Doctors in the United Kingdom need not go to North America for their training. Indeed a number of doctors from Canada and the United States are now studying medical education in Dundee.

## Deep vein thrombosis

Dr P J GREEN (Department of Haematology, St Mary's Hospital, Portsmouth PO3 6AG) writes: Mr John H Scurr and others (2 July, p 28) demonstrate that more than 60% of deep vein thromboses after operations occur in patients after discharge from hospital. They did not record, however, whether these patients were treated and what the outcomes were. If the thromboses were merely "iodine disease" and if the outcome in all cases was complete resolution with no long term morbidity then the current practice of stopping prophylactic anticoagulation as the patient leaves hospital would seem to be justified.

## Hagard on health

Dr SPENCER HAGARD (Health Education Authority, London WC1A 1AH) writes: I wish to comment about misapprehensions that may have arisen as a result of Dr Stella Lowry's report (16 July, p 160). On the question of risk of human immunodeficiency virus (HIV) infection and AIDS I referred to "people at risk through their behaviour" rather than to "at risk groups," a term that I always avoid. Anyone may be at risk through particular behaviour, and my phrase helps to engage a widespread interest in the need for prudent behaviour. Conversely, the concept of "at risk groups" has a distancing effect on people not belonging to the categories specified however risky their actual behaviour might be. On the question of advertising I questioned the immediate future use of high profile, short run, mass media campaigns ("big bang"), not their past use, about which I am on record in support of their remarkably successful effort in raising awareness and providing essential basic information to the British public about HIV infection and AIDS (S Hagard, world summit of ministers of health on programmes for AIDS prevention, London, 1988).

## Restless legs syndrome

Dr VICKY RIPPERE (Institute of Psychiatry, Denmark Hill, London SE5 8AF) writes: Dr J M S Pearce suggested using clonazepam or synthetic opioids to treat the restless legs syndrome (23 July, p 278). An even safer treatment may be simply stopping caffeine. Lutz noted that Thomas Willis's original description of the syndrome in 1685 coincided with the establishment of coffee drinking as an English social habit, and he concluded on the basis of a series of 62 sufferers that caffeine may be the major factor in the syndrome's aetiology.[1] Many of his patients became completely asymptomatic after stopping taking caffeine, with or without a short course of diazepam. Increased exercise was also beneficial in patients engaged in sedentary occupations. It must be preferable to prevent the adverse effects of an unnecessary drug by stopping that drug than to give another, potentially more hazardous, drug to relieve them. Perhaps fewer elderly patients would be poisoned if this principle were more widely adopted.[2]

1 Lutz EG. Restless legs, anxiety, and caffeinism. *J Clin Psychiatry* 1978;**39**:693-8.
2 Anonymous. Need we poison the elderly so often? *Lancet* 1988;ii:20-2.

## Specialisms in general practice

Dr M KEITH THOMPSON (Croydon CR0 5NS) writes: Dr E Martin contends that the more special interests we identify the more careful we have to be to give competent care to those patients who do not fall into these groups (23 July, p 288). His own practice has set up special clinics for diabetes, hypertension, child development, antenatal care, menopausal symptoms, asthma, skin disease, and minor surgery. Noticeably absent was my special interest—the care of the elderly, the greatest consumers of health care in developed countries. The answer to Dr Martin's problem is to undertake a special interest that is applicable broadly to general practice. There is a danger in a group practice of all working at the primary care level. At my practice we identified those colleagues to whom we could refer a problem before using the hospital services. Each doctor undertook to present cases at regular lunchtime meetings, bring along patients for demonstration, and be examined by the audience about aspects of his management. We found that this has great learning potential.

## Routine ultrasound screening

Mr THOMAS B HUGH (St Vincent's Hospital, Darlinghurst 2010, Australia) writes: Messrs R A P Scott and H A Ashton and Dr D N Kaye (18 June, p 1709) noted gall stones in 29 of the 1404 patients whom they scanned, a frequency of 2%. This is surprisingly low. The frequency of gall stones increases with age, and in other studies they have been noted in 20-25% of elderly white patients.[1] Did the authors specifically scan the biliary tract in each case? If not it might be wise to include this examination in future surveys. Complications of gallstone disease may be an important source of morbidity after operations for abdominal aortic aneurysms, and gall stones should be detected before the operation to allow for their planned removal if indicated.

1 Coleman MJ, Ham JM, Watts JM, *et al*. A debate: asymptomatic gallstones should not be removed. *Aust NZ J Surg* 1987;**57**: 897-903.

## Intravenous volume replacement

Dr PETER F S LEE (Department of Anaesthesia, Royal Preston Hospital, Preston PR2 4HT) writes: Mr G Ramsay (21 May, p 1422) gave a fine appraisal of the issues involved in intravenous volume replacement but he seemed to end with an illogical recommendation. Having extolled the virtues of a study of a mixture of colloid and crystalloid he revealed "the colloid I use is gelatin." The study, however, showed that the best results were from using a mixture of dextrans and crystalloids.[1] Dr Kenneth J Power (9 July, p 134) claimed advantages for dextrans but omitted to point out that with the introduction of hapten prophylaxis the risk from anaphylaxis to dextrans has been virtually eliminated.[2] There is much to recommend the use of dextran-colloid mixtures for volume replacement. Dextrans do not interfere with the opsonising function of fibronectin, as does gelatin,[3] and seem to possess several helpful effects including reducing hypercoagulability,[4] reducing thrombocyte adhesion,[5] etc. It would seem reasonable for hapten prophylaxis to be made available in the United Kingdom as soon as possible, so making the use of dextrans much safer.

1 Smith JAR, Norman JN. The fluid of choice for resuscitation of severe shock. *Br J Surg* 1982;**69**:702-5.
2 Renck H, Ljungström K-G, Hedin H, Richter W. Prevention of dextran-induced anaphylactic reactions by hapten inhibition. *Acta Chir Scand* 1983;**149**:355-60.
3 Brodin B, Hesselvik F, von Schenk H. Decrease of plasma fibronectin concentration following infusion of a gelatin-based plasma substitute in man. *Scand J Clin Invest* 1984;**44**:529-33.
4 Modig J. Effectiveness of dextran 70 versus Ringer's acetate in traumatic shock and adult respiratory distress syndrome. *Crit Care Med* 1986;**14**:454-7.
5 Aberg M, Hedner U, Bergentz SE. The effect of dextran on haemostasis and coagulation with special regard to factor VIII. In: Lewis DH, ed. *Dextran 30 years*. Stockholm: Almquist and Wiksell, 1977:23-30.

## Cervical screening

Dr J M LAURENT (Chorleywood, Hertfordshire WD3 5EA) writes: Is ours the only general practice that thinks that the cervical screening programme has got totally out of hand? Women at least risk demand the most screening while more vulnerable women often need to be persuaded to attend. We have always accepted that the yield would be low. Nevertheless, we started our own scheme in a modest way long before cervical screening attracted any payment and gradually extended our remit to include all sexually active women over 16, with a normal recall every three years. We computerised our programme about a year ago. We currently have to cope with a statutory nationwide programme imposed on family practitioner committees which often conflicts with our own up to date scheme. The last straw was when patients were removed without notice because they had failed to inform the family practitioner committee of a change of address within the area of our practice. The tail may not be wagging the dog, but the cervix is certainly wagging the body politic, and the confusion, anxiety, and even morbidity created are becoming unacceptably high.

## Treating the premenstrual syndrome

Dr KATHARINA DALTON (London W1) writes: Drs D Gath and S Iles (23 July, p 237) rightly refer to the many unsuccessful treatments for premenstrual syndrome, which they attribute to problems of diagnosis and research methods. They also emphasise that the diagnosis depends on the timing of the symptoms in the menstrual cycle. Their insistence that drug trials should be rigorous, randomised, controlled, and double blind, however, displays a lack of familiarity with this disease. The preparation of a protocol to study the premenstrual syndrome is difficult because of individual variations in menstruation, symptoms, absorption of progesterone, age, parity, and previous postnatal depression.[1] The dose and frequency of administration of progesterone need to be tailored individually for each woman, as does the insulin requirement for each diabetic. A survey of 1096 women with the premenstrual syndrome who became symptom free after progesterone showed that only 23% benefited from a low dose of 400 mg suppositories daily. Eight per cent did not absorb the drug adequately from the vaginal or rectal routes and required daily intramuscular injections of progesterone or implantation.[2] Parous women required higher doses. One cannot claim that progesterone has failed to relieve the premenstrual syndrome until intramuscular progesterone has been tried. So far all clinical trials of progesterone can be faulted on the grounds of poor diagnosis or inadequate dose,[3-7] and all have used insufficient subjects.[8] Women with only mild or moderate symptoms do not require progesterone, but one must consider whether it is ethical to withhold effective treatment during trials from those women with severe premenstrual syndrome, who are subject to suicidal attempts, psychotic episodes, alcoholic bouts, baby battering, epileptic attacks, or hospital admissions. All of these women do require progesterone.

1 Dalton K. *Premenstrual syndrome and progesterone therapy*. 2nd ed. London: Heinemann, 1984:167-77.
2 Dalton K. *Premenstrual syndrome and progesterone therapy*. 2nd ed. London: Heinemann, 1984:258.
3 Sampson GA. Premenstrual syndrome: a double blind controlled trial of progesterone and placebo. *Br J Psychiatry* 1979;**135**: 209-15.
4 Maddocks S, Hahn P, Moller F, Reid RL. A double blind placebo controlled trial of progesterone vaginal suppositories in the treatment of premenstrual syndrome. *Am J Obstet Gynecol* 1986;**154**:573-81.
5 Andersch B, Hahn L. Progesterone treatment of premenstrual syndrome—a double blind study. *J Psychosom Res* 1985;**29**: 489-93.
6 Richter MA, Haltvick R, Shapiro SS. Progesterone treatment of premenstrual tension—a double blind study. *Current Therapeutic Research* 1984;**36**:840-50.
7 Rapkin A, Chang LH, Reading AE. Premenstrual syndrome: a double blind placebo controlled study of treatment with progesterone suppositories. *Journal of Obstetrics and Gynaecology* 1987;**7**:217-20.
8 Pocock S. *Clinical trials: practical approach*. New York: Wiley, 1983.

## Delayed communication between hospitals and general practitioners

Mr C M JAMES (Winchester, Hampshire SO22 5ND) writes: Drs D A Sandler and J R A Mitchell (16 July, p 204) might achieve even better rates of hand delivery of discharge letters if they avoided using medical jargon when addressing the general public. The Plain English Campaign found that a significant proportion of the population do not understand "Do not exceed the stated dose" or "Consult your doctor if symptoms persist." Will such people be motivated by "The contents include a clinical summary of your admission for your doctor"? I doubt it. I suggest that "This letter tells your doctor about your stay in hospital" would be much more comprehensible to the population at large.