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Apolipoprotein E phenotype and CHD in diabetic patients

Genetic variations in apolipoprotein E phenotypes are thought to be associated with susceptibility to coronary heart disease. Diabetic patients, particularly those with non-insulin dependent diabetes, have an increased risk of coronary heart disease, and classic risk factors do not seem to explain this excess risk. Laakso *et al* (p 1159) studied the relation between coronary heart disease and apolipoprotein E phenotypes in men with non-insulin dependent diabetes mellitus from East Finland. The apolipoprotein E phenotypes E4/4 and E4/3 were strongly associated with coronary heart disease (definite myocardial infarction, ischaemic electrocardiographic changes, angina pectoris, or combinations of these signs), although cardiovascular risk factors were similar in men with these and with other phenotypes. The findings suggest a role for apolipoprotein E phenotype in modulating the risk of coronary heart disease in non-insulin dependent diabetes.

Predictive antibodies in coeliac disease

The diagnosis and monitoring of coeliac disease now require jejunal biopsy, and much effort has been put into developing non-invasive methods of diagnosis. The presence of antibodies to gliadin, endomysium, and jejunum has been suggested as one method, although the reported predictive values are variable. McMillan *et al* (p 1163) have evaluated the antibody assays in patients selected for jejunal biopsy on the basis of clinical assessment and simple blood tests. An enzyme linked immunosorbent assay (ELISA) for gliadin IgA gave 100% specificity, sensitivity, and predictive value when judged against clinical diagnosis with the European Society of Paediatric Gastroenterology and Nutrition revised criteria for coeliac disease. Such assays can improve the selection of patients for jejunal biopsy and may eventually make biopsy unnecessary in diagnosing this disease.

Routine ultrasonography for detecting fetal abnormalities

Most pregnant women in Britain are offered a fetal ultrasonography. The examination is recognised to improve the diagnosis of multiple pregnancies and the estimation of the expected date of delivery, but its value in detecting fetal structural abnormalities in low risk pregnancies is less clear. Chitty *et al* reviewed the results of routine second trimester ultrasonography at a district general hospital where detailed fetal anatomical examination is performed by radiographers (p 1165). Over two years about three quarters of all significant structural abnormalities were detected in fetuses examined. Routine ultrasonography in a low risk population is effective in detecting fetal structural abnormalities and may decrease perinatal mortality. Knowing the fetus is normal reassures parents, but counselling may be difficult for abnormalities with uncertain prognoses.

Can asthma morbidity in primary school children be reduced?

Many primary school children miss school or games because of untreated or undertreated asthma. Hill *et al* (p 1169) conducted an intervention study in 102 schools in Nottingham. In about half, children with asthma were referred to their general practitioner for assessment and teachers were educated about asthma. The other schools served as controls. Despite good compliance and improvement in the intervention schools' policies on managing asthma, there was no appreciable reduction in morbidity.

Closing the rubella immunity gap

While effort is being directed toward achieving high primary immunisation targets in childhood more could be done to ensure that women of childbearing age have rubella immunity. On p 1174 Berkeley *et al* report the results of a study of 239 women in Grampian found to have low or absent titres of rubella virus antibody. At least 98 were neither given rubella vaccine nor tested for seroconversion. Women who were pregnant when screened were significantly less likely to receive rubella immunisation and follow up testing for antibody than those who were not pregnant. The virus laboratory in Grampian has initiated a prompting system to alert general practitioners that notification of expected rubella immunisations is overdue. If other health authorities set up similar systems the immunity gap could be reduced.

Skin biopsy by GPs

Minor surgery done in general practice has advantages for both patients and doctors. The new general practitioner contract encourages such surgery and has resulted in an increase in biopsy specimens sent to histopathology laboratories. McWilliam *et al* (p 1177) studied skin biopsy specimens sent to their laboratory and found that, although most patients with malignant lesions were identified, a few were not. About two thirds of lesions (and 80% of malignant lesions) were not completely excised. The conclusions—that general practitioners should be given training in minor surgery and that the funding and staffing of laboratories may need to be reviewed—are reinforced by two short reports on the subject (pp 1179, 1180).

Continuity of care and use of resources

Is continuity of care mainly socially pleasant or does it influence decision making and have economic implications? On p 1181 Hjortdahl and Borchgrevink link Norwegian general practitioners' knowledge about their patients to the use of resources in the consultation. In most consultations increased knowledge of the patient saved time, reduced the use of laboratory tests, increased the writing of sickness certificates, and increased the use of expectant management and referrals. Prescribing was least influenced by accumulated knowledge. In a few consultations increased knowledge was felt to be an obstacle.

BMA NOTICES

Fate of motions referred to 1991 BMA craft conferences

The 1986 representative meeting of the BMA resolved:

"That when a motion is properly submitted for the annual representative meeting agenda but is then deferred to a craft committee conference the relevant minutes of that conference or the fate of that motion, if not debated, should be published in the *BMJ*."

The fate of some of the motions referred to BMA craft conferences in 1991 were published on 2 November (facing p 1123 (General Practice), facing p 1111 (other editions)). The remaining ones are published below.

Any motions not reached are referred back to the sponsoring constituencies, which are invited to submit a written memorandum requesting that the motion be considered by the appropriate committee.

LMC	=LMC conference
S	=Senior staffs conference
J	=Junior staffs conference
PH	=Public health conference
CO	=COMAR (conference of academic representatives)
C	=Carried
CR	=Carried as a reference
L	=Lost
NR	=Not reached

ORMSKIRK AND SKELMERSDALE

That the new restrictions in working hours for junior doctors should be strictly observed to prevent "moonlighting." — NR (S), NR (J)

That nulliparous women should be excluded from the target figures for cervical smears in general practice. — C (LMC)

PLYMOUTH

That this meeting deplores our negotiators' acceptance of the differential night visit fee and demands immediate renegotiation for its abolition. — C (LMC)

That this meeting demands that the secretary of state should ensure the continuance of nationally agreed pay structures for senior hospital staff in NHS trust hospitals. — NR (S)

That this meeting declares that target systems for reimbursement are inappropriate in medicine and are contrary to good medical practice. — NR (LMC)

PORTSMOUTH AND SOUTH EAST HAMPSHIRE

That this meeting deplores the fact that the 1990 contract has failed to lead to an equitable system of performance related pay. — C (LMC)

That this meeting deplores the Department of Health's intention to claw back money from general practitioners because of the "higher than expected" take up of non-capitation based payments during 1990-1. — C (LMC)

That, in order to introduce an equitable system where performance and pay are related, the concept of net intended remuneration should be abolished. — C (LMC)

That all target payments be immediately removed from the main remuneration system for general practitioners. — C (LMC)

That the differential night visit fees should be abolished. — C (LMC)

That the Department of Health should accept liability for interest payments made by general practitioners with cash flow problems caused directly by family health services authorities' administrative inefficiencies. — C (LMC)

That the government should immediately increase the reimbursement of computer costs to all general practitioners to the level which currently exists for fundholding general practitioners. — C (LMC)

That general practitioners should be adequately rewarded for the work undertaken in updating incomplete and inaccurate data bases held by district health authorities and family health services authorities for the purposes of national screening programmes. — C (LMC)

REDBRIDGE AND STRATFORD

That the 70% direct reimbursement for ancillary staff must continue in the interest of good primary care service for patients, and this meeting should oppose the patronage which the NHS and Community Care Act has given to FHSA managers in this regard. — C (LMC)

ROCHDALE

That this representative body believes it is right for the profession to regulate its own postgraduate education. A mechanism for appeal centrally, in the event of refusal to accredit locally, should exist. — NR (LMC)

ST HELENS AND KNOWSLEY

That the cash limits imposed on family health services authorities should not lead to a poorer service. — NR (LMC)

That the association deplores the lack of uniformity shown by different family health services authorities in their interpretation of the new general practice contract. — NR (LMC)

SEFTON

That this meeting reaffirms the BMA's rejection of the new contract for general practitioners. — C (LMC)

That this meeting feels that the locum allowance for singlehanded rural practitioners should be extended to all singlehanded general practitioners. — NR (LMC)

That this meeting feels that the representative body should consider the payment of deprivation allowance to general practitioners is divisive and recommends that this should be scrapped and the funds released should be targeted on local needs. — NR (LMC)

SHEFFIELD

That this meeting deplores the underfunding of postgraduate medical education and study leave and calls for the allocation of at least £2000 per hospital doctor per annum to provide adequately funded compulsory continuing medical education. — NR (S)

SOUTH BEDFORDSHIRE

That this meeting believes that standard referral forms as proposed are unacceptable and, most of all, do not protect patient confidentiality. — NR (LMC)

SOUTHAMPTON AND SOUTH WEST HAMPSHIRE

That this meeting considers that regular study leave for permanent senior hospital medical staff must be an integral and recognised part of their contracts necessary to enable them to remain fully accredited, and must be seen to be allocated efficiently and fairly by medical audit and external quality assessment, particularly in this era of rapid technological change and scientific advance. — NR (S)

SOUTH MIDDLESEX

That this representative body believes that the most effective way of achieving reasonable hours of work for junior hospital doctors is to price the units of medical time at equal to or greater than the price of normal hours. — CR (J)

SOUTH WARWICKSHIRE

That this meeting urges the GMSC and Department of Health to heed the problems of rural practice engendered by the new general practitioner contract. — NR (LMC)

STOCKPORT

That more adequate and individual representation on the GMSC be made. — NR (LMC)

SUTTON AND WEST MERTON

That the 72 hour week should be mandatory for junior doctors. — NR (S), NR (J), NR (PH)

WALSALL

That this representative body believes, in view of the comprehensiveness of the new job plans, that there should be no distinction in salary terms between whole time and maximum part time consultants. — NR (S)

WEST BERKSHIRE

That this meeting deplores the situation prevailing in some districts where, contrary to agreed requirements, junior staff are unable to obtain hot food while on duty. — C (J)

WEST GLAMORGAN

That this meeting regrets the failure of GMSC to ensure that adequate funding would be available to pay for the extra work imposed on general practice by the implementation of the change of contract on 1 April 1990. — C (LMC)

That this meeting regrets that the review body did not award an increase in net average remuneration to general practitioners to take account of the extra work caused by the implementation of the change in the contract on 1 April 1990. — C (LMC)

WEST HERTFORDSHIRE

That this meeting condemns the two tier night visit fee as being ineffective in promoting continuity of care. — C (LMC)

That this representative body urges the review body to treat clinical medical officers/senior clinical medical officers' salary scale as a continuous scale rather than an interrupted one, in the same way as the registrar/senior registrars' scale in public health medicine operates. — NR (PH)

That this representative body recommends that separate accreditation arrangements are made for the consultants in communicable disease control/medical officers for environmental health. — NR (PH)

That this meeting insists that practice nurses and health promotion staff should not be included in the existing ancillary staff scheme, and that their salaries should be separately reimbursed. — NR (LMC)

WEST NORFOLK AND WISBECH

That this meeting urges the BMA to ensure there are appropriate study leave budgets for consultants based on a minimum of 1% of the total consultant payroll in each district and trust. — CR (S)

That this meeting urges the BMA to ensure relevant details of individual performance review for the unit general manager which have a direct bearing on the working conditions of the senior medical staff of that unit are made available to the hospital medical staff committee. — NR (S)

WIRRAL

That this ARM requests that an adequate expansion of the consultant grade is occurring in the acute sector specialties and seeks action if it is not. — NR (S)

WOKING AND CHERTSEY

That this ARM is asked to note that for a single "average list" general practice since the inception of the new contract and practice computerisation, the extra paper produced amounted, in one year, to 442 sq metres. — C (LMC)

That this meeting congratulates the chairman of the GMSC on his new approach to the Department of Health and wishes him and his team every success in present and future negotiations for the profession's wellbeing. — C (LMC)

WORCESTERSHIRE

That this meeting requests an examination of the basis of consultant remuneration in the light of the recent changes. — CR (S)