accord with the committee's recommendations, and the committee felt able to reject the recommendations of its visitors in 1985 that recognition should be withdrawn at that stage.

In 1987 the visitors reported that, although the regional criteria were within the committee's recommendations, there were still problems in implementation and that two practices did not fulfil the basic criteria. This was discussed further by the officers of the committee and the representatives of the region. In February of this year the committee decided that, in the light of the reports of its visitors over six years, it could no longer recognise vocational training in the North East Thames region and that recognition should be withdrawn from 1 February 1989.

Dr Stella Lowry (7 May, p 1320) asked why action against individuals could not have sufficed. The committee has no direct relation with trainers or training practices. Its visits are to regions and its appraisal is of the regional organisation. Any action that its takes can only be in relation to a region. Responsibility for selecting trainers rests with regional general practice subcommittees, and they can take action against individuals.

The committee has always believed in the importance of the advisory and educational aspects of its visits. The issue on this occasion, however, was the failure of a regional organisation to achieve basic standards which were adopted by the committee three years before its most recent visit. We hope that those responsible for training in the North East Thames region can implement changes before the end of this year and satisfy the committee of progress so that the action proposed for February 1989 can be avoided.

DOROTHY M B WARD

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SIR,—Dr Stella Lowry discusses the action taken against North East Thames (7 May, p 1320). We would like to invite Professor Pereira-Gray (chairman of the council of the Royal College of General Practitioners) to attend one of our meetings, which are held every Wednesday afternoon at the Whittington Hospital for the trainees on the University College Hospital, Middlesex, Whittington, and Royal Free vocational training schemes. As the people directly affected by the recent withdrawal by the Joint Committee on Postgraduate Training for General Practice of recognition of training in the North East Thames region and the subsequent decision by the Royal College of General Practitioners to prevent trainees in this region from sitting the MRCGP examination, except on the basis of individual assessment, we would welcome the opportunity to have the issue discussed and the situation clarified by him.

We are committed doctors practising in the inner city—supposedly the very people the government is trying to encourage to raise standards of practice in the inner city. The criticism of training in the region and the statements of the college may jeopardise our futures, whether in this region or outside it. Whatever the outcome, this controversy will have lasting and detrimental effects on the prospects of present and future trainees from this region. We have been placed undeservedly at a disadvantage in competition with our peers for jobs and will remain so for many years to come. We applaud the aims of the college to maintain and raise standards of postgraduate education, but we question whether the methods used in this episode are in the best interests of our training.

CAZ SAYER, and 20 others

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SIR,—We consultants, course organisers, and trainees, having met to discuss the Royal Free vocational training scheme, would like to make public our anger at the blanket manner in which general practitioner training in the North East Thames region has been branded as inadequate.

Visitors to our scheme from the Royal College of General Practitioners in 1987 claimed that the training was satisfactory. In 1988, however, we read in the medical press that all trainees in the North East Thames region are now stigmatised as a result of a visit to five inner London practices, associated with a previous visit in 1985 to five practices in Essex, none of these practices having anything to do with our scheme.

It is difficult to think of any other professional body concerned with standards criticising a whole region (over 100 trainees) on such limited evidence. The result is that the trainees coming off our scheme and applying outside the North East Thames Region now feel they have been disadvantaged, while those responding to our present advertisement to join the scheme may consider withdrawing their application.

We protest at this unjust criticism of our training on the grounds that the problems identified have nothing to do with the Royal Free scheme. We ask that those in authority in the Joint Committee for Postgraduate Training in General Practice to rectify immediately the difficulty they have created for our trainees.

J MORRIS

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SIR,—Dr Stella Lowry argues that many answers are required as a result of the decision to withdraw recognition of training from North East Thames region (7 May, p 1320). As a former regional adviser in general practice, I support this submission and argue that the matter should be placed before the council of the BMA. There are three issues at stake which impinge on many professional interests.

Firstly, the annual report of the Joint Committee on Postgraduate Training for General Practice for 1987 gives no hint of an impending crisis in training anywhere. The section on the visitors' meeting and study day contains bland remarks about trainee assessments and the objectives of visiting. As a result of some visits, however, a working party chaired by Dr Peter Sprackling was set up to consider the procedures which may be followed after an unsatisfactory report from the visitors. No report from this working party is evident yet. It seems, therefore, that the committee's action in North East Thames region was not backed by research from the working party. One can conclude only that the committee, in describing its work, did not see the need to lay any foundation for action against a region.

Secondly, recognition or approval of training for general practice is split between two separate bodies. The approval of trainers is a statutory function of the regional general practice subcommittees and cannot be subsumed by any other authority. The approval of hospital posts is mediated through the royal colleges, and the regional postgraduate committees select those considered suitable for general practice training. The colleges do not seem to have been consulted by the committee about the changed status of their posts in North East Thames region or the manpower blight that could result.

Thirdly, the committee's power to influence training standards resides solely in its responsibilities to issue or withhold certificates on application.

These powers are exercised in relation to individual applications. There are no provisions to make prospective judgments, either for a single applicant or a group of applicants from a region. I have, therefore, to disagree with Dr Marie Campkin and others (7 May, p 1331) when they suggest that the committee could take disciplinary action against the regional and associate advisers. That this could even be suggested underlines the utter confusion that has followed the extension of powers taken by the committee so that it is now seen as virtually taking over the function of the general practice subcommittee.

The consequences of this action will be severe however the matter is resolved. The whole profession has an interest in seeing the matter settled. The evidence relied on by the committee should be submitted to the council of the BMA for rigorous review and ultimate report.

JOHN D SINSON

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SIR,—Dr Stella Lowry (7 May, p 1320), Dr Marie Campkin and others (7 May, p 1331), and Dr H J N Andreyev (7 May, p 1326) draw together a common theme of standards of teaching and training. I comment from the perspective of a past regional adviser in general practice who made many visits of inspection to vocational training schemes in other regions.

In general practice a statutory framework has allowed (or compelled?) the definition of criteria for those wishing to have trainees in their practices. In hospital those trainees are an indispensable component of the clinical teams, and their service contribution means that if the standards of training are inadequate withdrawal of recognition has dire consequences. The lack of formal assessment of teaching ability and commitment when consultants are appointed can, of course, lead to the situations described so graphically by Dr Andreyev. On the other hand, when training standards in general practice are perceived, rightly or wrongly, to be inadequate by the visitors the options set out by Dr Campkin and colleagues are all available. The trick is to use the right one. On one of my visits our team criticised the lack of central monitoring and control of standards in what was, admittedly, a large region. We thought that we had expressed our opinion rather wittily and were surprised and alarmed to hear that our report was considered libellous by some of the recipients.

If, as in hospitals, professional common sense and conscience dictate training standards a marvellous job will be done with occasional horrible lacunae. If, as in general practice, more formal systems are adopted the results will still be a marvellous job, with occasional horrible rows and, one hopes, fewer lacunae. I favour open accountability, which must mean defining ways of selecting acceptable trainers and adequate assessment of the training. There must also be enough sanctions to make the system work. We all perform best when we know that our efforts will be suitably judged.

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Rheumatic fever

SIR,—Dr J G Bissenden (30 April, p 1215) advises of the need to prepare for a return of rheumatic fever, and our recent experience suggests that this warning is apposite.

A 37 year old woman developed a sore throat, fever, and cough with green sputum. Four days later she developed a flitting annular red rash on her legs and arms, which lasted for 48 hours. The

appearance of this rash was considered compatible with erythema marginatum. On the seventh day she noticed painful, swollen ankles and wrists. Investigations on the seventh day showed a haemoglobin concentration of 117 g/l, a white cell count of $14.1 \times 10^9/l$ (with a neutrophilia), and an antistreptolysin O titre of 1200 IU/l. She received erythromycin 500 mg four times daily and aspirin with symptomatic improvement.

A recrudescence of her arthropathy, however, required hospital admission on the 14th day of the illness. On admission she was afebrile with swollen and tender wrists and ankles. A mid-systolic cardiac murmur was heard on auscultation. Investigations showed a haemoglobin concentration of 112 g/l, white cell count of $12.9 \times 10^9/l$ (with continued neutrophilia and reactive lymphocytes), antistreptolysin O titre of 800 IU/l, anti-DNAase B titre of 1200 IU/l, and erythrocyte sedimentation rate (Westergren) of 123 mm in the first hour. A throat swab did not grow any pathogens, and an electrocardiogram and echocardiogram were normal. Rheumatoid factor, antinuclear factor, and autoantibodies were not detected. She was treated with penicillin 500 mg four times daily, bedrest, and aspirin and improved over the following four weeks. The erythrocyte sedimentation rate fell to 45 mm in the first hour by the time of her discharge. Repeated electrocardiograms and echocardiograms were normal. Further history taking elicited the fact that one grandparent and an aunt had died of cardiologic sequelae of rheumatic fever.

This woman's illness meets the revised criteria for acute rheumatic fever.¹ As in many of the recent cases in the United States this patient was middle class.² Many of the United States cases also occurred in adults.³ The family history of relatives affected by rheumatic fever suggests that she may have been predisposed to the disease. She had four young children, who may have been a source of rheumatogenic streptococci. It is not only paediatricians who should be alert to the recrudescence of rheumatic fever. General practitioners and doctors practising adult medicine should also be diligent in their approach to streptococcal pharyngitis and tonsillitis.

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- 1 Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association. Jones' criteria (revised) for guidance in the diagnosis of rheumatic fever. *Circulation* 1984;69:204-8A.
- 2 Veasy LG, Wiedmeier SE, Orsmond GS, et al. Resurgence of acute rheumatic fever in the intermountain area of the United States. *N Engl J Med* 1987;316:421-7.
- 3 Odio A. Resurgence of acute rheumatic fever. *N Engl J Med* 1987;317:507.

SIR,—Dr J G Bissenden (30 April, p 1215) thinks that we have "gone soft" on the streptococcus. The evidence is the other way round, that the streptococcus has gone soft on us. It is not substantiated that antibiotics helped the decline of acute rheumatic fever,¹ and social factors seem to have been more important.

The streptococcus can be isolated from 30% of throat swabs from patients with sore throats but also from 10% of healthy controls. It certainly is unusual to treat sore throats with intramuscular penicillin followed by 10 days of oral penicillin. Such treatment makes little difference to the duration of the illness whether or not it is caused by the streptococcus, and, more importantly, it

does not seem to influence the development of rheumatic fever² or acute glomerulonephritis.³

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- 1 McCarty M. The beta-haemolytic streptococcus. In: Dubos RJ, Hirsch JG, eds. *Bacterial and mycotic infections of man*. London: Pitman Medical Publishing Company, 1965:356-90.
- 2 Howie JGR, Foggo BA. Antibiotics, sore throats and rheumatic fever. *J R Coll Gen Pract* 1985;35:223-4.
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SIR,—Dr J G Bissenden (30 April, p 1215) deals with a future possibility rather than the present situation in Britain. Studies in general practice in Britain provide little support for the treatment of sore throats with antibiotics. The speed of recovery¹ or risk of rheumatic fever² seems to be uninfluenced by this, and, while I accept that disease patterns change, mucoid strains of group A streptococci, which are possibly "rheumatogenic," do not seem to be important pathogens here.

In the Salt Lake City cases discussed by Dr Bissenden fewer than one third of patients complained of a preceding sore throat.³ Throat swabs do not exclude the carrier state, which may not be associated with a systemic immunological reaction. In 1987 and 1988 between 24 and 37 patients attended this practice each week complaining of an illness in which sore throat was a major feature.⁴ This is equivalent to a full morning's surgery list for a general practitioner in a partnership of seven, and we think that education of patients to deal with minor symptoms without recourse to a doctor is important. No major complications were seen, and the return rate of patients was uninfluenced by whether antibiotics were given.

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- 1 Whitfield MJ, Hughes AO. Penicillin in acute sore throat. *Practitioner* 1981;225:234-9.
- 2 Howie JGR, Foggo BA. Antibiotics, sore throats, and rheumatic fever. *J R Coll Gen Pract* 1985;35:223-4.
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Acute appendicitis and social class

SIR,—Professor D J P Barker and colleagues (2 April, p 953 and 956) reported a correlation between the incidence of appendicitis, as measured by appendicectomies, and the availability of certain household amenities and consumption of vegetables. Their conclusions are taken to support the hypothesis that "appendicitis is primarily caused by Western housing rather than by Western diet."

Their indicator of the incidence of appendicitis is actually the rate of appendicectomy, and it may be worth considering other possible explanations. Some years ago we reported a strong familial predisposition to appendicectomy, which we later interpreted in terms of a social class bias in classes I and II towards appendicectomies.¹ We drew attention to a paradoxical bias of "chronic appendicitis" in classes IV and V as suggestive evidence that it was the operation and not the inflammation that was social class related.² The same factor could explain the familial clustering of appendicectomies and the housing and dietary correlations reported by Professor Barker and colleagues.

In the absence of detailed understanding of the social class selection to appendicectomy or the housing and dietary characteristics of children who

suffer appendicitis but do not present for surgery it would be useful to know the social class composition of children whose appendicectomies confirmed histological appendicitis compared with those with negative histology. Community rather than hospital based studies may help to take into account potential selection to medical attention by social class.

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- 1 Andersson N, Griffiths H, Murphy J, et al. Is appendicitis familial? A case-control study. *Br Med J* 1979;ii:697-8.
- 2 Andersson N, Cockcroft A, Myers J, Murphy J, Panico S. Acute appendicitis and social class. *Br J Clin Pract* 1981;35:272-3.

Malaria prophylaxis

SIR,—Dr C J Ellis states that thrombocytopenia is an argument for empirical treatment of febrile patients from areas where malaria is endemic (2 April, p 952.) He also states that all patients who have taken a prophylactic regimen that includes chloroquine must be treated with quinine, however mild the illness. This opinion is shared by Drs E L C Ong and E M Dunbar (30 April, p 1259).

It is unwise to treat a patient with falciparum malaria with any drug that has been used for prophylaxis. The mere fact that the patient has developed malaria despite prophylaxis indicates that the efficacy of the drug used is uncertain.

Although thrombocytopenia is present in 80% of all patients with malaria,¹ its predictive value is not established as 15% of febrile patients who are not suffering from malaria but come from endemic areas also have thrombocytopenia (unpublished observation). Empirical treatment for malaria would sometimes lead to non-treatment of serious bacterial diseases. Thrombocytopenia is present in 35% of patients with septicæmia and endocarditis.² Empirical treatment might also lead to less vigilance in the search for a correct diagnosis and could be justified only in the rare cases when microscopic examination of a thick blood film is impossible and the symptoms are suggestive of malaria.

We do not agree with Dr Ellis, who would give quinine to all febrile and thrombocytopenic patients taking chloroquine prophylaxis, or with Drs Ong and Dunbar, who advocate that quinine should be used to treat falciparum malaria without discussing other alternatives available outside the United Kingdom.

Treatment with quinine at the recommended dose of 10 mg/kg three times daily for 10 days is almost invariably associated with tinnitus, vertigo, and dizziness. The patient can rarely return to a normal life before the treatment ends. On the other hand, treatment with sulfadoxine and pyrimethamine is given as a single dose. This drug is still largely effective against African *Plasmodium falciparum* and can be given to patients who are not seriously ill. Side effects are few but might be serious, and all patients who are treated with this combination should, therefore, be asked about previous side effects from sulphonamides. When treatment with sulfadoxine and pyrimethamine is not acceptable patients with mild disease should be given a single dose of mefloquine rather than quinine. Nausea and vomiting often occur after mefloquine³ but these wear off within 24 hours, after which the patient can look forward to an uneventful convalescence.

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