Two previous reports had suggested an increased incidence in winter of fatal pulmonary embolism after total hip arthroplasty² or among subjects who died suddenly,³ but the conclusions were derived from small numbers of events. Moreover, other confounding factors might theoretically be responsible for an increased incidence of fatal pulmonary embolism in winter. Although the embolic source, leg thrombosis, is no more frequent, winter related comorbidities might contribute to a reduced tolerance to small emboli.

Our survey has limitations. Firstly, it is retrospective, but the data used were all registered prospectively and their quality was ascertained in a randomly selected sample. Secondly, the diagnosis was not made by means of venography in most cases, but objective, non-invasive diagnostic means with recognised diagnostic performances were used. Moreover, if we extrapolate our 318 yearly events to the 380 000 inhabitants of Geneva, the yearly incidence of confirmed thromboses was eight per 10 000, similar to the

five per 10 000 found in population based studies. Lastly, we found no seasonal variations in the number of suspected cases of deep vein thrombosis, a condition which is not dependent on a diagnostic procedure.

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Concerns about AIDS in general practice

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General practitioners are regarded as well placed to help prevent the transmission of HIV infection.¹⁻³ In 1988 a study was started in the Netherlands to get more information on concerns about AIDS among the non-infected population and on the general practitioner's role in providing advice and health education about AIDS. In this paper we present the results after five years (April 1988-April 1993).

Subjects, methods, and results

Since April 1988 general practitioners participating in the Dutch sentinel practice network recorded all face to face consultations with non-infected patients in which the subject of AIDS was brought up, either by the patient or by the general practitioner. When the subject of AIDS was a substantial part of the consultation, the general practitioners filled in a questionnaire giving information on the contents of this HIV related consultation and on the patient. If an arrangement for HIV testing was made the result of the test was recorded on a separate form.

The Dutch sentinel practice network (45 general practices, 62 practitioners) is a national network that can be regarded as representative of Dutch general practice. It covers about 1% of the Dutch population.^{4,5} The participating general practitioners collect data on different topics every year. In the process of data

collection several checks are built in to ensure a representative and valid database.

A total of 1082 HIV related consultations were recorded, of which 890 (82%) were first HIV related consultations. To make allowances for differences in the size of the practice populations, the number of HIV related consultations was calculated per 10 000 patients. For trend analysis the numbers of HIV related consultations (per 10 000 patients) were aggregated per three month period according to degree of urbanisation and geographical area. Changes in the size of the total patient population over time and the effect of seasonal variation were accounted for. A stepwise linear regression analysis was applied. For associations a χ^2 test was used. All statistics were tested with α of 0.05.

In the five years of the study an average of 17 HIV related consultations per 10 000 patients a year (range 0 to 57 per 10 000) were recorded in Dutch general practice. A time trend analysis (fig 1) showed a significant increase in the number of HIV related consultations over time: from 14.4 (95% confidence interval 14.1 to 14.7) to 24.6 (24.3 to 24.9) per 10 000. The decrease in the number of these consultations in rural areas (from 5.7 (95% confidence interval 5.3 to 6.1) to 3.0 (2.6 to 3.3) per 10 000) was in contrast with this growing trend. A time trend analysis of only first HIV related consultations showed similar trends as the analysis of all HIV related consultations.

The possibility of HIV testing (67%: 723/1082) was by far the most important topic of conversation. Time trend analysis showed that HIV testing became even more important over the five years (rising from 57% to 75%). For 85% (626/723) of the tests requested an arrangement for testing was made, the "need for reassurance" being the commonest reason (76%: 478/626). In 1% (5/573) of the tests actually performed the result was HIV positive.

Only in 6% (21/335) of the consultations in which concerns about physical complaints in relation to HIV (32%: 335/1082) were discussed did the general practitioner share his or her patient's anxiety. Men and women differed strikingly in their concerns about the possible hazards of sexual contacts. Women (32%: 166/527) more often than men (18%: 99/555) were worried about regular sexual contacts ($\chi^2=27.28$, $df=1$, $P<0.001$). General practitioners took the initiative to talk about HIV infection in only 4% of the contacts recorded. The initiative was taken more frequently in combination with the general practitioner observing potentially HIV related physical complaints: 29% (14/48) versus 3% (29/1034) ($\chi^2=48.17$, $df=1$, $P<0.001$).

Fig 1—Number of HIV related consultations per 10 000 patients by degree of urbanisation (quarterly data points and trend lines)

Comment

The data show that the number of HIV related consultations in Dutch general practice is rather low. However, the increase observed in the number of these consultations during the study period and the differences in the numbers of consultations recorded between practices are remarkable. General practitioners can play an important role in reassuring their concerned patients providing that they can translate the general information about AIDS/HIV to the needs of the individual patients.

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Methods for managing the increased workload in anticoagulant clinics

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Following evidence of clinical benefit in non-rheumatic atrial fibrillation,¹ increasing numbers of patients with cardiac conditions are being referred to outpatient anticoagulant clinics, necessitating review of existing services.² In one anticoagulant clinic in a north London hospital the number of new patients referred increased by 27% and clinic attendances by 77% between 1991 and 1993. Methods for managing this increase have been reported,^{2,3} but we have developed a system which can operate within existing resources by selecting patients requiring consultation with a clinic doctor.

Patients, methods, and results

A weekly anticoagulant clinic was administered by a phlebotomist with the help of two health care assistants, and all patients were seen by the clinic doctors (a consultant haematologist and a registrar) for dosing and counselling. In 1991 a baseline audit of 152 notes and details of anticoagulant control over six months was conducted. As only half of clinic attenders spend more than half the time within therapeutic limits,⁴ 100 patients were required to have an 80% chance of detecting a 20% change in the proportion of patients spending most of the study period within their target range. The first group (group 1) was a 1 in 2 sample of patients attending the clinic for more than six months (n=105), selected alternately from an alphabetical list. Because control of anticoagulation is more variable at the start of treatment,⁵ a second group (group 2) was formed from consecutive new patients (n=47). Control of anticoagulation was audited against the patients' individual international normalised ratio (INR) target ranges. We estimated the time which each patient spent within therapeutic limits during the six months

by calculating the interval between INR tests and dividing it equally between INR results at the beginning and end of each interval.

After the baseline audit the clinic system was modified so that fewer patients were required to see the doctors: new attenders until control had been stabilised, patients whose INR was outside therapeutic limits, those asking to see the doctor, and those who had experienced five key events relating to anticoagulant control (bruising or bleeding; attendance at an accident and emergency department; admission to hospital; starting, stopping, or changing any medicines; notification of dental treatment or surgery due within two months). Health care assistants were trained to ask each patient about the five key events at each visit (excluding first attendance), to record the answers on the revised treatment card, and to refer to the doctors any patients who said they had experienced any of the events. All other patients had their doses determined by the doctors without consultation.

In 1993 seven months after these changes were implemented we repeated the audit. Owing to an increase in the number of patients attending clinic, the second sample consisted of 206 patients: 122 patients in group 1 and 84 in group 2. The second audit included four patients in group 1 and 37 in group 2 from the first audit.

Table 1 shows the outcomes of both the baseline audit and the second audit. Although there was a 50% reduction in the number of patients seeing a clinic doctor, the second audit showed that the median proportion of time spent within therapeutic limits remained unchanged.

Comment

This audit suggests that a simple screening system and a revised treatment card is a suitable method for managing the increasing numbers of patients without incurring additional costs, such as buying computer dosing systems³ or by shifting anticoagulant services to primary care.² The quality of clinical practice was maintained (even among patients with cardiac conditions) despite the reduction in the number of patients having a medical consultation.

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Table 1—Results in anticoagulant clinic before and after introduction of a system of screening patients so that only some saw the doctor

	Baseline audit		Second audit	
	Group 1	Group 2	Group 1	Group 2
No of patients	105	47	122	84
No with cardiac conditions	82	11	79	37
Interval between appointments (days)	33	13	38	14
% Of time in target range:				
All patients	50 (33-75)	40 (17-62)	57 (38-72)	45 (25-60)
Cardiac patients	54 (33-75)	33 (10-50)	54 (36-74)	43 (22-62)
No (%) spending ≥ 50% of time in therapeutic range	61 (58)	20 (42)	73 (60)	41 (49)