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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Neurological emergencies

SIR,—I was interested to read Dr T P Lister's discussion (15 August, p 473) of the role of the general practitioner confronted by a patient with an acute stroke. The Frenchay Stroke Unit is developing an integrated domiciliary-care service to help general practitioners manage acute strokes at home. During our five-month pilot study I assessed 121 patients with acute strokes, of whom 40 were at home. I feel that the particular role of the general practitioner needs emphasising. This role includes:

(1) Helping the family to cope with the immediate practical problems: the first is immobility. Many patients will need to be got into bed (only 17% of our patients were asleep at onset), and the relatives shown how to transfer him in and out of bed. Problems with urination and defecation come next and are best overcome by the rapid (same day) provision of a commode. Difficulty with swallowing is the third major problem: 10% of our patients choked when attempting to swallow water, and a further 10% could swallow only slowly and with great difficulty. An urgent visit from a district nurse may help overcome some of these practical difficulties, and even the provision of a limited amount of help at this critical stage will give the patient and his family some hope.

(2) Giving information: most of the patients I have seen have had little idea about the nature of a stroke and its possible prognosis. The provision of a simple booklet—for example, *Twenty Questions about Stroke* from the Chest, Heart, and Stroke Association—may give the family more confidence.

(3) Arranging referral to hospital. There are four general reasons why this may be necessary. (*a*) to cope with nursing problems, which will depend upon the degree of disability and social circumstances; (*b*) for investigation. Several acute illnesses —for example, hypoglycaemia, meningitis, myocardial infarction—can present as acute stroke and need to be considered at the first visit. Then, if the later course of the stroke is unusual one must remember that mass lesions—for example, tumour, subdural haemorrhage—may initially present as acute stroke; (*c*) for specific treatment. Although a recent review concluded that there was none,[1] it is possible that the use of computed tomography will allow successful treatment to be developed—for example, evacuation of intracerebral haemorrhage; (*d*) for rehabilitation. This will be rare since domiciliary or outpatient treatment is usually available.

The general practitioner clearly has a vital role to play in the acute and long-term management of this disabling disease.

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[1] Matthews WB. *Recent advances in clinical neurology.* Edinburgh: Churchill Livingstone, 1978:9-14.

Preconception clinics

SIR,—Your leading article (12 September, p 685) on preconception clinics implies that there is something new in the idea of a service that combines counselling with preventive medicine for women before pregnancy. In fact, in health centres up and down the country such services are available, certainly in a less formal and possibly in a more appropriate manner than that suggested in your article. Indeed, GPs see the great majority of their patients during the months preceding pregnancy and are able to offer advice and treatment where necessary, often with a knowledge of the patient and her background which the consultant cannot possibly gain during his few short contacts with her.

Many consultant obstetricians would refer patients with the chronic diseases you mention to other specialists rather than manage these conditions, of which most of them will have little enough experience themselves. Surely, the GP is in the best position to do this.

The GP will inquire into a patient's smoking habits, weigh her, measure her blood pressure, probably check her rubella state, and possibly measure her haemoglobin and do serological tests for syphilis when he first offers contraceptive advice, which the great majority of women will seek before presenting to their GP with a first pregnancy. We should not be encouraging any more duplication of effort than is really necessary in our already overburdened health service.

Finally, I hope women are not really going to be encouraged to attend a booking clinic as soon as pregnancy is suspected. If all the women a couple of weeks late for a period were to see a consultant obstetrician before having at least a pregnancy test, which the GP can most appropriately arrange, then I am sure there would be little time left for gleaning a greater understanding of the causes of spontaneous abortions and fetal anomalies.

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SIR,—I fully support the suggestions made in your leading article "Preconception clinics" (12 September, p 685). You seem, however,