of retropharyngeal abscess or bony destruction. Sputum was negative for acid-fast bacilli on microscopy and culture. The results of blood cultures were negative. No other organism was seen on microscopy or cultured from the fluid aspirated from the neck.

Treatment with azathioprine was stopped and prednisolone was continued at a dose of 15 mg a day. Treatment with daily intramuscular streptomycin and oral rifampicin, isoniazid, and ethambutol was started. The swelling in the neck and the temperature gradually diminished over the first week in hospital. Two weeks after she was admitted to hospital a tablespoonful of pus was expressed from the neck; azathioprine 100 mg daily was reintroduced because of increasing joint stiffness. The patient was discharged receiving prednisolone, azathioprine, ethambutol, rifampicin, and isoniazid. Five months after admission she remained well, the neck swelling had settled, and her chest x-ray films showed improvement.

Comment

Tuberculous lymphadenopathy commonly presents as a painless, progressive swelling. In this patient the onset was

acute over two days, and the swelling was very tender and erythematous. Symptoms of the pulmonary tuberculosis had been fully suppressed by this patient's treatment before the veritable explosion of inflammation in the neck. Fortunately, the characteristic features of pulmonary tuberculosis seen on the chest x-ray films led us to examine the fluid aspirated from the neck for acid-fast bacilli. This experience suggests that pathological samples from patients receiving immunosuppressive treatment who develop acute lymphadenitis should be examined for acid-fast bacilli.

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Letters to a Young Doctor

Choosing to become a general practitioner

PHILIP RHODES

More than half of the doctors in the United Kingdom are general practitioners. Numerically, therefore, general practitioners are the most important group. They deal with perhaps 90% of all illness for which patients decide that medical help is needed. Their range of work is immense and on a very broad front, as opposed to the relatively narrower range of the hospital specialist. The specialist's knowledge is deep and his skills are esoteric, covering every aspect of his subject. The GP's knowledge is wide, with skills to match so that they cannot normally be complete in any one branch of medicine.

This generalisation is mainly true but has many obvious exceptions in individuals, both general practitioners and specialists. The best physicians, for instance, may seem to be closely similar to general practitioners, and vice versa. Many GPs have trained as physicians, surgeons, and obstetricians and have higher qualifications in many specialist subjects, so that there may be much overlap between general and hospital practice. Indeed, many general practitioners undertake work in hospitals as clinical assistants and hospital practitioners so that they have and retain specialist knowledge and skills. And outside major urban centres many general practitioners care for inpatients in hospital beds in what used to be called cottage hospitals.

Dividing lines are therefore often far from clear, and every specialist is aware that in his outpatient clinics he may be carrying out much that might be classified as being the work of a general practitioner. It is probably ridiculous to try to categorise in this fashion. Medicine is medicine and covers the whole human condition and is therefore not to be broken up into watertight compartments. There is a continuous spectrum running from what is manifestly general practice to what is obviously specialist, with a large intermediate part which may be either the one or the other. Making the distinctions is unproductive.

Nevertheless, there are differences between consultants and general practitioners. GPs tend to be fiercely independent and entrepreneurial. They are indeed independent contractors to the National Health Service, earning from various practice payments, capitation fees for each patient on their lists, and fees for items of service. In short, they are not salaried staff as the hospital staff are. This makes it possible for them to shape and mould the content of their work in a way which is not open to specialists. Every specialist is in some sense a bureaucrat, since he takes his responsibilities from the office that he holds, and nowadays there is a job description for him which will not vary much throughout the UK for those holding appointments in his subject.

This is not so for general practitioners. Each practice has its own nuances, kinds of responsibility, and organisation. Urban practices differ from suburban ones, and rural ones are different again. There are single-handed GPs and practices with many partners. In group practices there may be some degree of specialisation. Some partners will undertake obstetrics or minor

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surgery; others will not. Some practitioners will be part-time. Some practices take on trainees. The various combinations are legion as the characteristics of the doctors and their attitudes are endless in their variety. It may be easy to choose to be a general practitioner, but the ultimate choice of which practice to go into may be extremely difficult because of a bewildering selection of types. The choice must be circumspect, emphasising again the importance of analysing one's capabilities, attributes, and desires for the future in terms of work and psychological and social needs. This may become clearer to you as you go through vocational training.

Vocational training

Vocational training for general practice became required by law under the National Health Service (Vocational Training) Regulations 1979. Broadly, these regulations mean that to have a contract for service as a principal in general practice with a family practitioner committee the applicant for the contract must be able to show that he or she has had an appropriate training. The type of training is laid down in the regulations. Essentially three years of training is required, of which one year must be spent in a selected practice and two years in hospital in approved posts. There are variations on this, but this is how it usually works out.

The regulations actually say:

"(i) at least 12 months whole-time employment or its equivalent shall be training as a trainee general practitioner, and

(ii) the remainder shall be training as a practitioner in educationally approved posts and shall include not less than six months whole-time employment or its equivalent in each of two of the following specialties—general medicine, geriatric medicine, paediatrics, psychiatry, one of accident and emergency medicine or general surgery, any one of obstetrics or gynaecology, or obstetrics and gynaecology."

All over the UK there are now vocational training programmes

under the control of the regional adviser in general practice. There is at least one regional adviser in every region of the NHS, and he is closely associated with the postgraduate dean. The training schemes consist of three years, of which one is spent in general practice and the other two in hospital in senior house officer posts. The two years in hospital may consist of four six-month posts, of which two must be in the "compulsory" subjects required by the regulations and the other two are "electives" decided on by the graduate in consultation with the regional adviser.

Entry to these programmes is fiercely contested after open advertisement. The hospital posts and the training practice are all in the same geographical area so that the incumbent does not have to move about much during the three years. Later the trainee may find that he can obtain a post as principal in his training practice or one nearby. Moreover, the trainee will know that his service in the practice and in the hospitals is approved and that he will obtain a "certificate of prescribed experience."

The certificate is absolutely essential. The experience has to be approved by the regional adviser in general practice and forwarded by him to the Joint Committee on Postgraduate Training for General Practice (JCPTGP). This committee issues the certificate, which is formal evidence on which the Medical Practices Committee can issue a contract for the person to be a principal. You must therefore keep in contact with the regional adviser in general practice. Certificates of satisfactory performance of duties have to be returned to his office at the end of each post. It is wisest to obtain these certificates when you complete the post and not leave it till some time after. Delay may compound the difficulties of getting the certificates. At the end of your three years of training the regional adviser then has all the evidence he needs about your experience and can send this off to the JCPTGP, from which the certificate will be quickly forthcoming.

In the next article I shall discuss how you can become a general practitioner if you do not enter a three-year training scheme.

A 10 year old boy attending an enuresis clinic suffers from classical giggle micturition. His midstream urine shows no infection and he does not suffer from nocturnal enuresis. Examination gave normal results. Is there any effective treatment?

Giggle micturition in boys is much less common than in girls. It is also much more certain of complete cure as the boy reaches adolescence. At the age of 10 his bladder neck and sphincter will be undergoing the natural hypertrophy that occurs at puberty in boys in order to prevent reflux ejaculation. This begins to show both histologically and on rectal examination against any instrument in the urethra with increased thickening at the neck of the bladder. The gradual hypertrophy of the bladder neck will continue to develop over the next three to four years. Parents may, therefore, be reassured with almost complete certainty that the giggle micturition will disappear at any time in the next year or two. For that reason I would not advise any active treatment, either medical or surgical.—J P MITCHELL, honorary professor of surgery (urology), Bristol.

Is it wise to treat viral infection in children with aspirin?

The decision to use aspirin in the symptomatic treatment of viral infections in children should follow due consideration of the arguments which suggest that temperature should not be lowered. These include the possibility that fever may be protective to the child, and is generally self-limiting and rarely serious, that the risk of use may outweigh symptom morbidity, and that clinical findings of diagnostic and prognostic value may be obscured. Recent reports have suggested that aspirin may cause Reye's syndrome,^{1,2} particularly in children suffering from influenza B or varicella infections, and, though such evidence remains unconfirmed, it seems unwise to use aspirin in these circumstances. The child with a non-specific presumed virus illness presents a slightly different problem, but the well-documented aspirin hepatotoxicity with chronic high dosing in children, par-

ticularly those with collagen disorders, and the tendency for salicylate concentrations to increase disproportionately to dose in routine use,³ makes the case for using aspirin difficult to sustain. Paracetamol is hepatotoxic in single large doses as in accidental ingestion, but its toxicity may be limited and probably prevented by appropriate action. Its analgesic and antipyretic effects similar to those of aspirin and its non-implication in Reye's syndrome make it the preferred choice of antipyretic or analgesic treatment when this is indicated in childhood virus infections.—G RYLAND, consultant in paediatric clinical pharmacology.

¹ Sillanpää M, Makela A-L, Koivikko A. Acute liver failure and encephalopathy (Reye's syndrome) during salicylate therapy. *Acta Paediatr Scand* 1975;**64**: 877-80.

² Starko KM, Ray CG, Dominguez LB, Stromberg WL, Woodall DF. Reye's syndrome and salicylate use. *Pediatrics* 1980;**60**:859-64.

³ Wilson JT. Special problems for drugs used in children. *South Med J* 1976;**69**: 779-86.

Can cyproterone acetate be used for prostatic cancer, and if so what is the dosage?

Most prostatic cancers are androgen dependent and will therefore respond to orchiectomy or oestrogen administration. Cyproterone acetate is an antiandrogen that blocks production of testosterone by the testes and also androgen secreted by the adrenals. It is therefore a feasible alternative approach to the treatment of prostatic cancer. The usual dose is 300 mg daily, taken as 50 mg tablets thrice daily. The incidence of gynaecomastia and cardiovascular complications is much less than with stilboestrol. The outstanding disadvantage of treatment with cyproterone acetate is the cost, which is about £75 a month. Its role at present in the management of prostatic cancer is that of an alternative to orchiectomy in those patients with metastases and co-existing cardiovascular disease in whom treatment with stilboestrol is best avoided. It may have a place in the treatment of the relapsed patient after previous orchiectomy, but this has yet to be evaluated.—J C GINGELL, consultant urologist, Bristol.