Training surgeons to meet the surgical needs of Africa

SIR,—In the light of the article by Messrs D A K Watters and A C Bayley (26 September, p 761) I am concerned at the increasing irrelevance of some modern ophthalmic techniques for doctors training in Britain who intend to return to Africa and other countries. Now, even the ancient art of cataract extraction has become high tech.

In 1949 at St Thomas's Harold Ridley was the first to replace the cataractous human lens with an artificial one. He used an extracapsular technique and a posterior chamber acrylic lens implant, but over the next 30 years it was the intracapsular technique that was gradually perfected, combined latterly when desired with an anterior chamber implant. This could be performed with a relatively simple microscope, or even a good pair of operating spectacles, and was suitable for use world wide. Like any operation it had to be properly performed; it produced excellent visual results and a low rate of operative and long term complications.

Over the past 10 years the extracapsular technique has been revived and now popularised here and in the United States because it may have an even lower rate of complications; it is combined with a posterior chamber implant. However, it requires expensive equipment and optimal operating conditions—both major drawbacks in developing countries, particularly in rural areas, where most of the blindness due to cataracts is to be found. Yet it is this expensive extracapsular technique which most overseas doctors training in Britain are now having to learn, to the virtual exclusion of the intracapsular method. Indeed, the intracapsular method is even frowned on in some quarters, despite its good record and despite the fact that in the foreseeable future it is the only method by which millions of the world's blind can have their sight restored. For this reason the training of overseas doctors here must include the mastering of intracapsular cataract surgery.

A few years ago Professor Barrie Jones had the vision to establish a department of preventive ophthalmology, which is closely linked with Moorfields and the Institute of Ophthalmology, which teaches the scientific and medical principle of tropical ophthalmology. Our contribution in the National Health Service, which is largely staffed at junior levels by overseas doctors, must be to include practical surgical techniques for use at home—in particular intracapsular cataract surgery—to dilute the diet of lasers, vitrectomies, scans, extracapsular surgery, etc, many of which will not be available in their own countries in their lifetimes.

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Lay treatment of children's symptoms

SIR,—Drs Sarah Cunningham-Burley and Sandy Irvine (19 September, p 700) stated that parents taking their children to a general practitioner tended to have attempted treatment at home and were more concerned to receive advice and reassurance than a prescription. However, the authors did not quantify their statements.

In a study conducted as part of a recent elective period in general practice I questioned 126 patients presenting during two consecutive weeks in a semirural practice in south Wales. Patients were presenting for the first time with a new complaint and were asked, among other things, about attempted treatment at home and their expectations from the consultation. The results confirm those already reported.

While 46% of adults had attempted treatment of their symptoms, home treatment of children's symptoms had been attempted in 35% of cases. Fifty three per cent of adults expected to be given a prescription, but only 35% of parents expected a prescription for their child. Parents were more likely to expect advice and explanation of their children's symptoms, 88% of parents expecting advice compared with 67% of adults consulting on their own behalf.

General practitioners estimate that patients expect a prescription in about 80% of consultations, whereas patients report expecting a prescription on 43% to 52% of occasions.[1] The results of this survey indicate that adults consulting on their own behalf and parents consulting about their children behave in different ways with regard to home treatment and expectation of receiving a prescription. General practitioners should not underestimate parents' need for explanations, advice, and reassurance.

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1 Stimson GV. Doctor-patient interaction and some problems for prescribing. *J R Coll Gen Pract* 1976;26(suppl 1):88.

Not the first multiresistant pneumococcus in Britain

SIR,—Drs J H Paton and D S Reeves described the isolation of a multiresistant pneumococcus from a patient in the United Kingdom (3 October, p 810). Such strains were in fact recorded in the United Kingdom in 1985 (Public Health Laboratory Service, Communicable Disease Surveillance Centre, unpublished) and we published an account of a single outbreak affecting six patients in Newcastle in July 1987.[1] Unlike the authors' patient, our patients had no apparent contact with any known endemic area, and implied case to case transmission occurred.

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1 Gould FK, Magee JG, Ingham HR. A hospital outbreak of antibiotic resistant Streptococcus pneumonia. *J Infect* 1987; 15: 77-9.

SIR,—The isolation of a pneumococcus resistant to several antibiotics is a cause for concern, particularly as this is not an isolated occurrence. Clinical isolates of *Streptococcus pneumoniae* resistant to three or more antibiotics are becoming increasingly common in the United Kingdom.

Over the past few years there has been a sharp increase in the number of such isolates referred for typing to the division of hospital infection of the Central Public Health Laboratory. The table shows antibiotic resistance data on strains received over the past four years including the number of isolates resistant to one or more antibiotics commonly used to treat pneumococcal infection (penicillin, tetracycline, chloramphenicol, and erythromycin). The number of isolates resistant to three or more of these antibiotics has shown a rapid rise, particularly over the past two years. These multiresistant isolates all belong to serotypes 6, 19, or 23; type 23 resistant to penicillin, tetracycline, and chloramphenicol is the most common. Most of these multiresistant pneumococci were also resistant to trimethoprim and sulphamethoxazole (minimum inhibitory concentrations >2 mg/l and >32 mg/l respectively). All, however, were fully susceptible to vancomycin and rifampicin.

Pneumococci resistant to one or more of penicillin, tetracycline, chloramphenicol, and erythromycin. Strains received at the division of hospital infection 1984-7*

Year	No of isolates received	No (%) showing any resistance	No of strains resistant to the following number of antibiotics: 1	2	3	4
1984	681	35 (5·1)	25	8	2	0
1985	678	48 (7·1)	25	13	10	0
1986	808	79 (9·8)	33	12	32	2
1987†	638	86 (12·3)	29	17	37	3

*Resistance defined as follows (minimum inhibitory concentration; tests performed on Diagnostic Sensitivity Test Agar (Oxoid) with 5% lysed blood.): Penicillin > 0·25 mg/l, tetracycline 1 mg/l, chloramphenicol 4 mg/l, erythromycin 0·5 mg/l.
†Up to 7 October 1987.

The case reported by Drs Paton and Reeves was an eye infection in a neonate; in contrast, most multiresistant pneumococci examined here have been sputum isolates from elderly men in hospital. The problem of multiresistant pneumococci is not confined to a particular geographical area. Over the past four years such strains have been received from laboratories in 14 of the 15 health regions in England and Wales and from Scotland and Ireland.

Antibiotic treatment of pneumococcal infections both in the community and in hospitals may be seriously compromised if this trend towards multiple resistance continues. Consequently, routine susceptibility testing of pneumococci (particularly from serious infections) is of increased importance. Infections not responding to standard treatment regimens should be reviewed with this problem in mind.

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Greeks bearing gifts

SIR,—The leading article by Dr Mike Pringle (26 September, p 738) is both negative and misleading and I should like to clarify the subject for the benefit of those considering computerisation.

Several of the facts quoted were based on the report of the "Micros for GPs" scheme and are therefore several years out of date. General practice software has advanced considerably in the past two to three years, bringing ease and speed to repeat prescribing and morbidity recording, and improved facilities for preventive medicine. The Value Added Medical Products Limited (VAMP) "No Cost Option" scheme was developed as a result of a two year pilot study under Professor Stuart Walker of the Centre for Medicines Research. This study demonstrated that reliable data could be collected in general practice without burdening the practitioner. There are now over 100 new VAMP practices taking part in this scheme, where thorough training has been given and a good working relationship built up. All these practices knew exactly what was wanted from the beginning and have not experienced major difficulties. The issues of confidentiality and contracts have been addressed by the General Medical Services Committee in its guidelines, and the advisory body mentioned in the article has been formed specifically to monitor the schemes on behalf of the medical profession.

Br Med J (Clin Res Ed): first published as 10.1136/bmj.295.6607.1208 on 7 November 1987. Downloaded from http://www.bmj.com/ on 28 September 2023 by guest. Protected by copyright.