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Gonad protection in young orthopaedic patients

EDITOR,—We agree with Nicholas Kenny and John Hill that gonad shields tend to be omitted or inadequately positioned in many radiographic examinations.¹ We can see a potential pitfall, however, in the authors' suggestion that gonad shielding should be used during radiographic assessment of congenital dislocation of the hip (developmental dysplasia of the hip).

In the initial assessment of children with developmental dysplasia it is important to exclude congenital lumbosacral abnormalities. There is also value in checking for correct alignment of the symphysis pubis. Our practice, therefore, is to perform the initial examination without a gonad shield, reserving this for subsequent studies. Dosimetry studies with a phantom have shown that we can reduce the radiation dose to the whole region by performing the examination with a fluoroscopic unit equipped with a 100 mm camera. The quality of these images is adequate for measuring the acetabular shape and assessing bony morphology. With a fluoroscopy time of five seconds and a single exposure, the radiation dose to the skin is roughly one sixth of that delivered during a standard radiographic examination. Using fluoroscopy increases the chance of correct alignment on first exposure and reduces the number of repeat films necessary.

In young patients the cumulative effects of ionising radiation are a concern, and we see no reason why magnetic resonance imaging should not be used for all examinations for slipped capital femoral epiphysis.

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Epidemiological aspects of travel related illness

EDITOR,—We agree with John D H Porter and colleagues about the need for appropriate surveillance systems, improving communication between health professionals, quantifying risks, facilitating targeted education, and a nationally coordinated computer database to combat the increasing problem of travel related illness.¹

Since 1978 a surveillance programme involving 13 816 travellers returning from abroad has been carried out at the Communicable Diseases (Scotland) Unit both to establish the pattern of travel related illnesses and in response to specific episodes of reported illness.² Comparative analysis of the data has enabled a risk profile to be defined³; this profile correlates with similar studies conducted in Switzerland⁴ and Finland.⁵ To broaden the epidemiological picture further, analyses have been made of hospital admission data,² the collated laboratory reports for infections imported into Scotland,^{6,7} deaths of Scots abroad,⁸ travellers attending a local clinic for immunisation against yellow fever,⁹ and travellers' immunity to infections that are preventable by immunisation.²

The availability of computer technology in primary care has considerable potential for travel medicine. For example, in Scotland one system is common to over 700 practices, covering 60% of the population.¹⁰ The possibility exists of conducting a data search for patients attending for health advice before travelling and, some months later, comparing this with an analogous search for those patients treated for a travel related illness.

There is logic in this approach in view of the general practitioner's role in giving advice both before travel and after return.¹¹ In recognition of the difficulties that the general practitioner may have in giving advice a computerised database (Travax) was established in 1982.¹¹ This nationally accessible database is freely available to NHS users with suitable hardware; it contains recommendations on immunisations for individual countries, advice on preventing malaria, and details about particular vaccines with information to help make a balanced judgment when indications are not clear cut. A recent development is the installation of a telephone networking system throughout the United Kingdom, enabling easier access by local telephone call from a suitable modem linked to a screen display. Much remains to be done, but progress has been made.

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Day hospitals for elderly people

EDITOR,—The results of the Bradford community stroke trial at six months¹ and of the Canadian² and New Zealand³ trials of day hospitals give little support to the use of day hospitals in rehabilitation, yet in recent decades geriatricians have tended to rate rehabilitation as the main purpose of day hospitals.⁴ This expensive service will be under intense scrutiny by those planning services for elderly people.

Rehabilitation is only one of the functions of day hospitals. In the early days of geriatric day hospitals their primary objective was stated to be the physical and social maintenance of frail and vulnerable people.⁵ In the 1990s this means keeping patients in their own homes and out of nursing homes. This previously unfashionable aspect of care in geriatric day hospitals has been less well studied but may become fashionable again in the wake of attempts to implement changes in the provision of social services.

In the studies from New Zealand and Bradford the patients were relatively young (average age

about 70) and the rates of admission to nursing and residential homes were not quoted. In the Canadian study the patients were considerably older (average 79), and a small, non-significant trend towards lower rates of admission to nursing and residential homes was seen in the day hospital group. Preliminary results from an elderly group (average age 79) in a randomised study in Nottingham, however, indicated that death rates and rates of admission to nursing and residential homes were lower in patients attending day hospitals than in those receiving domiciliary rehabilitation.⁶

The Bradford community stroke trial has shown that rehabilitation is better delivered at home than in a day hospital: this is a step forward for the care of patients with stroke. Some of these patients, however, need maintenance rather than rehabilitation, and day hospitals may best fulfil that role.

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Implementing patient's charter in outpatient services

EDITOR,—Charles Collins's editorial about implementing the patient's charter in outpatient services is mainly about outpatient appointments for those needing surgery.¹ For those visiting a rheumatology department who will never need surgery the position is entirely different. They need more than is apparently envisaged in the casual direction to explain any treatment, which is slipped in among all the other items suggested to be essential in 20 minute consultation. They need considerable help and counselling about how to manage their arthritis, and it is commonly accepted that those who receive adequate information are likely to make better progress than those who do not. Of course the consultant will not have time to do this, but there should be someone in the team who has.

Arthritis Care believes that the provision of a rheumatology practice nurse in every rheumatology department is essential and would welcome the BMA's support for this in any discussions about the patient's charter.

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EDITOR,—In his editorial on implementing the patient's charter in outpatient services Charles Collins advocates the judicious use of telephone contact with patients.¹ Experience in genitourinary medicine indicates that this can be valuable, but it has staffing costs. Standard practice in most genitourinary medicine clinics has been to allow patients to telephone to learn the results of their investigations with the aim of avoiding unnecessary visits, and of course the results and advice may have to be amplified.

The use made of this facility was monitored in a