like Zimbabwe, India,[5] and Egypt,[6] where the widespread use of home remedies has reduced mortality from acute diarrhoeal disease. The principles of oral rehydration in acute gastroenteritis should be common knowledge among parents in Britain (as it is in Zimbabwe) and they should be encouraged to make up solutions as a first aid measure before seeking medical advice.

ROBERT J D MOY

Department of Paediatrics,
University of Zimbabwe,
A178 Harare

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Patients' assessment of out of hours care

SIR,—In their paper on out of hours care in general practice (19 March, p 829) Dr Mary Bollam and colleagues acknowledge that their sampling frame contains only patients who succeeded in contacting a practice doctor.

A total of 1027 calls were recorded during a composite four week period and the 177 calls analysed in greater detail resulted in 123 visits. This suggests that 714 visits would have been made by or on behalf of the 59 principals working in the urban group practices which participated in the study, the equivalent of almost 160 out of hours visits per general practitioner per year. If we assume the national average of 2000 patients per principal this represents 80 such visits for every 1000 registered patients and correlates well with previously reported findings from general practice. The number of patients who attend accident and emergency departments outside normal hours, however, is significantly higher and is now more than 100 visits per 1000 population per year. It is therefore possible, and even probable, that the total number of out of hours calls received during the period of study significantly underestimated the number of patients who sought medical advice outside normal hours during that time. Indeed, Dr Bollam and her colleagues acknowledge that parents of children under the age of 16 were consistently less satisfied than older patients, and the letter from Dr Herman in the same issue (19 March, p 860) draws attention to the high number of self referred children seen in accident and emergency departments at nights and weekends.

Some of these hospital attendances may seem to be inappropriate or even unnecessary, but for whatever reasons, and they are often complex, more patients are seen in accident and emergency departments outside normal hours than are visited by a general practitioner during these times. Many of these departments have insufficient medical staff to cope with the increasing demand but they need to recruit about 60% of medical graduates every year to fill the junior posts that do exist. It is not surprising, therefore, that some posts remain unfilled and that the resulting pressure in these departments is immense. The Casualty Surgeons Association is bringing this serious situation to the attention of the Minister of Health in the hope that some solutions can be found to a problem which has been long recognised but remains unresolved.

DAVID J WILLIAMS

Casualty Surgeons Association,
Royal College of Surgeons,
London WC2A 3PN

Hypnotic drug use among the elderly living at home

SIR,—We agree with Dr Kevin Morgan and others about the high prevalence of hypnotic drug use in elderly people (27 February, p 601).

With the help of a group of general practitioners our department carried out an epidemiological study on a large elderly population living at home in Brescia, Italy. One of the measures assessed was insomnia and the pattern of drug consumption in 1201 70-75 year olds (386 men and 815 women).

Our data indicated that insomnia (subjectively reported) was frequent in the elderly: 38% of men and 54% of women suffered from this sleep disorder. Only 43% of those suffering from insomnia used hypnotic drugs, while 10% took sleeping pills despite the absence of this symptom. Thus 26% of the total elderly population took regular hypnotic drugs, mainly benzodiazepines (82%), barbiturates (15%), and neuroleptics (3%).

Sleep disorders are often related to loss of life satisfaction and worsening of both physical and psychological wellbeing experienced by the aged: insomnia, however, is not a necessary consequence of aging itself. Adequate care of sleep disorders in the elderly should direct our attention not only to the high prevalence of hypnotic drugs used and their possible side effects but also to the high proportion of the elderly suffering from insomnia and not receiving adequate pharmacological or psychotherapeutic treatment.

As physicians concerned in the comprehensive care of the elderly we must address our efforts towards recognising insomnia and at the same time towards a rational therapeutic approach. There would be little benefit to the health of the elderly if our concern for the incorrect use of psychotropic drugs influenced negatively our ability to improve sleep conditions, which are of particular relevance to wellbeing during aging.

RENZO ROZZINI
ANGELO BIANCHETTI
GIULIANO BINETTI
MARCO TRABUCCHI

Centre for the Study of the
Elderly Condition,
25122 Brescia, Italy

Section 47 of National Assistance Act: a time for change?

SIR,—I agree with Dr J D Fear and his colleagues (19 March, p 860) that section 47 requests often follow a breakdown of social support for the elderly. Community physicians in Birmingham put this information to positive use and attempt to find out and correct weaknesses in the safety net in the provision of care for the elderly.

Social workers are required by the local authority to complete an extensive protocol, while community physicians ask the general practitioners for a joint domiciliary visit for every section 47 request. This is followed by a case conference, and an attempt is made not only to resolve a particular situation but also to ensure that it does not happen again. The system works well.

General practitioners have the competence to provide leadership in such cases as suggested, but I doubt they would have the time and the know how to resolve complex issues of patient care. In maintaining that the community physician should not be concerned with implementing section 47 the Acheson report has grievously misled itself in not appreciating that a report for a section usually points to a service deficiency, which is the bread and butter of community medicine.

A section 47 admission is not carried out in Birmingham if any party to the case conference or relative objects to its use, provided he or she has the needs of the patient as the prime interest. An appeal mechanism or an independent advocate to represent the interests of the patient would be useful only if the independent advocate, for example, would be in a position to provide an alternative source of care.

Changes in the law are always difficult to bring about and new laws are not necessarily any better than the old ones. I believe that the provisions of section 47 are generally used to positive effect with compassion and due regard to the rights of the patient and there is little evidence to show that section 47 is misused or abused.

S S BAKHSHI

Office of the Medical Officer for
Environmental Health,
Environmental Services Department,
Birmingham B3 2EZ

A licence for breast cancer screening?

SIR,—Dr J B Witcombe must be applauded for his emphasis on the necessity for quality control in the breast screening programme (26 March, p 909), an aspect of health care often ignored in an era biased towards cost effective policies. As he highlighted, radiological skills remain undeniably the most important front line aspect of the programme. In the final instance, however, mammography merely divides the population into either "normal" or "abnormal requiring assessment." The ultimate diagnosis of benign or malignant breast disease results from the application of cytological or histopathological skill.

It is consequently unfortunate that pathology comprised such a small component of the Forrest report. The stated consultant requirements (0·1 whole time equivalent per week per basic screening unit) are now widely considered to have been underestimated by at least 100%. Also, regrettably, no consideration was given to medical laboratory scientific officer staffing or workload. Pathologists now have the unenviable task of defending such omissions to implementation managers, and, needless to say, financial resources remain inadequate. Even with the necessary resources, however, it is improbable that enough trained cytopathologists will be available in the foreseeable future; these numbers are already inadequate for the cervical screening programme. There must also be doubt whether individuals will want to restrict their professional activities to such limited areas of pathology, especially with the presumed medicolegal implications of false positive cytological diagnosis.

Probably, however, the most serious omission from the Forrest report was a requirement for the quality control of cytology and histopathology. If pathological diagnostic accuracy cannot be assured the value of treatment becomes questionable, and data interpretation becomes pointless. Any overdiagnosis of benign or borderline breast lesions as malignant will be reflected in long term improvements in mortality from breast cancer. Although this mortality trend will be acceptable to the government and will lend support to the value of the screening programme, these improvements will be false and will have been achieved at the

expense of patient morbidity. For these reasons participation of consultant pathologists in an external quality assessment scheme would appear to be essential. In pathology this will then largely avoid Dr Witcombe's proposal of accreditation (unless, of course, the screening service is privatised).

In addition, I have recently attended courses at two of the centres taking part in the United Kingdom trial of early detection of breast cancer, and it is evident that national standardisation is required in pathological terminology, diagnostic criteria, and methods. For example, an important prognostic factor in breast cancer is tumour diameter. If, however, one major training centre measures diameter on fixed tissue microscopically and the other on fresh tissue macroscopically comparison of results between the two centres is difficult.

The importance of pathology in the breast screening programme warrants substantially greater consideration than it has been given by the Department of Health and Social Security. The enlightened view of regional health authorities such as Trent unfortunately seems to be the exception rather than the rule.

DAVID SLATER

Rotherham District Hospital,
Rotherham S60 2UD

SIR,—I share Dr J B Witcombe's concerns about the prospect of a national breast screening programme proceeding without national quality control and a unified pattern of recording of data (26 March, p 909). The British trial for the early detection of breast cancer had very detailed pathological, radiological, and clinical data collection and analysis and nothing less will do for the British national screening campaign.

I also share his concern that if this scheme goes into full action too quickly there will be insufficient time to assess the competence of all those who take part. Training of radiologists and radiographers, histopathologists and cytopathologists, and surgeons is a priority.

The results of the Swedish trials quoted by Dr Witcombe have been paralleled quite closely by the Edinburgh and Guildford studies. Those of us who have participated in them believe that the lessons learnt over the past nine years should be made available to all who intend to set up breast screening programmes and thus ensure that the learning curve starts at an acceptable level. It is true that safety demands a moderate number of false positives in the radiological assessment of mammographic defects in a screening programme, but the review system and suitable reference to an experienced surgical team will result in a biopsy rate which is acceptable in a population study. In Guildford the biopsy rate for suspicious lesions in the first year was 1 malignant to 1·77 benign. The development of review systems with teamwork between radiologists, screening doctors, cytopathologists, and surgeons has over the years led to our present biopsy rate of 1:0·4 (malignant to benign). This is the sort of rate which should be the goal of screening programmes and it takes a lot of skill, interest, and high quality equipment used well to produce this.

It is difficult to reach any conclusion other than the one hinted at in the Forrest report, that the review and assessment and subsequent care of patients with impalpable lesions are done best in breast units, which should be established at a subregional level and staffed by people who have the equipment and skill and time to do the job properly.

The author mentions the problems in the training of radiographers and "breast physicians." The title of breast physician is new and I believe it to be a misnomer. The high degree of efficiency in both the Edinburgh and Guildford programmes has depended much on the performance of expert screening doctors. They are specialists in the true sense of the word, but the task of a physician is not only to diagnose but also to treat patients. Surely this is not the remit of those who are going to be conducting the highly time consuming and responsible task of screening organisation and review. Screening centres must have surgeons appointed who are responsible for the final reference and decision making, the necessary biopsies, and subsequent treatment.

P S BOULTER

Guildford Medical Centre,
Royal Surrey County Hospital,
Guildford, Surrey GU2 5XX

Hypocalcaemia after parathyroidectomy

SIR,—We note with trepidation that Drs T J Thompson and T J Neale (26 March, p 896) had to resort to intraperitoneal calcium to treat hypocalcaemia after subtotal parathyroidectomy because the long term effects of large doses of calcium on the peritoneal membrane are not known.

At Liverpool we have subjected more than 15 patients with end stage renal failure and secondary hyperparathyroidism to total parathyroidectomy, and not once have they noticed symptomatic hypocalcaemia. Two weeks before surgery these patients are started on alfacalcidol in doses ranging from 1 to 2 μg daily. Postoperatively they continue taking alfacalcidol together with oral calcium, both titrated to the requirements of the patient.

Subtotal parathyroidectomy is not only a waste of time and effort, but later the remaining parathyroid gland is more than likely to become hyperplastic, which will require unnecessarily yet another operation.

MOHAMMED YAQOOB
RASHEED AHMAD
ERIC SIMKIN

Royal Liverpool Hospital,
Liverpool L7 8XP

Clinical carpal scaphoid injuries

SIR,—We are surprised at the way Mr M R A Young and others (19 March, p 825) manage scaphoid injuries. The use of isotope bone imaging is well described in published reports.[1,2]

We manage patients with scaphoid injuries as follows. All new patients are examined and those with tenderness in the anatomical snuff box undergo *x* ray examination, including scaphoid views. Patients with positive findings are managed in scaphoid plaster. Those with no radiographic abnormalities have a wool and crêpe bandage applied to their wrist and are reviewed three days later; if the wrist is still tender they are referred for immediate isotope bone imaging of their wrist. Those with a positive image are treated as having scaphoid fractures and have plaster of Paris applied. Those with negative results are treated only symptomatically and discharged to the care of their general practitioners.

Among the past 50 patients we have referred for isotope bone imaging four had positive results. The remainder were discharged from follow up at that stage. As far as we are aware none returned with problems secondary to missed fracture of the scaphoid. This method of management reduces dramatically the number of attendances and number of radiographs that the patients require. As the patients are not in a plaster cast for lengthy periods they can usually return to work earlier than those managed by conventional means. This means that the overall cost is also reduced.

M REICHL
M A KHAN

Accident and Emergency Department,
Southampton General Hospital,
Southampton SO9 4XY

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Körner, nomenclature, and SNOMED

SIR,—There is so much understanding of the problems of classification in Mr Richard Earlam's article (26 March, p 903) that his enthusiastic support of SNOMED (systematised nomenclature of medicine) is surprising.

His statement that it is "unknown and untested in the United Kingdom" is too strong. SNOMED has been considered in some depth in Britain and its limitations recognised though it is used in several pathology departments. Its detailed structure is beneficial in this discipline, and the fact that its tumour morphology field is identical with that of International Classification of Diseases-9 reduces problems of compatibility.

In clinical medicine its multiaxial structure is a drawback. The SNOMED authors have recognised this and have created an anomalous "D axis" for diseases to try to compensate. In spite of Mr Earlam's assertion, the classification copes poorly with "fuzzy," ill defined problems. The use in SNOMED of a varying number of fields of varying types to code a single entity can cause difficulties—for example, tonsillitis needs a morphology field M-40000, which indicates inflammation, and a topography field T-61100 for tonsils, while for streptococcal sore throat a disease field D-0180 is used. I can find no code for a simple sore throat. It is difficult to map SNOMED terms on to existing national and international statistical classifications, which we have to live with.

I wonder if Mr Earlam is familiar with the Read clinical classification.[1] This has been developed in the United Kingdom for use on computers and is exciting much interest here and overseas. It is a comprehensive, hierarchical nomenclature and classification covering all aspects of medicine including diagnosis, signs and symptoms, radiology, laboratory tests, operations, procedures (diagnostic, therapeutic, preventive, and administrative), occupation, and drugs.

The code is alphanumeric, using upper and lower case, and, with five characters, it could specify uniquely over 650 million entities. The new version provides precise codes for 150 000 medical terms.[2] By coding preferred terms and then linking recognised synonyms it allows the doctor to define the patient's problems in natural language. In most computer systems using the system coding is automatic, avoiding clerical coding and inputting errors and encouraging direct data input by clinicians. More than 1500 doctors are using the system daily.

By identifying and allocating codes to distinct concepts in medicine and by its space to expand the Read classification provides a nomenclature for medicine that is cross referenced to the International Classification of Diseases-9CM and its subsets, OPCS-4, diagnostic related groups, Körner datasets, and so on, allowing statistical