Points

Ultrasonography for diagnosing appendicitis

Dr DEREK CRICHTON (Durban 4000) writes: Dr R H Pearson recommends "high resolution ultrasonography in patients with equivocal findings" suspected of acute appendicitis, yet he accepts that ultrasound diagnosis may miss an acute appendix in no less than 20% of cases (30 July, p 309). Undue reliance on ultrasonography can too easily encourage the unwary to procrastinate unsafely in a case of acute appendicitis. Furthermore, resolution ultrasonography is not widely available on an emergency basis and can in itself lead to a dangerous delay before the diagnosis is actually made. Dr Pearson says that an overall appendicectomy rate of 15-20% is regarded as generally acceptable to avoid missing an acute appendix, but this figure is almost 40% in women. In women it is laparoscopy which can revolutionise the accuracy attainable in diagnosing acute appendicitis in doubtful cases (14 May, p 1363). I failed to visualise the appendix (as my routine observation) in only one case in 76 laparoscopies. Tell tale surrounding oedema and adhesions will usually alert the surgeon to underlying disease even if the appendix cannot be seen, and if the disease is really in the ovary, tube, uterus, or elsewhere in the pelvis or lower abdomen the diagnosis can be made with an accuracy that approximates to 100%.

Decision making for routine immunisation

Dr W J NOONAN (Gloucester GL1 1XR) writes: The algorithm of Dr Angus Nicoll and Dr Douglas Jenkinson (6 August, p 405) should help increase the unacceptably low rate of immunisation. Nicoll *et al* emphasised the importance of planning the organisation of a child health clinic, resulting in a more deprived population of preschool children being seen,[1] and James *et al* identified open access and the regular presence of a doctor to prescribe for minor ailments and to give reliable advice as important factors in increasing rates of immunisation.[2] In the light of these and other papers we reassessed our immunisation strategy. An audit of case notes in our practice identified a high proportion of children who had started but not completed primary immunisation and who had not been immunised against measles. We therefore instituted a policy of giving measles immunisation at the same time as the third triple and polio injections soon after the first birthday, which has significantly increased the uptake. Linking completion of primary immunisation to a highly important event, the child's first birthday, rather than 13, 14, or 15 months, was important. There are far fewer defaulters, and having two needles in one day for their children is well accepted by parents, who appreciate having one less visit to organise (especially those in disadvantaged circumstances).

1 Nicoll A, Mann N, Vyas H. The child health clinic: results of a new strategy of community care in a deprived area. *Lancet* 1986;i:606-8.

2 James J, Clark C, Rossdale M. Improving health care delivery in an inner city well baby clinic. *Arch Dis Child* 1986;**61**:630.

Non-operative management of perianeurysmal fibrosis

Messrs J F THOMPSON and A D B CHANT (Royal South Hampshire Hospital, Southampton SO9 4PE) write: The leading article by Mr Nigel Bullock (23 July, p 240) summarises the evidence linking retroperitoneal fibrosis with mediastinal and perianeurysmal fibrosis and the place of steroids in treating patients with retroperitoneal fibrosis who are unfit for operation. This approach has been reported in the treatment of inflammatory aneurysm.[1-3] We report an interesting but fatal complication of conservative management. A 72 year old man was found to have a 12 cm tender inflammatory abdominal aortic aneurysm. Computed tomography also showed a 5 cm adrenal mass, which proved to be a non-secretory adenoma. At operation the adrenal gland was removed, but extensive dense perianeurysmal fibrosis precluded resection of the aneurysm. A right ureterolysis was performed and the abdomen closed. After an uneventful recovery prednisolone 5 mg twice daily was started. Ten days after discharge he was readmitted with a massive haematemesis, and an aortoenteric fistula was diagnosed. At laparotomy the previously dense fibrosis had virtually liquefied, being replaced by amorphous tissue. The aortoduodenal fistula was closed, and the infrarenal aorta, which was easily mobilised, was oversewn. Extra-anatomical bypass was performed with an 8 mm axillobifemoral graft. Unfortunately he died of multiorgan failure 48 hours postoperatively, having received 35 units of blood. A dramatic response to low dose corticosteroids has not been reported. The early improvement in renal function when patients with obstructive uropathy secondary to retroperitoneal fibrosis are treated with steroids may be due to a similar rapid response. We recommend that patients are closely supervised during the early phase of steroid treatment of inflammatory aortic aneurysm.

1 Thompson JF, Darke SG. Portal hypertension and chronic pancreatitis complicating an inflammatory aortic aneurysm. *European Journal of Vascular Surgery* (in press).

2 Clyne CA, Abercrombie GF. Peri-aneurysmal retroperitoneal fibrosis: two cases responding to steroids. *Br J Urol* 1977;**49**: 463-7.

3 Feldberg MA, Hene RJ. Peri-aneurysmal fibrosis and its response to corticosteroid treatment: a computerised tomography follow up in one case. *J Urol* 1983;**130**:1163-4.

Heartsink patients

Dr D G WILSON (Cambridge CB4 1HX) writes: The interesting articles on difficult patients by Dr David Jewell, Dr T C O'Dowd, and Drs T J Gerrard and J D Riddell (20-27 August, pp 498, 528, and 530, respectively) pose difficult questions and offer some useful suggestions towards solutions. Perhaps I can offer a longer term perspective as in 1971 I reviewed the outcome in 100 really difficult patients identified from the records of my consultations in general practice in 1960[1] and analysed the results again in 1981 a year before my retirement. Though these patients were not all strictly in the heartsink category, they were certainly all burdensome and usually puzzling as well. After 21 years of follow up I found that of the original 78 women, I was still treating 13, and of the 22 men, 4; their problems (significant change of word) remained considerable, but with retirement a mere year ahead, hardly burdensome for me. Of the total 100, 39 had died, and in addition 15 had moved away from our district. Nineteen patients had changed to other practices, and a further three had transferred their allegiance to one of my partners. I classed 10 as recovered, and only one was a hospital inpatient in 1981. These figures hardly represent any kind of therapeutic triumph for my methods but do indicate that doctors can survive their patients' troubles and make space, in the face of such formidable difficulties, for managing other, apparently less demanding patients. The strategies offered by the articles are valuable, as were the insights offered by a Balint group to me. I would add that general practitioners need to pace themselves, recognising that, on the one hand, many of these people will be attending for years whatever is done for them and, on the other hand, that the natural course of this syndrome results in the painless removal of most heartsink patients either to the care of other doctors or up to that "great clinic in the sky."

1 Hopkins P, ed. *Patient-centred medicine*. London: Regional Doctor Publications, 1972.

Hospital referrals

Dr PAUL A REILLY (Christchurch Hospital, Christchurch, Dorset BH23 2JX) writes: The recent article by Dr M Marinker and colleagues (13 August, p 461) was well thought out and nicely written. They state the case for auditing hospital referrals by general practitioners but highlight the difficulties that such an audit would present. I have worked in the north east of Scotland, Glasgow, the west country, and now on the south coast of England, and in my own experience the quality of general practitioner referrals is generally good. If an audit is deemed necessary, however, I would suggest that the easiest method may be to contact doctors working in hospitals and ask them to name general practitioners whose letters of referral are shoddy (for example, "please see and treat as necessary") and those whose name crops up more often than the rest. For acute admissions to hospital the best people to ask would be the senior house officers and registrars concerned with emergency receiving, and for outpatients perhaps senior registrars and consultants would give the most reliable information. It would not take long to identify local general practitioners whose pattern of referrals merit closer scrutiny. Similarly, it does not take long for a hospital doctor to recognise from the referral letters general practitioners who are diligent and competent and whose clinical acumen is worthy of respect. If the same general practitioner's name was mentioned by hospital doctors practising in widely differing specialties this might show a need for closer investigation. Perhaps general practitioners might also like to engage in an audit of hospital doctors, by considering the speed at which an appointment is offered, the quality of the letter sent back, and whether the patient is satisfied with the consultation. Once again, if the same doctor's name cropped up repeatedly further investigation might be worth while.

Dr D J PRICE (Joint Committee on Postgraduate Training for General Practice, London SW7 1PU) writes: Dr Marshall Marinker and colleagues (13 August, p 461) refer to the possibility of annual reports and practices being used as part of the "recognition by the joint committee . . . as a teaching practice." The Joint Committee on Postgraduate Training for General Practice does not have responsibility for selecting trainers in general practice. This is a function that is assigned by the Department of Health to the university educational subcommittees in general practice in each region.

Asian mothers' risk factors for perinatal death

Drs ALFREDO PISACANE and GIANFRANCO MAZZARELLA (Department of Paediatrics, University of Naples, 80131 Naples, Italy) write: Professor MICHAEL CLARKE and colleagues (6 August, p 384) reported that manual work on the part of the woman was a perinatal risk factor in both Europeans and Asians. Few data are published on the relation between work by the mother and perinatal mortality in developed countries. We carried out a case-control study of perinatal deaths in the Campania region of southern Italy; the cases were all of the 975 singleton perinatal deaths that occurred in 1982 among women who had had little schooling (little schooling was defined as having attended no school at all or having had only seven years at primary school) and the controls were 983 perinatal survivors randomly chosen from among the 63 600 singletons born in the same year to women from the region who had had little schooling. No difference was detected between cases and controls in the distributions of maternal age and parity, legitimacy, and husbands' occupation. The risk of a stillbirth was significantly associated with manual work on the part of the woman for babies whose birth weights were both under and over 2500 g (odds ratio (95% confidence interval) 2·8 (1·2 to 6·6) and 3·0 (2·1 to 4·3), respectively, whereas the risk of early neonatal death was significantly associated with such work only for babies whose birth weight was over 2500 g (1·8 (2·2 to 2·8)). Death certificates in Italy do not report details about the type and the duration of manual work on the part of the woman; for this reason prospective studies are urgently needed to clarify the relation between such work and perinatal mortality.

What went wrong at Exeter?

Dr HENRY WEATHERBURN (Department of Medical Physics, University of Aberdeen, Aberdeen AB9 2ZD) writes: While it is true that the Department of Health and Social Security would not provide funds for a multicentre dosimetry intercomparison, which brought the problem at Exeter to light, Dr Jeffrey S Tobias omits to state that this was not true of the Scottish Home and Health Department (6 August, p 372). In fact, following discussion at one of last year's biannual meetings of the Scottish Radiotherapy Physicists Group, which are organised by the Common Services Agency for the Scottish Health Service, the agency agreed to request, and indeed did obtain, funding from the department for travelling expenses for a Scottish dosimetry intercomparison. When this was complete it in turn set the ball rolling,