acenocumarol for a long time without any apparent adverse reaction. Because of the rise of the triglyceride

level detected in a blood test, the simvastatin had been stopped and was replaced by cerivastatin 0.4 mg/day plus gemfibrozil 900mg/day combined regimen. The symptoms began only seven days after the lipid-lowering therapy administration. The patient was admitted to hospital where laboratory studies revealed: creatinine 78 μmol/l, urea 7.7 mmol/l, creatine kinase 71.000 U/l (this level raised up to 21 3000 U/l), aspartate aminotransferase 770 U/l, and myoglobinaemia 650 μg/l. However, the patient did not developed renal failure. Laboratory abnormalities and symptoms were normalised within 10 days of hospitalisation.

Rhabdomyolysis is an uncommon syndrome associated with several aetiologies. It is characterised by acute and severe muscle destruction with secondary myoglobinuria and the potential for renal failure. There is evidence of HMG-CoA reductase inhibitor (HMG-CoA-RI) muscular toxicity, although the mechanism responsible is as yet unknown.[1,2] Rhabdomyolysis occurs in approximately 0.5% of the patients who receive HMG-CoA-RI monotherapy.[2] Despite this, the incidence is increased when HMG-CoA-RI are used in combination with agents that share a common metabolic path.[2]

Used alone, any statin can cause toxicity that manifests itself as elevated serum transaminase levels, myopathy, rhabdomyolysis, and acute renal failure.[1,3] However, the risk of toxicity increases when statins are co-administered with certain drugs. The combined use of fibrates and HMG-CoA-RI is generally not recommended because of the potential for increased risk of myopathy.[1,3]

There are other drugs that likewise interact with HMG-CoA-RI and should be avoided. In those cases, myopathy is believed to occur as a result of the interference of the cytochrome P_{450} enzyme system, causing an increase in HMG-CoA-RI activity.[4,5] CYP3A4 represents one of the two major pathways for cerivastatin metabolism, but it also has a secondary pathway, the CYP2C8.[2,4] The CYP3A4 isoenzyme is responsible for the metabolism of a large number of drugs, including the azole antifungal agents, calcium antagonists, immunosupressive agents, macrolide antibacterials, HIV protease inhibitors and certain antihistamines.[2] The co-administration of two CYP3A4 substrates may cause an increase in the circulating concentrations of one or both of them. In addition, co-administered drugs may be inhibitors of the isoenzyme. Rhabdomyolysis is associated with a high concentration of HMG-CoA reductase inhibitor in plasma.[2] Such high concentrations may be idiosyncratic or secondary to the concomitant use of an interacting drug. Other statins have a theoretical advantage in a combination therapy; pravastatin is not significantly metabolised by CYP enzyme and fluvastatin is metabolised by multiple CYP pathways.[2]

Cases such as the one described above, involving drugs whose clinical use is widespread, demonstrate the basic requirement of postmarketing surveillance and the work of family physicians as the first step between patients and health services.

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General practice in 1952

I write as a GP who practised in central London for most of the period since the inception of the National Health Service.

Dr Irvine Loudon, in the December issue, rightly reports that 'by the 1970s, enormous improvements had occurred in the standards and organisation of general practice and in practice premises and equipment'.[1]

It is a pity that he did not give credit (nor did other writers) for the main cause of this, namely the 1966 GP Charter which had been put into effect by the then Minister for Health, Kenneth Robinson.

By changing the basis of GPs' remuneration the result was better premises, ancillary staff, and postgraduate education, among other benefits. It also encouraged what is to my mind one of the most important features of a modern GP's armamentarium: the primary health care team.

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I was fascinated by Irvine Loudon's recollections of almost 50 years ago.[1] Like him, I spent some years in the army (in my case mostly overseas, ending up as a junior officer in No. 1 Commando). His comments regarding the attitude of some of our consultant colleagues is valid, but this was engendered in great measure by Aneurin Bevan seizing upon Lord Moran's disgraceful remark that a general practitioner was a doctor 'who had fallen off the ladder of success'. Loudon goes on to refer to the generous educational grants enjoyed by the ex-service students. Yes indeed — though it might be added that, in the main, these had to be earned. In fact, when I was granted my first house appointment in 1950, my gross pay went down from £400 a year to £350 a year, my net pay being £17 and five shillings per month, with a wife and two children to support. However grim some practices were, there was little option.

Perhaps I was fortunate in joining a two-partner rural practice, catering for a scattered community occupying 37 villages and hamlets. By the end of 1951 I had become only the fourth

principal since 1864! My senior partner had already built his modest surgery premises and within four years I did the same in a rather larger village. Eight years later, we had a third partner and three purpose-built surgeries, with the six of us holding six higher degrees and two gold medals. Real country bumpkin practice, from which there emerged many papers and several books.

I was invited to join the College by John Hunt (whose letter I treasure today) after I had won my first Clare Wand prize — for education in general practice! This was in 1956, when I believe that I was the first to propose the setting up of chairs of general practice, on a part-time basis. It was all very much pre-supermarket practice but, within the therapeutic limits of the day, I think we offered a highly personal service of reasonable quality. Of course it was hard work, but a great many patients were grateful. Yet, our undergraduate education had been sadly lacking in preparing us for the job. Thanks largely to the College, things have indeed changed.

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Cancer recognition and primary care

I enjoyed reading this editorial[1] and found it a useful summary of the current diagnostic difficulties we face in diagnosing cancer in primary care. I hope secondary and tertiary specialists (and patients and journalists) can hear the message about our difficulties and will understand some of the reasons behind them.

And yet I found myself wondering whether the difficulties in diagnosing cancer promptly might actually lie at a level below symptoms and their presentation to clinical services. The difficulty with cancer is that it has to develop and grow through many cell divisions before it is large enough to give rise to any dysfunction that may be felt as a symptom. By the time even the earliest symptoms occur, the cancer has already become established.

Any one of us could have an early cancer developing within us now. With this reality, if you plan to reduce cancer mortality, the obvious approach is to screen before symptoms develop. I wonder about how far off the day is when we will have a detailed surveillance MRI scan each year. (I think some American centres already do this) Maybe technology will take the need for physical diagnosis out of our hands and out of our surgeries.

For the present we are not there yet. And even if the machines can help us make the diagnosis more effectively we will still be needed to help patients make sense of the results. And I have a great fear that plans to produce a laudable result, such as reducing cancer mortality, will have inadvertent side-effects on the population's health psychology (and expenditure), leading to more harm from fear of the disease than ever came from the disease itself.

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Reference

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Aetiology of respiratory tract infections

The study by Lieberman *et al*[1] is well done, and appears to show convincingly that doctors cannot diagnose bacterial aetiology of respiratory tract infection (RTI) with any accuracy. This agrees with the findings of many years that doctors' clinical judgement is poor when it comes to accurately identifying group A streptococcal pharyngitis without throat culture.[2] So is it time to abandon clinical judgement in RTI?

Our own study[3] would appear to say 'no', and to shed a different light on the subject. We looked at 60 successive families with RTI, seen in continuous care in a solo family practice and enrolled from November to April. The clinician's clinical judgement of 'bacterial' was significantly correlated with the presence of a positive bacterial culture. This clinical judgement was based not only on history and physical examination of the presenting patient, but was conditioned by knowledge of illness and culture results of other family members.

Unlike Lieberman *et al*, which allowed the physician to choose only 'bacterial' or 'viral', our study included a third category of 'indeterminate', which was used much more frequently during the waning of the influenza season, a confusing time for clinicians. We also had positive cultures for *Staphylococcus aureus* and non-group A streptococcus — organisms shown to be associated with bacterial RTI[4,5] and not looked for by Lieberman *et al*, when they performed serologies. Unlike Lieberman, we cannot show causation, since we did not do serologies.

Lieberman *et al*, do not tell us if the primary care physicians had any continuity with the studied patients or with their families. Nor do they say if any cultures were performed. Finally, they do not mention if the primary care physicians did any better than the emergency physicians who also were part of the study.

How can the evidence and diametrically opposed conclusions of these two studies of clinical judgement and RTI be reconciled? What is needed is to study the predictive value of clinical judgement of physicians who were informed by cultures and by continuity of family care, comparing them with physicians who were not informed by cultures, and without knowledge of the family epidemiology, using serologies as the gold standard in both groups. Such a study might well show that clinical judgement in RTI is valid, but only in the right clinical context.

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In their article, Lieberman[1] and colleagues found that the one group of primary care physicians were unable to differentiate viral from bacterial/atypical lower respiratory infections on the basis of the clinical assessment they made. However, unsupported conclusions are extrapolated from this finding. They conclude, '... physicians' ability to assess whether the infectious aetiology of RTI is viral or bacterial/atypical is low and no more reliable than tossing a coin'.

It is wrong to generalise this finding to all physicians from such a small sample and when we know so little about them. We cannot tell how representative they are of primary care physicians; all we are told is that they were board certified.

It is also wrong to conclude, as mentioned in the accompanying summary, 'How This Fits In', that 'the value of such clinical appraisal is much lower [than serological tests]'. There are established procedures for investigating the sensitivity and specificity of clinical features but these have not been followed in this study. We are not informed of what clinical features the researchers included in their 'detailed structured questionnaire' so we are unable to judge which clinical features are supposedly of low value.

This is an important study into the validity of routine clinical evaluation but I would suggest a more accurate conclusion from the findings as follows.

These findings raise doubts about the reliability of discriminating the infectious aetiology of lower respiratory infections in primary care. If these findings are representative of primary care in general, then the poor discrimination may arise from either from failure of physicians to correctly identify clinical features or the poor sensitivity/specificity of the features themselves.

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Reflexology and irritable bowel syndrome

I wish to disagree with the conclusion of Tovey's paper suggesting a greater investment in reflexology research.[1] His paper demonstrates no effect of reflexology and there is no logical reason why it should. Surely money would better spent on something that at least is based on a rational hypothesis. Can't we leave reflexology to the leisure industry? What's next — a randomised controlled trial of primary care astrology?

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Starting warfarin as an outpatient

Warfarin treatment for thromboprophylaxis in patients with atrial fibrillation has increased rapidly over the past few years because of its proven benefit.[1,2] Most starting regimens involve loading with a large dose and then adjusting the maintenance dosage on a daily basis using the international normalised ratio (INR) as a guide,[3] and it takes about five to seven days to reach a stable state. However, when anticoagulation is required for prophylactic reasons there is less need for haste. There are clear health economic benefits in managing the patient as an outpatient as well as major advantages for the patient.

We designed an outpatient initiation regimen specifically for elderly patients with atrial fibrillation that requires only weekly attendance for blood testing.[4] It was designed to avoid over-anticoagulation and is therefore conservative in its dosage choices; it aims to get the INR in the therapeutic range (2.0 to 3.0) within six weeks. Warfarin is prescribed in a dosage of 2 mg per day for two weeks; the INR obtained then predicts the maintenance dose (Table 1). Patients re-attend weekly for INR measurements so that subsequent dosage adjustments can be made. However, dosage adjustments should be kept to a minimum. If the INR is more than 4 but there is no bleeding then the warfarin is omitted for two days and then re-started at a dose 1 mg lower. If the INR is less than 2.0 then the dosage is not changed initially. If there are two consecutive weeks when the INR is less than 2.0 then the dosage of warfarin is increased by 1 mg. Fine tuning of warfarin doses by using alternate-day regimens of, for example, 2 mg/3 mg can be used if the INR fluctuates too much. Once the INR is within the target range for two consecutive readings then the frequency of testing can be reduced to six weekly, with further reductions in frequency to a maximum of 10 to 12 weekly if the INR remains stable.

This method of warfarin initiation lends itself to an outpatient service run by a nurse practitioner. There is a need for medical back-up, both from GPs if the patient presents to the primary care anticoagulation clinic with other medical problems and from specialists within secondary care to deal with anticoagulation problems.

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References

Table 1. Predicted maintenance dosage of warfarin based on the sex of the patient and the INR after two weeks of warfarin 2mg/day.[4]

Male		Female	
INR at Week 2	Maintenance dose	INR at Week 2	Maintenance dose
1.0	6 mg/day	1.0–1.1	5 mg/day
1.1–1.2	5 mg/day	1.2–1.3	4 mg/day
1.3–1.5	4 mg/day	1.4–1.9	3 mg/day
1.6–2.1	3 mg/day	2.0–3.0	2 mg/day
.2–3.0	2 mg/day	>3.0	1 mg/day
>3.0	1 mg/day		

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Integrated teams

We are employed as Integrated Team Facilitators by Central Manchester PCT with the remit to establish a framework for a PCT-wide implementation of Integrated Teams.

As part of our strategy we would like to make contact with fellow health professionals involved in establishing and developing this approach. In order to learn from colleagues nationwide who are currently developing Integrated Teams in their various forms, we would like to establish a national forum to create a working knowledge base and develop a creative space where the issues an be shared and debated.

We intend to organise the first forum in Manchester in May 2002 and that this approach of sharing in a forum setting will support us all in our work in order to contribute towards the National Plan.

Anyone involved in Integrated Teams at any level please contact us.

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Assessment of pain intensity

The recently published research report on discordance between patients' and general practitioners' assessment of pain intensity provides useful data,[1] but it also highlights the profound inadequacy of our present ability to understand and care for patients with persistent pain.

The study depends for its validity upon a visual analogue scale (VAS). Such a device is, as Mantyselka *et al* observe, 'a simple technique for measuring subjective experiences such as pain, and … feasible in primary care research.' At best, however it is a semi-quantitative measure of a subjective experience and thus open to modification in response to the patient's beliefs and life experiences. For example, it seems unlikely that the phrase, 'worst imaginable pain' means the same thing to a person who has never experienced pain worse than that of an ankle sprain, compared with one who has recently suffered ureteral colic or a major skin burn. The VAS is a useful pain assessment tool, but its limitations must be recognised.

We do not know if the discordance of perception between physicians and patients described by Mantyselka *et al*. is a bad thing or a mere untidyness. This is, in substantial part, because we do not know the reason or, more likely, reasons for its existence. Common observations suggest that aetiological factors in individual instances could include any of the following: simple differences in interpretation of pain scales; reluctance of stoic doctors to condone expressions of suffering by patients; discomfort of psychologically vulnerable doctors in the face of pleas for caring and support from distressed patients; loneliness, anxiety and/or depression in patients, leading them to overinterpret pain stimuli; conscious or unconscious exaggeration of symptoms in an attempt to move caregivers perceived as detached or uncaring; or manipulative behaviour directed toward various types of secondary gains.[2-5]

It seems unlikely to this observer that quantitative 'modern' science will be able to analyse and describe these subtle but probably important variables in the foreseeable future. However, ignoring them may carry such a high price, both economic and in terms of human suffering, that the only rational course is to leave the high road of science where it ends and plunge into the thicket of human behaviour, fearlessly utilising whatever limited truth we can discern there.

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