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