epidemiological data the screening of unidentified undefined volunteers as part of a suitably designed inquiry.

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Case notes chaos

Sir—Dr Stephen M W Hutchinson (23 March, p 813) has done a doctors a reminder to allow the importance of patient records as essential tools of medical care.

In 1983, on consultant initiative, our district adopted a new medical record system to slow the increasingly worsening situation of multiple notes containing ephemeral and duplicated material.

The policy is based on the concepts of a unitary record, sequentiality, common user inserts, and a weeding and documentation policy. Thus it specified that a single record (bringing together all records other than those from the psychiatric and surgically transmitted disease departments) should accompany a patient as he or she moved around the hospitals and clinics of the district. All handwritten notes, laboratory reports, and correspondence should be filed separately in strict chronological order; documentation should be simplified on a specialty basis subject to central specifications; and index notes and ephemera should be identified and destroyed, subject to medicolegal constraints.

After four years most active notes now comprise “self-filing,” four compartment folders. All specialties (other than surgical) have agreed to adopt this method. Sequential recording has found general acceptance, and, after foot dragging by the lawyers, a weeding and destruction procedure has been started. We run seminars on the use and handling of medical records, issue a handbook, and print instructions on the patient folder itself. We have cut costs by unifying folders and reforming stationery, in the latter case by £10 000.

We have not achieved complete success. There is a trend, for example, for each consultant to hijack the first position in the record. District availability of the unique record is difficult to ensure because of transport problems. None the less, our records compare with the standards in Germany and some parts of the United States.

Dr Hutchinson’s efforts in Edinburgh will be of no avail until he has convinced most of his colleagues of the need for a record centred on the patient rather than the consultant and the need to invest in administration and user education in respect of patient records. It is to be regretted that 22 years after the Tunbridge report most health districts have yet to get round to this position and that their medical records departments still have the worst staffing and accommodation.

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Bronchial asthma

Sir,—As general practitioners, we may have ourselves to blame if an article on bronchial asthma (Dr J Valman, 21 March, p 753) we are mentioned only twice. The first is a negative reference about what to do if a general practitioner is not immediately available to provide nebuliser treatment in an acute attack, and the second is simple because we could review a child discharged from hospital completely well after such an attack.

The standardisation of general practitioners’ management of asthma and the universal availability of nebulisers to primary health care teams would improve our standing in managing this common chronic condition, which, in all but a few cases, is ideally suited to management by the primary health care team.

Dr Valman’s article does not seem to encompass the primary care approach. Firstly, a chest radiograph would not form part of the initial assessment unless presentation was atypical—or should 8% of under 5 year olds be having chest radiographs? Dr Valman says that failure to respond to chronic glucocorticosteroids or theophylline is an indication for treatment with inhaled steroids. I would not routinely use theophylline in general practice, firstly, because this would mean subjecting the young child to invasive tests and, secondly, because of the beta stimulation drugs, administered by spacer devices or nebulisers in the younger child, are effective and worthy of consideration before inhaled steroids are prescribed.

In acute asthma, the early use of nebulisation of a beta stimulant bronchodilator followed if necessary by a short course of prednisolone and further observation at home, with repeat nebulisation if effective, can and does prevent many hospital admissions.

If I sound paranoid about the lack of recognition of the general practitioner’s role then I despair at the lack of recognition of the role of parents, who often manage their children’s asthma better than the professionals prescribed beta stimulant auto-mony by the general practitioner or consultant. Discussion, education, cooperation, and confidence in a management protocol are the foundation of good care.

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Abdominal aortic aneurysms

SIR,—We agree with Dr N F Gowland Hopkins (28 March, p 790) that the number of hospital admissions for abdominal aortic aneurysm repair is increasing. In the first three months of this year we repaired 21 such aneurysms, without deaths, compared with only eight in the corresponding period in 1986.

Improved perioperative monitoring and operating techniques have reduced the mortality from elective aneurysm in the past 15 months to one out of 65 (1.5%). We are, therefore, in favour of early detection and surgery but suggest that a screening programme need not be random and could therefore be less costly. A logical screening programme could be based on the observed familial aggregation of aortic aneurysm. The yields from screening could be increased twofold to tenfold by focusing on the relatives of patients with abdominal aortic aneurysm, and the specificity could be improved by first screening those relatives with a smoking history of younger patients and female patients. The merits of such a screening programme are already being assessed in the United States.

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Infection by airborne Chlamydia trachomatis in a dentist cured with rifampicin after failures with tetracycline and doxycycline

SIR,—The report by Dr M Midulla and colleagues (21 March, p 742) on airborne infection by Chlamydia trachomatis in a dentist cured with rifampicin after tetracycline treatments had failed is of interest to all those concerned with chlamydial infections. It is a reminder that the resistance strain of C psitaci has been described, but hitherto no tetracycline resistant strains of C trachomatis have emerged. In the past, reports of C trachomatis being isolated after what should have been effective treatment have been based on false recognition of chlamydial inclusions in cell cultures. Thus inclusions seen after treatment were as spurious as those seen before treatment.

With regard to the paper by Dr Midulla and colleagues, only two conclusions may be drawn. Either the diagnoses of chlamydial infections were false, the authors having made the same mistake as others, or the authors have truly recovered teta-