the cubicles. A third and a fourth patient can then be interviewed. As the panel lights go on the doctor can see who is ready. If interviews are long or patients undress quickly the first two may be ready before the third can be summoned. If interviews are short or patients undress slowly four patients may be interviewed before any are ready. After examination the first patient returns to his changing cubicle. When dressed he lights his panel. Meanwhile the second patient is examined, and so on until all have been examined. While they are dressing, notes and forms may be completed. Those requiring further interview can be called back into the consulting room: others can leave through the outer door of their cubicle. Patients not needing to undress can be seen entirely in the consulting room. Those requiring a biopsy, patch-test, or some other procedure go to the treatment room via the waiting area. They are given a note for the nurse, who prepares the necessary equipment. Soundproofing of rooms and cubicles is adequate, so that privacy of consultation is achieved. Belongings are safe in the locked cubicles during examination, and the indignity of walking about a clinic in communal ill-fitting gowns is avoided.

Improvements in the suite were made when designing the new Shrewsbury district general hospital. The doctor can operate a light in the changing cubicle from his desk to call the patient into the examination room and, later, into the consulting room. There is a door from one examination room to the treatment room so that the doctor and patient need not go via the waiting area. Ceiling fans prevent cubicle stuffiness in one suite and a more open style of cubicle in another, and in each suite the doors on one changing cubicle are wide enough to take a wheelchair.

Comment

Only one clerk is needed to bring patients and their notes to the clinic and a qualified nurse to organise special tests and treatments. At both hospitals the suites have been duplicated, and the same staff serves two doctors. The design of the rooms is best suited for clinics with a high turnover of patients who need to undress. The doctor has to overcome the difficulty of remembering the problems of up to five patients at a time, but with practice the facility is readily acquired and may even be stimulating.

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Shrewsbury Hospital, Shrewsbury

ALAN B SHRANK, FRCP, consultant dermatologist

Steroid-responsive leukaemia

Here we describe a patient with acute myelomonocytic leukaemia in whom steroids given alone induced a remission lasting 15 months.

Case report

A 74-year-old woman presented with weakness, dyspnoea on exertion, and tender lumps on the limbs. Clinical anaemia was present, and there were skin nodules on both thighs and the right arm. She had buccal ulcers, and a Stevens-Johnson reaction developed during treatment with ampicillin. Results of blood and bone-marrow analysis were consistent with acute myelomonoblastic leukaemia (table).

Progressive improvement succeeded treatment with prednisone 45 mg daily, the nodules taking five months to resolve. She led an active life, enjoyed two holidays, and resumed the care of her disabled husband. Blood and bone-marrow profiles were normal after eight months' treatment. The patient died in blastic relapse after a short terminal illness 15 months later, the blood containing 80% monoblasts and the marrow showing 90% blast cells.

Comment

This response of acute myelomonocytic leukaemia to steroids is most unusual and contrasts with the fairly common response in acute lymphatic leukaemia.^{1,2} In acute myelocytic leukaemia combination treatment with cytotoxic agents and a steroid produces a 30% remission rate in adults.¹ It is doubtful whether steroids alone, even in massive dosage, ever benefit adults with acute myelocytic leukaemia.¹ Spontaneous remission is rarely described³ in association with infection and carcinoma, which were not present here.

Results of analyses of blood and bone marrow before and after treatment

	Before treatment	After treatment
Blood		
Haemoglobin (g/dl)	8.8	14.4
Red cell count ($\times 10^9/l$)	2700	4780
White cell count ($\times 10^9/l$)	2	8
Neutrophils ($\times 10^9/l$)	0.86	6.5
Lymphocytes ($\times 10^9/l$)	1	0.72
Monocytes ($\times 10^9/l$)	0.14	0.56
Platelets ($\times 10^9/l$)	130	217
Erythrocyte sedimentation rate (mm in first hour) (Westergren)	113	2
Bone marrow		
Blast cells (%):		
Undifferentiated	10.5	—
Monoblasts	8.0	—
Myeloblasts	11.5	1.5
Neutrophils (%)	9.5	43.0
Monocytes (%)	16.5	1.5

This case shows that steroids given alone are still worth while in cases of myeloid series leukaemia in which, especially if the patient is elderly, intensive and potentially toxic regimens are hazardous. They also have a useful euphoriant effect and help in cases of cytopenia and autoimmune haemolytic anaemia.

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² Ezdinli, E Z, *et al*, *Cancer*, 1969, **23**, 900.

³ Wiernick, P H, *National Cancer Institute Monographs*, 1976, **44**, 35.

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Department of Geriatric Medicine, Brighton General Hospital, Brighton BN2 3EW

A N G CLARK, MD, FRCP, consultant

S R OSMANI, MB, MRCP, clinical assistant

Relapsing polychondritis: an autoimmune disease?

The diagnosis of relapsing polychondritis may be suggested by characteristic clinical features and confirmed by the histological appearance of a biopsy specimen from an affected area of cartilage.¹ The cause of the disease is unknown, though the appearance of circulating anticardilage immunoglobulins² and the ability of cartilage antigens to transform lymphocytes from these patients^{3,4} suggest an organ-specific autoimmune aetiology.

We report a case of relapsing polychondritis with antecedent thyroid disease, diabetes mellitus, and vitiligo in which antibodies to human cartilage, thyroglobulin, intrinsic factor, and gastric parietal cells were present.

Case report

A 46-year-old woman developed hypothyroidism in 1971, 21 years after undergoing thyroidectomy for thyrotoxicosis. At the age of 31 she had developed insulin-dependent diabetes mellitus. Seven years later nasal swelling and tenderness occurred. After another seven years a second episode of nasal swelling resulted in destruction of the nasal septum. Both episodes remitted spontaneously. After 15 years of progressive, right-sided conductive deafness stapedectomy was performed at the age of 41. Intubation was difficult on two occasions. Aged 46 years she developed severe pain and inflammation in the third, terminal interphalangeal joint of the left hand, with similar changes in the right first metatarsophalangeal joint. Soon afterwards both pinnae became swollen, red, and extremely tender. Extensive vitiligo was present together with lipatrophy at sites of insulin injections. Bilateral exophthalmos with slight ophthalmoplegia was present.

Erythrocyte sedimentation rate was 90 mm in the first hour, and there was normochromic anaemia (Hb 10.9 g/dl) and polymorphonuclear leucocytosis (5.8×10^9 – $10.65 \times 10^9/l$ (5800–10 650/mm³)). Serum vitamin B₁₂ and urate concentrations were normal. Tests for antinuclear factor and lupus erythematosus cells and the RA latex test were negative and serum immunoglobulin concentrations normal. IgG antibodies reacting with human fetal cartilage matrix but not with rat cartilage were detected by immunofluorescence (titre 1/4). Reactions with antisera to IgM, IgA, and complement (β1C) were negative. Thyroglobulin haemagglutination titre was 1/320;

results of thyroid microsomal immunofluorescence and haemagglutination tests were negative; and gastric parietal cell and intrinsic factor antibodies were present but there was no immunofluorescence on pancreatic islets, adrenal tissue, or pituitary tissue.

Comment

Intermittent acute inflammation of aural, nasal, and articular cartilage is typical of relapsing polychondritis.¹ Laboratory tests are unhelpful, though a raised erythrocyte sedimentation rate and mild leucocytosis are usually present.¹ Definitive diagnosis was made by the histological appearance of affected cartilage. Audiovestibular damage may occur as the presenting symptom,¹ and in our patient deafness may have been the first manifestation of the disease. Difficulty with intubation many years later suggests that tracheal cartilage was affected.

Hashimoto's thyroiditis with myxoedema,⁵ goitre,¹ and diabetes mellitus^{3, 6} have been associated with relapsing polychondritis and often precede the cartilaginous manifestations by many years.¹ To our knowledge there has been no report of Graves's disease, diabetes mellitus, and vitiligo occurring in a patient with relapsing polychondritis and gastric parietal cell and intrinsic factor antibodies.

We postulate that the associated widespread autoimmune disease in this case of relapsing polychondritis suggests an organ-specific autoimmune aetiology for the condition. The presence of circulating specific antihuman cartilage antibodies supports this view, though the antigen is unidentified. The finding of anticartilage antibodies in two out of three cases led to a similar conclusion.² The relation between clinical disease of cartilage and circulating anticartilage antibodies is at present unknown. Cell-mediated immunity to cartilage has also been reported in polychondritis.^{3, 4} A search for anticartilage antibodies together with clinical and immunological evidence of other autoimmune disease should be made in all suspected cases.

The autoantibody tests were performed in the Department of Immunology, the Middlesex Hospital, London. We are most grateful to Professor D Doniach and Dr G F Bottazzo for their help.

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² Hughes, R A C, *et al*, *Quarterly Journal of Medicine*, 1972, **163**, 363.

³ Herman, J H, and Dennis, M V, *Journal of Clinical Investigation*, 1973, **52**, 549.

⁴ Gange, R W, *Clinical and Experimental Dermatology*, 1976, **1**, 261.

⁵ Keye, R L, and Sones, D A, *Annals of Internal Medicine*, 1964, **60**, 653.

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Department of Medicine, University of Birmingham, Edgbaston, Birmingham B15 2TH

R N CLAYTON, BSC, MRCP, senior registrar
R HOFFENBERG, MD, FRCP, professor

Time and the consultation in general practice

Buchan and Richardson have shown that the average time for a consultation in general practice is five minutes.¹ This brief contact is generally regretted¹⁻⁴ and it is assumed that a longer interview would help the patient's recovery. My inquiry tested this assumption in a group of patients with minor complaints in whom no definite diagnosis could be made, by comparing the outcome of long and short interviews during which "treatment" and "no treatment"⁵ were given.

Patients, methods, and results

At 52 general practice surgery sessions 200 patients in whom no diagnosis could be made were randomly selected for one of four treatments. Short treatment and short no treatment were given at consultations which lasted under five minutes, and long treatment and long no treatment were given at

consultations intended to last over ten minutes. In the short consultations there were no unnecessary discussions or investigations and the interview was ended as soon as possible, either by giving a plausible diagnosis and prescribing treatment, or by telling the patient that as no evidence of disease had been found he required no treatment. Short consultations averaged 3.7 minutes. In the long consultations additional investigations were made, discussion of the complaint was encouraged, and attempts were made to explore the patient's psychological and social background. In long-treatment interviews the patient's complaint was accepted, he was confirmed as ill, an acceptable diagnosis was made, and he was given treatment. In the long no-treatment interviews time was spent in convincing the patient that he was not ill and that treatment was unnecessary. Sometimes it was difficult to prolong the long consultation for the full ten minutes, particularly where the patient saw his complaint as simple and physical. Long consultations averaged 10 minutes.

All the patients were asked to return in a week if they were no better. Their record cards were examined a month later to discover whether they had returned to see any of the doctors in the practice with the same or with a different complaint. This was the criterion of outcome on which the four treatments were compared, and the results of using this correspond with those obtained by asking the patients at the end of the month whether they got better or not.⁶

The results of the four treatments are shown in the table. No significant difference was found among them.

Results of the four treatments

	Short treatment	Long treatment	Short no treatment	Long no treatment
Patients who did not return	36	36	37	44
Patients who returned with the same complaint	7	7	8	3
Patients who returned with a different complaint	7	7	5	3
Total	50	50	50	50

$\chi^2 = 5.53$. DF = 6 (not significant).

Comment

In this investigation the results of both treatment and no treatment were unaffected by the length of the consultation. This suggests that for this group of patients the effective part of the consultation was simple and depended on brief contact between patient and doctor. The mechanism of this healing process is not known. It would seem, however, that complicated techniques requiring more time were unnecessary. I was surprised by this finding: being accustomed to holding lengthy consultations, I had assumed that time was a vital factor in my treatment (the therapeutic illusion).⁵

The patients in this inquiry were a special group—the "undiagnosed" patients,⁵ who had only minor illness—and it would be reasonable to assume that patients with definite disease, or with psychological and social problems, would benefit from longer consultations—although no one has shown that this is so. For example, in one survey of general practice the consultation time for treating psychoneurosis was 5.3 minutes.¹ Do those doctors who use Balint's methods, and therefore much longer sessions, produce better results?

I thank Mr J R Compton, who was responsible for the statistical work.

¹ Buchan, I C, and Richardson, I M, *Time Study of Consultations in General Practice*. Edinburgh, Scottish Home and Health Department, 1973.

² Hart, J T, *Journal of the Royal College of General Practitioners*, 1976, **26**, 892.

³ Stevens, J, *Journal of the Royal College of General Practitioners*, 1974, **24**, 7.

⁴ Hopkins, P, *Six Minutes for the Patient*, p 142. London, Tavistock Publications, 1973.

⁵ Thomas, K B, *British Medical Journal*, 1978, **1**, 1327.

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Waterlooville, Portsmouth P07 7AH

K B THOMAS, MD, general practitioner