Effects of legal termination on subsequent pregnancy

SIR,—We are sorry that our Bristol colleagues Drs Ruth E Coles and Beryl A Tully (3 July, p 45) seem to feel that their observations are not informative of their termination will not admit of termination during a future pregnancy casts some sort of slur on such excellent organisations as the Brook Advisory Centre in which they work.

If our statement was capable of such misconception then we do indeed apologise, but the fact remains that we have in our own experience recently encountered two women who attributed their lower abdominal scars to urological surgery in one case and an ovarian cystectomy in another and who, during the course of the pregnancy that we had charge of, ruptured the hysterotomy scar which they had denied. It is, of course, not possible to know how many women have had vaginal terminations who have withheld information from their obstetrician, but we do not think it unreasonable to assume that such concealment does occur if the far more dangerous procedure of abdominal hysterotomy is denied.

GEOFFREY DIXON
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Department of Obstetrics and Gynaecology, Royal Maternity Hospital, Bristol

Compensation for drug side effects

SIR,—I read with dismay that Imperial Chemical Industries are paying out sums expected to amount to over £1m in “compensation” to patients who suffered side effects of the drug practolol (Esalol). Were ICI negligent in the conduct of their clinical trials? Were they dishonest who attributed their recent cystectomy in one case and an ovarian cystectomy in another and who, during the course of the pregnancy that we had charge of, ruptured the hysterotomy scar which they had denied. It is, of course, not possible to know how many women have had vaginal terminations who have withheld information from their obstetrician, but we do not think it unreasonable to assume that such concealment does occur if the far more dangerous procedure of abdominal hysterotomy is denied.

JOHN A L GORRINGE
Usk, Gwent

Reducing outpatient attendances

SIR,—I would like to support the views expressed by Mr R M Kirk (19 June, p 1521). There is little doubt that patients are asked to attend outpatient clinics far too often and that many issues can be sorted out by post or telephone before the initial visit.

I have been attempting to cut down patients’ visits to my clinic at this hospital by using the methods outlined in Mr Kirk’s paper. I can confirm how well it works to the mutual benefit of the patient and the doctor. I believe that the reason that we can do this easily at St John’s is because we are a small specialist hospital. The results of all investigations come back to the doctor who saw the patient and he goes through these at the start of each clinic. Reports are rarely sent astray and they are never filed until they have been seen by the doctor. It is then very easy to ask for the case-notes to be retrieved and a letter can be dictated to the patient and the family doctor.

It is very often the case that patients need to be seen again for medical purposes, but it often happens that they are brought back purely to hear the results of tests. If action needs to be taken because of the test results a letter to the patient and his family doctor will often suffice or else a further appointment can be sent. If a patient has a skin eruption that I expect to be cured within a limited period of time I will often give him an appointment to come back but ask him to phone me a few days before he is completely clear; this saves him a visit and allows another patient to be fitted in.

There are many ways in which these ideas can be developed. I think the system can work smoothly in a small establishment like ours, where all the staff know each other. In a large hospital it would probably be much harder. Results of tests cannot be relied upon to reach the doctor’s tray, and the patient’s case-notes are more likely to be mislaid. In spite of these difficulties it ought to be attempted. I think we are not sufficiently sensitive to the very great difficulties that patients have in attending as outpatients, especially in a large city like London. Anything we can do to reduce their visits is important. There is also benefit for the doctor who can bring a reasonable patient to giving a better service to a smaller number of patients in a slightly more relaxed environment.

JOHN A L GORRINGE
Usk, Gwent

Carpal tunnel syndrome and tennis elbow

SIR,—The symptoms of “spontaneous” median nerve compression in the carpal tunnel are frequently aggravated by occupations involving repetitive hand movements, such as knitting and packing. Some authors have concluded that occupation is indeed a causal factor, and Gunn, in a letter to the BMJ, reported that the carpal tunnel syndrome is frequently encountered by the Worker’s Compensation Board of British Columbia. Tennis elbow (lateral humeral epicondylitis) may also be considered to be an over-use phenomenon, being aggravated by activity and relieved by rest (and local corticosteroid injections).

Dr C F Murray-Leslie and Professor V Wright (12 June, p 1439) showed that 33% of 43 patients with proved carpal tunnel syndrome had also suffered from tennis elbow, whereas only 7% of controls matched for sex and age had this problem. We have analysed 138 cases of carpal tunnel syndrome confirmed by nerve conduction studies. Nineteen of the patients underwent surgery and 48 recovered after hydrocortisone injection alone. The prevalence of symptomatic tennis elbow was 8.9% and 16.7% respectively. The lower overall prevalence in our patients could be because signs of tennis elbow were sought only after a spontaneous complaint by the patient.

Could the greater prevalence of tennis elbow found by Dr Murray-Leslie and...