

based screening study rather than a geographically based study such as the Coventry diabetes study.² About 10% of our sample was not registered with a local general practitioner because the subjects either had remained registered with practitioners outside Coventry or had no general practitioner. This was not surprising for an area in which 20% of the adult population leave and enter every year.

The prevalences reported by us include extrapolations to take into account the incomplete responses to screening and to the glucose tolerance test. They suggested that 42% of white diabetics and 40% of Asian diabetics were undiagnosed in the community. The random sample included those aged over 80, and the two falsely negative subjects mentioned by Dr Yudkin were white women aged over 70 with fasting blood glucose concentrations of <5.0 mmol/l but concentrations after two hours >11.1 mmol/l. Glucose tolerance declines with age,³ and as false negative results were found only in elderly white women we did not wish to include an estimate of the number of false negative results in the other groups until the survey was complete.

We hope that the final results of the study will clarify these points further.

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Methylprednisolone and Graves' ophthalmopathy

SIR,—Professor Pat Kendall-Taylor and others reported the beneficial effect of methylprednisolone on Graves' ophthalmopathy.¹ We have treated 37 patients with acute severe Graves' ophthalmopathy with methylprednisolone infusions over the past eight years. Initially we infused 1 g of the drug intravenously daily (25 patients) for three consecutive days. More recently we infused only 0.5 g (12 patients) for three consecutive days. After the infusion period of three days the patients were treated with oral prednisolone, the dose being reduced to 10 mg daily over eight days and then maintained at that dose for two to three weeks, as required. Azathioprine was added as a long term measure to prevent immunological rebound in 19 patients.

Thirty two patients responded with a reduction in their exophthalmos. In six patients data from computed tomography were available before and after methylprednisolone infusion. Reduction in the bulk of extraocular muscles was significant in all patients.

There was no significant or consistent increase in the body weight of any of these patients at one or six months. One patient developed diabetes mellitus, which required insulin treatment for four weeks; it then resolved after the dose of steroids was reduced. There were, however, consistent subclinical side effects, which consisted of an increase in serum activity of exocrine pancreatic enzymes—trypsin, amylase, and lipase—after methylprednisolone.² This is suggestive of pancreatitis. There was also a fall in serum osteocalcin concentrations. Osteocalcin is a marker of osteoblast activity (unpublished observations). Clearly, therefore, this treatment affects the exocrine

pancreatic function and the activity of osteoblasts in the bone. Fortunately, the duration of treatment is not sufficient to induce a florid clinical side effect. Further studies are necessary to determine whether a smaller dose of methylprednisolone would be as effective as the doses used in our study and that of Kendall-Taylor *et al.*

Because of the lack of clinical side effects and the safety of this form of treatment it is now our treatment of choice in patients with acute or severe Graves' ophthalmopathy, or both, in preference to plasma exchange. The beneficial effects of plasma exchange in this condition have previously been described by us^{3,4} and others.⁵

We have not found it necessary to use ranitidine routinely in our patients.

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Disaster management

SIR,—How disheartening it was to read Dr D G Nancekievill's news item on disaster management advocating that the mobile team should consist of anaesthetists and gynaecologists.¹ He is obviously unaware of the massive developments that have occurred in accident and emergency medicine in the past few years and that most major district hospitals now have major accident plans detailing who should be members of a mobile team. Indeed, many accident and emergency departments have flying squads that already are practised in disaster management.

Members of a mobile team should be expert in the art of resuscitation and, I agree, should contain an anaesthetist. Other members should include nurses and doctors who are used to and skilled in resuscitation and extracting casualties from wreckage.

The fact that Dr Nancekievill advocates the use of gynaecologists makes me wonder just how many women are likely to be suffering a miscarriage at the scene of most major disasters. Indeed, I wonder how many gynaecologists finding themselves in a mobile team would (a) want to be there and (b) be skilled in acute resuscitation.

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SIR,—I cannot agree with Dr D G Nancekievill's opinion on the ideal constitution of a mobile team.¹ With all due respect to gynaecologists, they can hardly be considered to be practised in resuscitation, let alone at the scene of an accident.

Though anaesthetists will doubtlessly be exceedingly valuable for the few patients who require

urgent endotracheal intubation (those with severe head injury and facial injuries), they are not practised in the skills of triage, splinting of fractures, and the early recognition and management of potential spinal injury. They are also not practised in assessing blunt pelvic and abdominal trauma.

The hospital department most experienced in dealing with the types of problems encountered at major disasters is the accident and emergency department, especially those that have "flying squads." This viewpoint is confirmed by my experience at the M1 aircraft accident, to which the Leicester flying squad (consisting of one consultant, one senior registrar, one registrar, and one senior house officer from the accident and emergency department and other non-medical staff) was dispatched.

Not only is assessing multiple trauma our "bread and butter" but when a hospital flying squad already exists it is not unusual for senior ambulance, fire, and police personnel to be acquainted with at least one of the doctors. This is an important ingredient—it makes for confident and good communication. The accident and emergency department in Leicester was fully aware of the clinical condition of each referral and of the treatment each patient had received before he or she arrived in the department.

Hospitals that are designated major accident centres should ensure that their accident and emergency departments are adequately staffed and equipped to deal with disasters.

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Autosomal recessive disorders

SIR,—Dr Helen Kingston claimed that a child born to a parent with an autosomal recessive disorder was unlikely to be affected himself except in a consanguineous marriage.¹ This degree of "likelihood" depends also on the carrier frequency in the population from which the partner is drawn. In London among the black (African and Afro-Caribbean) population the frequency of sickle cell trait (heterozygous HbS) is very high (1 in 7.9² or 1 in 6.5 (unpublished WHO report, International Society of Haematology, Warsaw, 1985)). The chance of a parent with sickle cell anaemia (homozygous HbS) conceiving a child with sickle cell anaemia with a partner from the black community is about 1 in 13 to 1 in 16. This will not be regarded by many as an "unlikely" occurrence.

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Academic medicine: problems and solutions

SIR,—The report of the Academic Medicine Group¹ is both timely and welcome. It highlights, quite properly, the shameful and damaging reductions in the number of academic posts funded wholly by universities and sets out practical recommendations to remedy the problems identified. Although supporting the broad views expressed by the group, I am, however, puzzled and disappointed

to read that general practice is referred to merely as a "largely untapped teaching resource." Clearly, general practice has an important contribution to make in this vital area,² but it can, and is, also contributing to the two other components of the academic task: research and scholarship. There are now 32 departments of general practice in the United Kingdom, and many of their members are active in clinical research.³ Our discipline shares the problems of recruitment, career structure, and research funding experienced by our hospital based colleagues but is further constrained by very different contractual arrangements concerning clinical care. It seems unfortunate and paradoxical that while recognising that "academic medicine was not represented through any single forum" and that "such splintering diminished the impact of the academic voice" this recently formed group has not included a single general practice academic among its 31 members. Implementation of the group's recommendations might be more successful and future deliberations might be even more fruitful if this anomaly was rectified.

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- 1 Academic Medicine Group. Academic medicine: problems and solutions. *Br Med J* 1989;298:573-9. (4 March.)
- 2 Fraser RC, Preston-Whyte E. *The contribution of academic general practice to undergraduate medical education*. London: Royal College of General Practitioners, 1988. (Occasional Paper 42.)
- 3 Whitfield M. *Research intelligence*. Edition 18. Bristol: Royal College of General Practitioners, 1988.

Health visitors and postnatal depression

STR,—We would like to congratulate Dr J Holden and her colleagues on their intervention study on postnatal depression.¹ Postnatal depression has been concerning us in its possible relation to child care and indeed even as a contributory factor in some types of cot death.

During the past three years we have been using a questionnaire that is essentially a combination of the Edinburgh postnatal depression scale and the Leeds scale. These assessments are made at the health visitor's home visit one month after every birth in Sheffield. What has impressed us has been the extent to which physical factors, such as a mother having to care for many preschool children or caring for twins, seems to increase mothers' stress levels and make it difficult for them to attend clinics.

We were a little surprised that a series of eight half hour "non-directive" talks with health visitors had so much effect in isolation. We would like to know how representative the group under study was and if physically stressed mothers had accidentally been underrepresented. From what birth population were the 734 mothers who attended the clinics drawn? How many mothers with three children aged under 5 or with new twins were included? How many of the 734 mothers scored high at six weeks, and from what number of high scorers did the psychiatrist take the 60 selected for randomised care? What was the total family caseload of health visitors in the study? What was their normal pattern of home visiting, and were they all dealing with their own patients?

We are mainly concerned with children's problems occurring at around the age of 12 weeks. Why did the Scottish group wait until 12 weeks before assessing the mother and carrying out their intervention during the next three months? What about prevention? Would earlier care by health visitors have prevented this stress?

The paper also includes some possibly important comments—notably, "Some women described their health visitor as a friend, or said she was like a big sister, and three said that their health

visitor had been like a mother to them." Were the authors describing examples of the modern isolated nuclear family, and would a sensitive granny, aunt, or friend have done as much or more for many of these women as the health visitors apparently did? This could be important, as our health visitors are already overburdened with other duties and need to make a selection in their use of time.

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- 1 Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *Br Med J* 1989;298:223-6. (28 January.)

AUTHORS' REPLY,—We too have noted a possible association between postnatal depression and certain aspects of child care, including some instances of non-accidental injury. Stress factors, including the number of other children the mother is coping with, may indeed make women more vulnerable to depression, and the 50 depressed mothers who completed our trial tended to have more children than the Scottish norm. According to the annual report of the Registrar General of Scotland, in 1987 22% of recently delivered Scottish women had two or more children already, whereas 40% of our 50 mothers fell into this category.¹

Ours was not a prevalence study; we were looking for depressed women to include in a treatment trial. Our clinic based sample of 734 mothers represented 74% of the 986 births in the health visitors' caseloads during the study, and it is certainly possible that a high percentage of women who did not attend the clinic may have needed extra support. We did not think, however, that mothers who were physically stressed by having three or more preschool children to care for were underrepresented in our study. Although there were no twins, 12% of our sample had three children aged under 5, and 12% had four or more children altogether. Only 36% of the women had only one child to care for, compared with 41% for Scotland as a whole.

The Sheffield doctors ask about selection for the study. A total of 117 women who scored high at six weeks were assessed by the psychiatrist at about 12 weeks, and 60 were found to be still depressed. Regarding the timing of our intervention, our clinical experience suggests that early mood fluctuations often settle without treatment, and that the more continuous depressive disorders are optimally identified at about three months. Nevertheless, we would be interested to know the results of the Sheffield screening at one month after the birth.

The total caseloads of the health visitors averaged 2900 patients with 150-300 children under 5, and they were all dealing with their own patients. Health visitors are certainly overburdened with other tasks, but the successful functioning of the family is so dependent on the emotional wellbeing of the mother that intervention in postnatal depression could be regarded as central to the health visitor's role. We do not find it surprising that mothers with physical stressors should benefit from being given the opportunity to talk about their problems, nor do we believe that support afforded by grannies, aunts, or friends has a comparable therapeutic value in depression to that which can be provided by a professional with counselling skills who is not part of the family. The depressed women in our study were in any case noticeably lacking in social support, and most had no one in whom they could confide.

We are indeed interested in prevention, and a current trial of training for health visitors in Edinburgh, Lewisham, and Keele (funded by

the National Unit for Psychiatric Research and Development) includes aspects of both primary and secondary prevention of postnatal depression.

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- 1 Registrar General for Scotland. *Annual report 1987*. Edinburgh: HMSO, 1988.

Day case hysterectomies

STR,—Mr J P Nicholl and his colleagues state that cholecystectomies, hysterectomies, and total hip replacements are now being carried out as day case procedures in England and Wales.¹ Only for coronary artery bypass grafts, it seems, is inpatient treatment still essential. As gynaecologists we cannot speak for our general surgical or orthopaedic colleagues but we suspect that Mr Nicholl and others' "day case hysterectomies" represent an error in his statistics rather than a revolution in surgical technique.

As clinicians we are used to receiving printouts that purport to audit our work; all too often these contain figures that have passed from computer to photocopier without the intervention of the human brain. We are disappointed to find equally incredible figures in the *BMJ* in a paper written by statisticians from a "medical care research unit." We note that Mr Nicholl and others' figures have already been "largely confirmed" by the Independent Hospitals Association,² and we await with trepidation a letter from our manager (or his computer wielding representative) asking us why we still keep our patients in hospital for more than 12 hours after hysterectomy.

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- 1 Nicholl JP, Beeby NR, Williams BT. Role of the private sector in elective surgery in England and Wales, 1986. *Br Med J* 1989;298:243-7. (28 January.)
- 2 Byrne AJ. The role of the private sector in elective surgery. *Br Med J* 1989;298:455.

AUTHORS' REPLY,—Contrary to what Messrs Drife and Macafee imply, our paper reported national Hospital In-Patient Enquiry (HIPE) data, collected from NHS hospitals and collated by the Office of Population Censuses and Surveys, describing a number of day case cholecystectomies (two out of 25 758), hysterectomies (43 out of 48 113), and total hip replacements (56 out of 21 200). The medical care research unit has nothing to do with the collection or quality of HIPE data and we are all aware that they contain errors. We merely reported what the HIPE data set contains rather than fabricating our own view of what it should say.

The data we personally collected, on the other hand, are about independent hospital activity and contain no reference to any major operations being carried out as day case procedures in independent hospitals. As there were no errors of this nature in our data it is not surprising that the Independent Hospital Association's data were largely in agreement with our estimates.

We must make one small concession to Messrs Drife and Macafee, however, and also apologise to the Office of Population Censuses and Surveys. The 1985 HIPE data set in fact contains no records of day case cholecystectomies, the two reported in our paper being the result of a typing error, though