One of the most important attributes of a good general practitioner is the wisdom to know when to refer to specialist services. This also depends, however, on such services being accessible to all in need.

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Palliative care is integral to practice

EDITOR,—Zoe Kenyon's editorial on palliative care in general practice makes wide generalisations about the skills in and enthusiasm for palliative care of "many general practitioners" in Britain.¹ Few general practitioners shy away from palliative care, which, after all, is a large and satisfying part of their practice. Nor do general practitioners limit their definition of palliative care and its application to patients with cancer, as many hospitals do. On the contrary, most general practitioners expose themselves daily, if not hourly, to "painful emotions." Granted, there are exceptions, but the conclusions reported must be based on systematic research rather than potentially biased observations.

Fortunately, misconceptions about ceiling doses of opiates are disappearing and modern day general practice is not preoccupied with the science of controlling symptoms. Rather, it has advanced in both its teaching and practice to reduce suffering; pain control is only one element in this multi-dimensional approach. In other words, provision is made to prepare the "whole person" for a good death, which is probably preferable to a specialist pharmacologically controlled "biological death."

Both generalists and specialists have a role in palliative care, and they should work together, aware of each other's skills and emphasising the long held vision that "It is better to help a colleague with a difficult case than to tell him he is wrong and that he should make way for the expert."²

Rather than palliative care joining the ever growing list of subjects in which one can obtain a diploma, it should become an underpinning element of vocational training in general practice. This is particularly so with the shift in emphasis to community care, in which the general practitioner acts as the focal point for the primary health care team.

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Significant social class gradient in menstrual disorders

EDITOR,—Diana Kuh and Susan Stirling report significant educational gradients for risk of admission for diseases of the female genital system and breast, and in particular for menstrual disorders: 1% of highly educated women were admitted to hospital for menstrual problems compared with 19% of those with minimal qualifications.¹ Social gradients were also observed for hysterectomies

and dilatation and curettage: 37% and 44% of these procedures, respectively, were related to menstrual problems. The authors refer to a slight increase in rates of hysterectomy since the 1970s. They were unable, however, to establish whether increased risks of admission and surgery among less educated women and women of lower social class reflected the prevalence of disease or a different pattern of primary and secondary care.

Evidence for social differences in menstrual disorders, not affected by use of health services, is available from the 1958 British birth cohort study (table). At age 33, women reported whether they had ever had a menstrual problem. Eighteen per cent reported that they had, of whom 14% had had such a problem during the past year. There were strong associations between social position and menstrual problems.

Social class distribution of menstrual problems among women in 1958 British birth cohort study

	At birth		At age 33	
	% (No)	Odds ratio	% (No)	Odds ratio
Social class:				
I	10.5 (24)	1.00	10.9 (15)	1.00
II	13.1 (92)	1.28	16.8 (265)	1.66
IIINM	16.1 (84)	1.64*	16.5 (318)	1.63
IIIM	19.0 (508)	2.01*	16.3 (63)	1.59
IV	22.1 (144)	2.43*	21.8 (208)	2.28*
V	18.5 (83)	1.94*	23.0 (67)	2.45*
χ^2 For trend	23.2		17.9	
P value	<0.0001		<0.0001	
Educational qualifications:				
Degree			14.4 (211)	1.00
A level			18.1 (106)	1.32*
O level			17.6 (362)	1.27*
< O level			18.7 (179)	1.37*
None			26.4 (161)	2.13*
χ^2 For trend			32.5	
P value			<0.0001	

*P<0.05.

Evidence suggests an association between menstrual problems and obesity, with overweight and obese women having a higher risk of menstrual disorders (JL, CP, TC, unpublished observations).³ Women in lower social groups are also at a greater risk of obesity than those of higher socioeconomic status.² It is therefore important to consider whether the social distribution of obesity could account for the distribution of menstrual disorders highlighted in Kuh and Stirling's paper. The recent increase in obesity² may also be partly responsible for the increase in menstrual problems (and possibly hysterectomies and dilatation and curettage). If this hypothesis is confirmed then a reduction in the socioeconomic gradient in admissions for menstrual disorders (and possibly hysterectomies and dilatation and curettage) may be achieved by reducing the social gradient of obesity.

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Reflex sympathetic dystrophy in children

Dystrophic changes are less likely

EDITOR,—Having read Adrian R Lloyd Thomas and Gillian Lauder's article on reflex sympathetic dystrophy in childhood,¹ we would like to raise some points that reflect our experience of this problem. Over two years we have seen 11 children (10 girls and one boy) under the age of 15 with reflex sympathetic dystrophy.

The authors state that most patients with childhood reflex sympathetic dystrophy do not have a history of trauma. Only three of our patients could not recall a traumatic precipitant for their symptoms, although in three cases there was an asymptomatic period (of up to four months) between the traumatic episode that may have been responsible and the onset of symptoms. In the remaining five cases there was continuity between the symptoms directly attributable to trauma and the onset of the reflex sympathetic dystrophy. Whereas dystrophic changes are seen in the adult form of the condition, our experience suggests that these are relatively rare in children (only two patients had changes that could be construed as dystrophic (quadriceps and calf muscle wasting)).

The authors suggest the use of radiography to help diagnose this condition. Although osteoporosis is a well recognised late finding in the adult form of the disease, we have found it less common in children. Only four of our patients had possible radiological evidence of osteoporosis, and in all four it was mild. Additionally, osteoporosis cannot be reliably diagnosed in plain radiographs in the absence of fractures. Most reports suggest that the prognosis for childhood reflex sympathetic dystrophy is good.^{2,4} Our findings support this, although in one of our patients the condition had a protracted course, symptoms still being present after two years.

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Active early physiotherapy is the key to prevention

EDITOR,—The article on reflex sympathetic dystrophy in children is pertinent to the practice of paediatric accident and emergency care.¹ While the cases that the authors describe are extreme, they are by no means unusual. The authors, however, concentrate more on treatment than on prevention, and they state that the average time from onset of symptoms to presentation is 10 days.

Those of us who work in accident and emergency care, and especially those of us who see large numbers of children, are familiar with peri-adolescent girls presenting to the accident and

emergency department a short time after a relatively trivial injury. Even at this stage many of the signs described in the article are present. These include evidence of neuropathic pain, allodynia, and hyperaesthesia to all stimuli. These children often undergo extensive radiology as the pain is out of all proportion to the appearance on clinical and x ray examination. Many of the children are over-treated with plaster of Paris casts or other immobilisation splints, often by inexperienced junior staff.

This syndrome has been well recognised in accident and emergency care and has been named the "10-15 syndrome."² I believe that, when these children present, the last thing that one should do is immobilise them in any form of splint, including tubular support bandages. These children must be encouraged to move their limbs and ideally should be referred for physiotherapy as soon as possible. Unfortunately, physiotherapy services—and particularly physiotherapists with paediatric skill—are lacking in many accident and emergency departments.

Reflex sympathetic dystrophy in children is preventable. A greater awareness of the management of soft tissue injuries in children is needed.

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Child health booklets lack illustration of meningococcal rash

EDITOR,—A 14 month old child with advanced meningococcaemia died soon after admission to hospital. Medical advice had been sought when she had only four non-haemorrhagic spots, and she had remained at home for a further eight hours. Her parents, unaware of the diagnosis, watched the typical rash develop and tried to identify it by reference to a book on child health. The book contained no photographs of a meningococcal rash.

We reviewed two booklets given free to first time mothers.^{1,2} Although both contained colour photographs, neither had a picture of a meningococcal rash. Such a rash was described under "meningitis," but parents would have to consider this disease a possibility before finding the description. *BabyCare Guide*, which is given to mothers in complimentary packs, does contain a colour photograph of a meningococcal rash.³

Some families can afford to buy glossy hardback books on child care. Nine such books published since 1990 were available in local bookstores or libraries. None had a picture of a meningococcal rash. Many listed symptoms such as fever, vomiting, and fretfulness but did not emphasise that the development of the rash alone is sufficient for parents to call their general practitioner or "trust their instincts and go straight to the nearest Accident and Emergency Department."²

Over half (55%) of all cases of meningococcal disease occur in children under 5, and 30% occur in infants.⁴ In Europe purpuric skin lesions were associated with deaths due to meningococcaemia,⁵ and their importance must be immediately clear to all. We therefore recommend that all child health books include a colour photograph of a meningococcal rash.

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Audit suggests that use of aspirin is rising in coronary heart disease

EDITOR,—The uptake of low dose aspirin in the secondary prevention of ischaemic heart disease has become a popular subject for audit in general practice. This was provoked by the publication of several reports and factsheets in early 1994, which showed the benefits and urged doctors to ensure that patients received the treatment.^{1,3} For many practices the data are readily available and a computer search can provide the information in less than an hour.

In September 1994 six practices in Bath provided data about their patients aged 15-74 (33 293 patients in total). Three hundred and twenty five patients were known to have had a myocardial infarction, and 367 were recorded as having angina. Altogether 183 (56.3%) of the patients with myocardial infarction and 184 (50.1%) of those with angina were known to be taking low dose aspirin. A second audit eight months later showed a modest improvement to 204 (62.9%) and 260 (70.9%) patients respectively.

It has been shown that in acute heart disease women are likely to be treated later and less energetically than men.⁴ The data from Bath suggested that the same may apply in secondary prevention, since a greater proportion of men than women were treated. A logistic regression model, however, showed only weak statistical evidence of there being a difference between the treatment of men and women, with a P value of 0.19 and 0.07 in the first and second audits respectively. The sample was relatively small, and a larger series might confirm a difference.⁵

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Water shortage in West Yorkshire has serious health implications

EDITOR,—The current widespread shortages being experienced by customers of Yorkshire Water living in the Huddersfield and Halifax areas of West Yorkshire may necessitate cuts in supply, and this has led to serious public health concerns. In view of the unprecedented nature of this problem in Britain, we believe that it is prudent to highlight the risks and problems to all doctors for

their consideration now and in the future, should similar problems arise in other parts of the country.

Water supplies in the affected areas have been shrinking at an alarming rate during the summer and autumn and are currently at dangerously low levels. Although Yorkshire Water and other agencies have made repeated calls for customers to reduce demand, this has resulted in little noticeable effect on supplies.

Yorkshire Water is proposing 24 hour cuts in water supplied on a one day on, one day off basis. During the period of these cuts it would not be able to guarantee the water anywhere in the water distribution network affected, which means that all water used for drinking and to prepare food should be boiled. While hospitals would remain on a piped supply, bottled water would be necessary for use by patients and staff. Residential and nursing care homes would have tanked water supplies plumbed in. Washing and toilet management, in general, would be difficult during the cuts, and this would lead to an increased threat of community outbreaks of gastrointestinal disease. The effect on community care would potentially be severe. Patients who might have been cared for at home would be admitted to hospital, and discharges would be harder to arrange. Secondary illnesses, including myocardial infarctions, from unaccustomed activity would increase admissions to hospital, and a surge of either respiratory or gastrointestinal illness would be likely to overcome the capacity of local hospitals to cope with emergencies.

The nature of the potential problem in West Yorkshire is unprecedented. The health implications of the proposed cuts in local water supplies are extremely serious, and it is crucial that doctors working in hospitals, community health, and public health services now, and in the future, work to avoid the possibility of this situation arising again in Britain.

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Breast cancer and hormonal supplements in postmenopausal women

Benefits probably outweigh risks

EDITOR,—Hormone replacement therapy can undoubtedly alleviate the distressing symptoms associated with the menopause, and most research indicates that, in the short term at least, it is safe. Many women feel healthier and more vivacious when taking hormone replacement therapy and wish to continue it long term, and there is evidence that prolonged treatment is associated with a reduction in mortality and morbidity from degenerative disease of the cardiovascular and skeletal systems.

We must, however, balance the benefits against possible risks. For a 50 year old woman the lifetime risk of dying of coronary heart disease may be more than five times that of dying of breast cancer, but it is the fear of breast cancer that concerns women most. We need to look at epidemiological evidence as it unfolds, and the editorial by Klim McPherson is a welcome update of the situation.¹ The latest publication from the American nurses' health study did indeed find an increased risk in the incidence of breast cancer in current long term users of hormone replacement therapy, but it also showed that among women who had used hormone replacement therapy for up to five years in the past there was a reduction in the incidence of breast