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SATURDAY 26 JULY 1986

LEADING ARTICLES

Did the drug do it? MJS LANGMAN	219
The leaking labyrinth GM O'DONOGHUE, BH COLMAN	220
AIDS and swimming pools ARIE J ZUCKERMAN	221
Child health services in the community: making them work AIDAN MACFARLANE	222
Bladder dysfunction in progressive autonomic failure R SKIRBY, R BANNISTER	223
Graduated elastic stockings KG BURNAND, GT LAYER	224
Mrs Short's recipe for better prison health RICHARD SMITH	226

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Angina pectoris-like pain provoked by intravenous adenosine in healthy volunteers CHRISTER SYLVÉN, BJÖRN BEERMANN, BROR JONZON, RAGNAR BRANDT	227
Effect of maternal dietary exclusion on breast fed infants with eczema: two controlled studies AJ CANT, JA BAILES, RA MARSDEN, D HEWITT	231
Accuracy and reproducibility of a new contrast clearance method for the determination of glomerular filtration rate PH O'REILLY, PJ C BROOMAN, PJ MARTIN, AJ POLLARD, NB FARAH, GC MASON	234
Prevalence of multiple sclerosis in a south London borough EDWARD S WILLIAMS, RONALD O MCKERAN	237
Captopril in elderly patients with heart failure PATRICK J MURPHY, TISCHA VAN DER CAMMEN, JAMES MALONE-LEE	239
Cannulation of difficult oesophageal strictures with angiographic catheters MANDY S SHARPE, A H CHALMERS, K R GOUGH	240
Primary biliary cirrhosis after benoxaprofen C BABBS, T W WARNES	241
Insulinoma producing progressive neurological deterioration over 30 years JA SNOOK, R VANDERSTAR, R O WELER	241
Predicting risk of diabetic ketoacidosis in patients using continuous subcutaneous insulin infusion C BRADLEY, D S GAMSU, G KNIGHT, A J M BOULTON, J D WARD	242
Spontaneous pneumomediastinum in two stowaways SYLVIA M MALDRIDGE, S C GLOVER, C JOHNSON	243
Life threatening reaction to tuberculin testing M A SPITERI, A BOWMAN, A R ASSEFI, S W CLARKE	243
Natural killer cells in insulin dependent diabetes mellitus R G WILSON, J ANDERSON, B K SHENTON, M D WHITE, R M R TAYLOR, G PROUD	244
Correction: Self poisoning with oral cadmium chloride BUCKLER	236
Diagnosing cancer in general practice: when is cancer suspected? MAGNE NYLENNÄ	245

MEDICAL PRACTICE

Ethics of predictive testing for Huntington's chorea: the need for more information DIO CRAUFURD, R HARRIS	249
Pharmacology: analysis and exploration SIR JAMES BLACK	252
Slipped capital femoral epiphysis: continuing problem of late diagnosis I J BRENKEL, A J PROSSER, M PEARSE	256
Recommendations on the use of living kidney donors in the United Kingdom BRITISH TRANSPLANTATION SOCIETY	257
Health surveillance of preschool children AF COLVER, H STEINER	258
The central dilemma: destroy or develop T E LANKESTER	260
Any Questions?	251, 255, 261
Medicine and Books	262
Personal View JD HILL	264

CORRESPONDENCE—List of Contents	265
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NEWS AND NOTES

Views	275
Medical News	276
BMA Notices	277
Scientifically Speaking BERNARD DIXON	278

OBITUARY	272
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SUPPLEMENT

The Week	279
Firm reply to a weak agenda: GMSC's response to the government's "agenda for discussion" NORMAN ELLIS	280
BMA writes to Secretary of State on clinical academic salaries	284
GMSC approves interim report on agenda for primary care	284

CORRESPONDENCE

List size and quality of practice B Lee, MRCP 265	Sodium excretion in young children Valerie Walker, MRCPATH, and M E Allison, MB 267	Efficacy of a new nystatin formulation in oral candidiasis G K Crompton, FRCPD; P-J Lamey, MB, and L P Samaranayake, MRCPATH 270
Steroids, the eye, and general practitioners T C O'Dowd, MD, and L Beck, FRCS 265	O tempora, O Mary's P Richards, FRCP 268	Drug points Complete heart block induced by hyperkalaemia associated with treatment with a combination of captopril and spironolactone (M Lakhani) 271
Nursing dependency in registered nursing homes and long term geriatric wards D G MacMahon, MRCP, and others 265	Clinical competence and curiosity W D Dauphinee, FRCP, and others 268	Points Diffuse peritonitis and chronic ascites due to infection with Chlamydia trachomatis (Caroline Bradbeer and Jan Welch); Non-steroidal anti-inflammatory drugs and the kidney (J C Davidson); Transcutaneous oxygen tension during exercise in patients with claudication (C P Shearman and others); Sweet tooth maketh a sour disposition (A Comfort; J Yudkin); The doctor, the patient, and their contract (S J Watkins) 271
Psoriasis C E M Griffiths, MRCP, and others; R A Wakeel, MRCP, and D C Dick, MRCP 266	The doctor, the patient, and their contract M G Jacoby, MB 268	Correction: Asystole and electromechanical dissociation (Hopkins) 271
Does sodium restriction lower blood pressure? M R Lee, FRCPD, and others 266	What price academic general practice? R J Taylor, FRCP; R J Wolstenholme, FRCP 269	
Leucocyte sodium pumps in patients with essential hypertension V Oh, MRCP, and Elizabeth Taylor, PhD 267	Gastrointestinal investigation of iron deficiency anaemia C J Cahill, FRCS, and others 269	
Treatment of the premenstrual syndrome by subcutaneous oestradiol implants and cyclical oral norethisterone L O Simpson, PhD 267	Severity scoring in intensive care P O Collinson, MB, and others 269	
	Reye's syndrome, aspirin, and juvenile chronic arthritis Ann Hall, MRCP, and Barbara Ansell, FRCP 270	
	A comprehensive bibliography database using a microcomputer D W Bullimore, MD; D P Sellu, FRCS 270	

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

List size and quality of practice

SIR,—In discussions about optimum list size in general practice attempts at assessing clinical quality have, inevitably, to use factors that are measurable, such as extent of record keeping, time spent with patients, and consultation rates (Dr Martin Lawrence, 12 July, p 135).

It is harder to take account of a more nebulous, but fundamental, aspect: the need for the list to be big enough to supply an adequate mass of clinical material of wide range. If the mass is not large enough to keep the GP's diagnostic skills constantly engaged and stimulated his clinical acumen and intuition are bound to get rusty. For this reason there is a strong, though unfashionable, case for encouraging the GP to take on the maximum number of patients he can cope with. This applies especially where there is, effectively, competition between local hospitals and GPs for the "clinical material" available.

With its direct bearing on medical employment and unemployment in the NHS, list size is, of

course, a medicopolitical and economic hot potato. But it would be unfortunate for the patients and demoralising for those doctors who have jobs if a smaller maximum list, while leading to an overt fall in unemployment, brought with it a hidden rise in clinical underemployment of a degree that reduced quality.

It is probably a fallacy that the longer a doctor spends with the patient the better must be the quality of the clinical transaction. It may simply be that the doctor with even a medium size list is at his wits' end to know how otherwise to fill up his day, unless he also does a job outside his practice.

It may be that the problem of medical unemployment will have to be solved by work sharing, but we should not disguise from ourselves that that is what is happening, or try to ignore its effects on clinical competence.

BENJAMIN LEE

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Surrey

Steroids, the eye, and general practitioners

SIR,—The debate on steroids and the eye has become predictably adversarial (31 May, p 1448, 28 June, p 1737). By its very nature consultant experience is distilled from the (apparently very few) general practice cases that go wrong. Too much consultant admonishing means that GPs who prescribe steroids will do so without declaring this in their referrals. In this practice we recently had an audit of our use of steroids in the eye and found it difficult to find cases, though we do prescribe such steroids.

We would like to compliment Mr Patrick Trevor-

(4) Avoid steroids on a repeat prescription without expert opinion: patient may be a "steroid reactor."

(5) Avoid if there is a history of dendritic ulcer.

(6) Be more wary if problem is unilateral.

(7) Check cornea first with fluorescein.

We hope that the many GPs who prescribe steroids will find these guidelines helpful.

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Nursing dependency in registered nursing homes and long term geriatric wards

SIR,—We were interested in the contrasting levels of dependency found by Dr Anne E Capewell and colleagues between patients in nursing homes and those in geriatric wards in Edinburgh (28 June, p 1719). We recently surveyed the total provision for continuing care in one district of Cornwall, including public, private, and voluntary sectors, and confirm many of their findings.

The Edinburgh team allude to a smaller contribution by NHS hospitals to total long term bed provision in Britain than may have been hitherto assumed, and this was confirmed in our survey, which showed more than three beds in private nursing homes to each continuing care bed in hospital (151 v 44) and more less dependent patients in nursing homes than in hospital wards. However, given the greater numbers of nursing