epidemiological data the screening of unidentified subjects would be far less valuable than the testing of volunteers as part of a suitably designed inquiry.

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Case notes chaos

SIR—Dr Stephen M W Hutchinson (23 March, p 813) has done doctors a service by reminding us of the importance of patient records as essential tools of medical care.

In 1983, on consultant initiative, our district adopted a policy on medical records to solve the increasingly worsening situation of multiple notes containing ephemeral and duplicated material.

The policy is based on the concepts of a unitary record, sequentiality, common user inserts, and a weeding and documentation policy. Thus it specified that a single record (bringing together all records other than those from the psychiatric and sexually transmitted disease departments) should accompany a patient as he or she moved around the hospitals and clinics of the district. All handwritten notes, laboratory reports, and correspondence should be filed separately in strict chronological order; documentation should be simplified on a specialty basis subject to central specifications; and inactive notes and ephemera should be identified and destroyed, subject to medicolegal constraints.

After four years most active notes now comprise "self filing," four compartment folders. All specialties (other than surgical) have agreed to common user documentation, sequential recording has found general acceptance, and, after foot dragging by the lawyers, a weeding and destruction procedure has been started. We run seminars on the use and handling of medical records, issue a handbook, and print instructions on the patient folder itself. We have cut costs by unifying folders and reforming stationery, in the latter case by £10 000.

We have not achieved complete success. There is a trend, for example, for each consultant to hijack the first position in the record. District availability of the unique record is difficult to ensure because of transport problems. None the less, our records compare with the standards in Germany and some parts of the United States.

Dr Hutchinson's efforts in Edinburgh will be of no avail until he has convinced most of his colleagues of the need for a record centred on the patient rather than the consultant and the need to invest in administration and user education in respect of patient records. It is to be regretted that 22 years after the Tunbridge report most health districts have yet to get round to this position and that their medical records departments still have the worst staffing and accommodation.

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Bronchial asthma

SIR,—As general practitioners, we may have ourselves to blame if in an article on bronchial asthma (Dr H B Valman, 21 March, p 753) we are mentioned only twice. The first is a negative reference about what to do if a general practitioner is not immediately available to provide nebuliser treatment in an acute attack, and the second is simply that we could review a child discharged from hospital completely well after such an attack.

The standardisation of general practitioners' management of asthma and the universal avail-

ability of nebulisers to primary health care teams would improve our standing in managing this common chronic condition, which, in all but a few cases, is ideally suited to management by the primary health care team.

Dr Valman's article does not seem to encompass the primary health care team approach. Firstly, a chest radiograph would not form part of the initial assessment unless presentation was atypical—or should 8% of under 5 year olds be having chest radiographs? Dr Valman says that failure to respond to chromoglycate or theophylline is an indication for treatment with inhaled steroids. I would not routinely use theophyllines in general practice, firstly, because this would mean subjecting the young child to blood tests and, secondly, because prophylactic β stimulant drugs, administered by spacer devices or nebulisers in the younger child, are effective and worthy of consideration before inhaled steroids are prescribed.

In acute asthma attacks the early use of nebulisation of a β stimulant bronchodilator followed if necessary by a short course of prednisolone and further observation at home, with repeat nebulisation if effective, can and does prevent many admissions to hospital.

If I sound paranoid about the lack of recognition of the general practitioner's role then I despair at the lack of recognition of the role of parents, who often manage their children's asthma better than the professionals as a result of being allowed autonomy by the general practitioner or consultant. Discussion, education, cooperation, and confidence in a management protocol are the foundation of good care.

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Pretended paralysis requiring artificial ventilation

SIR,—The conclusion of Drs Anthony Hopkins and Charles Clarke that it is difficult to distinguish between hysteria and malingering in cases like the ones they describe (11 April, p 961) is hardly deserving of the title "Lesson of the Week." Lewis has pointed out that this diagnostic dilemma has been an issue for two and a half millennia.¹

On the basis of their two cases, though providing few details of the psychiatric examinations or the social histories of the patients, the authors deliver yet another "funeral oration" on the use of the terms "hysteria" and "malingering" in relation to patients who adopt neurological conversion symptoms. The word "pretended," the replacement suggested by Drs Hopkins and Clarke, is unlikely to prove advantageous in any respect. The everyday use of the word will confer implications of deception and fraud, irrespective of the authors' attempts to give the term greater dignity after close perusal of the *Oxford English Dictionary*.

The effort to rebuff the division between conscious and unconscious motivation suggests a degree of "belle indifférence" in the face of a difficult, though not insoluble, problem. A carefully taken psychiatric history and examination, an interview with informants and family, and a social report will help to establish if the disability is feigned for obvious and straightforward reasons. If the subject is fully aware of what he is doing then he is a malingerer.

The authors claim that the word pretended makes no judgments about the subject's stance towards his illness. In psychiatry the patient's attitude towards his illness is an important consideration and should not be dismissed so readily as it may provide a clue to diagnosis of the underlying condition and the prognosis. To fail to take this into account simply because "there is no test to

distinguish hysteria from malingering" would be inexcusable. The use of the term pretended may lull doctors into a false sense of security in their dealings with patients who have high rates of underlying and often unrecognised physical and psychiatric illness.² As Lloyd points out, it may be helpful to regard hysteria as a first stage in diagnosis before a careful search is made for neurological or psychiatric illness and influences that may be rewarding the patient's sick role.³

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- 1 Lewis A. The survival of hysteria. *Psychol Med* 1975;5:9-12.
- 2 Marsden CD. Hysteria—a neurologist's view. *Psychol Med* 1986;16:277-88.
- 3 Lloyd GG. Hysteria: a case for conservation? *Br Med J* 1986;293:1255-6.

Abdominal aortic aneurysms

SIR,—We agree with Dr N F Gowland Hopkins (28 March, p 790) that the number of hospital admissions for abdominal aortic aneurysm repair is increasing. In the first three months of this year we repaired 21 such aneurysms, with no deaths, compared with only eight aneurysm resections performed during the same period in 1986.

Improved perioperative monitoring and operating techniques have reduced the mortality from elective aneurysm in the past 15 months to one out of 65 (1.5%). We are, therefore, in favour of early detection and surgery but suggest that a screening programme need not be random and could therefore be less costly. A logical screening programme could be based on the observed familial aggregation of aortic aneurysm.^{1,2} The yields from screening could be increased twofold to tenfold by focusing on the relatives of patients with abdominal aortic aneurysm, and the specificity could be improved by first screening those relatives with a smoking history of younger patients and female patients. The merits of such a screening programme are already being assessed in the United States.

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- 1 Johansen K, Koepsell T. Familial tendency for abdominal aortic aneurysms. *JAMA* 1986;256:1934-6.
- 2 Powell JT, Greenhalgh RM. Multifactorial inheritance of abdominal aortic aneurysms. *European Journal of Vascular Surgery* 1987;1:29-31.

Infection by airborne *Chlamydia trachomatis* in a dentist cured with rifampicin after failures with tetracycline and doxycycline

SIR,—The report by Dr M Midulla and colleagues (21 March, p 742) of airborne infection by *Chlamydia trachomatis* in a dentist cured with rifampicin after tetracycline treatments had failed is of interest to all those concerned with chlamydial infections. It is true that a tetracycline resistant strain of *C. psittaci* has been described,¹ but hitherto no tetracycline resistant strains of *C. trachomatis* have emerged. In the past, reports of *C. trachomatis* being isolated after what should have been effective tetracycline treatment have been based on false recognition of chlamydial inclusions in cell cultures. Thus inclusions seen after treatment were as spurious as those seen before treatment.

With regard to the paper by Dr Midulla and coworkers, only two conclusions may be drawn. Either the diagnoses of chlamydial infections were false, the authors having made the same mistake as others, or the authors have truly recovered tetra-