Child health surveillance lists

Doctors should decide criteria for admission to lists and standards of practice

Many reasons exist why health services for children are best provided by the primary health care team. General practitioners and health visitors have a long tradition of caring for families and visiting them in their homes. The consultation in general practice is the ideal opportunity to offer preventive and therapeutic care. And general practice is based on local communities, accessible to 95% of the population, and cost effective.

Recognition of this dates back to the Court report (1976), which advocated that child surveillance should increasingly take place in general practice (rather than in the community services).¹ Progress towards the two tier delivery recommended by Professor Court has, however, been slow.

Milestones along the way include *Healthier Children—Thinking Prevention*,² which advocated that child surveillance should be part of the core of general practice, and the *Handbook of Preventive Care for Pre-school Children*.³ Later came *Health for All Children*, containing the views of a working party chaired by Dr David Hall, which looked critically at all aspects of child surveillance and recommended a core programme.⁴ A second edition refining earlier recommendations and defining responsibility will be published soon.

Since 1 April 1990 the new contract has remunerated general practitioners for carrying out child surveillance provided that they have been accepted for this by their family health services authorities and their names appeared on the approved lists.⁵ The Royal College of General Practitioners and the British Paediatric Association issued joint guidelines in December 1989, which were intended to help family practitioner committees (since renamed family health services authorities) in selecting general practitioners for admission to their approved lists.⁶ These guidelines are currently being updated in consultation with the General Medical Services Committee and Joint Committee for Postgraduate Training in General Practice.

Yet Evans and colleagues report considerable variation in the criteria adopted by the managers of family health services authorities for admitting general practitioners to approved

lists. Many general practitioners understandably resent the discrepancies that have led to approval by one family health services authority but not its neighbour (p 229).⁷ Standard setting should be a professional exercise. The widely varying standards highlighted by Evans *et al* are a telling reminder that leaving this to managers is likely to produce as many criteria for accreditation as there are family health services authorities.

Children are an investment in our future; allowing them to achieve their potential is the main purpose of child surveillance. This is too important to be left to local prejudice—parents and children deserve a uniform standard of care wherever they live. With its recommended core programme of child surveillance *Health for All Children* was an important step forward. But a core programme is not enough: national standards should exist, from which all children should benefit. Standards are a professional not a managerial responsibility.

Of course our ultimate aim should be to ensure that all future entrants into general practice are appropriately trained so that an accredited list is unnecessary. This issue is currently being addressed by the Royal College of General Practitioners and General Medical Services Committee working within the Joint Committee for Postgraduate Training in General Practice.

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When sex is a headache

Not funny but usually not serious

The term “benign sex headache” was coined to cover not the age old avoidance ploy but a headache that develops as sexual excitement mounts and culminates in a severe “explosive” headache at orgasm. It is analogous to “benign cough headache”¹ and “benign exertional headache”² in that it is applicable only to those patients without any structural neurological lesion. The term is preferable to “coital cephalalgia” because similar headaches may also be induced by masturbation.³

Hearing of sex headaches may bring a smile to the lips of the uninformed, but they are anything but amusing to those who have experienced them. The severity and abruptness of onset

(“like a blow on the head”) raises the fear of subarachnoid haemorrhage, which is not unreasonable—sexual intercourse was the precipitating factor in six of the 50 cases of subarachnoid haemorrhage studied by Lundberg and Osterman.⁴ Fortunately, most headaches associated with sexual excitement do not have any sinister underlying cause, and the benign forms have a characteristic pattern that enables diagnosis in most instances.

Benign sex headache may have two components.³ The first develops as sexual excitement approaches orgasm, usually as a dull, tight, or cramping sensation in the occipital region. This is probably related to excessive contraction of the head and

neck muscles as deliberate muscular relaxation relieves it. Masters and Johnson observed that "the muscles of the neck contract involuntarily in a spastic pattern" during intercourse.⁵ The second component, which may follow the first or arise without warning, occurs abruptly at the time of orgasm as a severe occipital or generalised ache, described as explosive or excruciating.

The mechanism of this, one of several "thunderclap" headaches described by Wijdicks *et al*,⁶ is particularly interesting. Such headaches may well be precipitated by an acute pressor response—during orgasm systolic blood pressure increases by 40-100 mm Hg and diastolic pressure increases by 20-50 mm Hg.⁵ These increases are comparable with those during the paroxysmal headaches caused by pheochromocytoma,⁷ which they closely resemble.

Occasionally symptoms of cerebrovascular insufficiency may accompany explosive sexual headache. Two young men have had a stroke as a result, one with a brain stem thrombosis³ and the other with infarction of the left cerebral hemisphere.⁸ Multiple areas of cerebral arterial spasm were shown angiographically in a 30 year old man after a coital headache that exertion had exacerbated.⁹ Happily, such vascular complications are rare. An association between benign sex headaches and migraine was found in 17 patients followed up by Silbert *et al*, eight of whom had a history of migraine and five a family history of migraine.¹⁰

Another, rarer type of headache was described by Paulson and Klawans.¹¹ They described three patients with postural headaches after coitus, which were present on standing, eased by lying, accompanied by a low cerebrospinal fluid pressure, and persisted for several weeks.

Does physical exertion play any part in these acute vascular headaches? Hippocrates thought so, commenting that "one should be able to recognize those who have headaches from gymnastic exercises, or running, or walking, or hunting, or any other unreasonable labor, or from immoderate venery."¹² The link between venery, moderate or not, and exertional headache has recently been explored by Silbert *et al*.¹⁰ Eighteen of their 45 patients subject to acute vascular headaches during sexual intercourse had also experienced headaches on exertion. Nine patients described a close link between the two sorts of headache, with one following the other within a few days and a dull generalised headache

persisting between the two acute events. During follow up for an average of six years two fifths of them had recurrences of their sex headaches, usually at times of fatigue or stress. In some patients there is no discernible link with exertion as the headache may develop when they are taking a passive role.

Benign sex headache has been reported in patients from 18 to 58 years of age, more commonly in men than women. Capricious in its appearance, it mysteriously develops on some occasions but not others, without any obvious change in sexual technique. It more commonly occurs when the subject is tired, under stress, or attempting intercourse for the second or third time in close succession. Sometimes the severe orgasmic headache may be preceded by a dull occipital ache, in which case the subject should desist on that occasion. When a clinician first encounters this syndrome there is a natural tendency to investigate the patient extensively. If the story is typical and computed tomography does not show any abnormality there is usually no need to proceed to lumbar puncture, cerebral angiography, or estimation of urinary catecholamine excretion. Explanation and reassurance may be all that is required. If such headaches recur frequently they can usually be prevented by propranolol.¹³

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The citizen's charter and the NHS

True citizens do more than consume

Details of the government's next "big idea," the citizen's charter, were published earlier this week.¹ How might it affect the NHS, still reeling from a few of the government's earlier big ideas?

In his foreword to the charter the Prime Minister writes of making public services more answerable to their users and of raising their overall quality. He sees this as continuing a programme of reform begun in the 1980s in schools, housing, and hospitals, which "gave people more say in how their services are run." The white paper is only the beginning: over the next few months ministers will be providing more detailed plans for each service. Expect a "patient's charter" from the Secretary of State for Health later this year (p 208).

Quality, choice, standards, and value are the charter's main

themes, and national charters for England, Scotland, and Wales will set out how these will be provided. As well as national and local charters providing much more information for the public, comparative information on the performance of health services will be published, specific and timed appointments will be given for all outpatients, and maximum waiting times for treatment will be agreed. (And if they are exceeded district health authorities "will seek provision elsewhere including, if appropriate, from the independent sector.")

The extolling of choice, competition, and commitment to service suggests that the government equates citizens' rights with consumers' rights. To conflate the two, however, is to miss much of the point of citizenship. Active citizenship