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Pain in the hand and wrist

Picture of injection is misleading

EDITOR,—It is a pity that Michael Shipley's article on pain in the hand and wrist contains a misleading picture showing an injection on the radial side of the tendon in the carpal tunnel syndrome; it may put many doctors off trying this technique more than once.¹ Unless the injection is given as described in the article the nerve may be damaged. The "ulnar bursa" of tenosynovium is the target and is conveniently situated halfway between two palpable bony landmarks (the tuberosity of the scaphoid and the pisiform) or, as stated, to the ulnar side of the palmaris tendon.

Generally, orthopaedic surgeons see these patients and have the advantage of visualising the deeper structures. Thus for trigger fingers or thumb they know that they have to inflate the tendon sheath in the finger rather than inject "around" the module. They also know how low the cure rate is for ganglions treated by aspiration (popping them is better). It might be a good idea to mention that the nodule in De Quervain's tenosynovitis may be bony hard and puzzles young doctors.

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- 1 Shipley M. Pain in the hand and wrist. *BMJ* 1995;310:239-43. (28 January.)

Treatment of fractures of the scaphoid

EDITOR,—In my opinion, Michael Shipley's advice regarding the treatment of fractures of the scaphoid is erroneous.¹ In Britain the standard treatment of a fracture of the scaphoid is to apply a so called scaphoid plaster, extending from the proximal forearm to the interphalangeal joint of the thumb, leaving the fingers free to move. Recent study by Clay *et al* has confirmed that there is no difference in the non-union rate (10%) when scaphoid plaster and Colles-type plaster is used.² The duration of immobilisation may vary from six to 12 weeks, depending on the progress to union and the opinion of the treating surgeon. It is wrong to state that prolonged immobilisation is the only effective treatment.

Early surgical stabilisation of fractures of the scaphoid should be considered if there is displacement at the fracture site, the fracture involves the proximal pole of the scaphoid, or there is an associated perilunate dislocation of the wrist.

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- 1 Shipley M. Pain in the hand and wrist. *BMJ* 1995;310:239-43. (28 January.)
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Pyridoxine supplements may help patients with carpal tunnel syndrome

EDITOR,—The standard treatment offered for the carpal tunnel syndrome is still a splint, a local injection of corticosteroid, or surgical decompression.

1 Awareness of a simple and effective nutritional intervention—supplementation with pyridoxine (vitamin B-6)—remains low despite overwhelming evidence of its efficacy.

Vitamin B-6 deficiency is a common finding in the carpal tunnel syndrome, and the total work up of patients with the syndrome "should include a nutritional evaluation and, in particular, a determination of B6 status."² Vitamin B-6 status can be determined by measurement of erythrocyte aspartate aminotransferase activity or plasma pyridoxal phosphate concentration. Several studies have shown that supplementation with pyridoxine (usually in doses of 50-200 mg a day) relieves the symptoms of the syndrome,³ and objective tests of median nerve conduction have shown that compression of the nerve is relieved.⁴ A therapeutic response may require supplementation for up to three months, with cure rates over this time in the order of 85%. Even Phalen, who originally described the carpal tunnel syndrome in 1952 and pioneered its surgical treatment, agrees that, in future, pyridoxine may be the treatment of choice.⁵

Although supplementation with pyridoxine may occasionally cause a sensory neuropathy in doses as low as 200 mg daily over three years, this is usually a concern only in people taking 2000 mg or more. The neurotoxicity is believed to occur when the liver's capacity to phosphorylate pyridoxine to the active coenzyme pyridoxal phosphate is exceeded. The resulting high blood pyridoxine concentration could be directly neurotoxic or pyridoxine may compete for binding sites with pyridoxal phosphate, resulting in a relative deficiency of the active metabolite. Supplementation in the form of pyridoxal phosphate should therefore avoid this risk.

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- 1 Shipley M. Pain in the hand and wrist. *BMJ* 1995;310:239-43. (28 January.)
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Author's reply

EDITOR,—The illustration of the injection technique for the carpal tunnel syndrome in the article is indeed incorrect and does not show what is described in the text. The needle should be introduced just to the ulnar side of the tendon of palmaris longus if this is present (figure). The use of the bony landmarks, as Christopher D Jefferiss describes, is a helpful alternative approach, but care should be taken that the needle is not inserted through a tendon. Although injection and inflation of the tendon sheath for trigger finger is clearly the

Injection for the carpal tunnel syndrome: needle is inserted at proximal palmar crease, just to ulnar side of palmaris longus tendon

ideal, this can be tricky and may prolong the procedure, to the discomfort of the patient and the operator. My article was directed at generalists with an interest in rheumatology, and in my experience the injection is successful when placed "around the nodule."

I am delighted to hear that a less cumbersome method of plastering is now practised in Britain for fractures of the scaphoid. I included this topic in the article to remind generalists that patients in whom this fracture is suspected should be referred to a fracture clinic for expert advice.

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Assessing health needs in primary care

Morbidity study from general practice provides another source of information

EDITOR,—We agree that more information is needed to support effective planning in primary health care.¹ Readers may be interested in the results of the fourth morbidity study from general practice, published last January.² Sixty practices, covering 1% of the population of England and Wales, recorded details of every encounter with a patient on their age-sex register between September 1991 and August 1992. Interviewers collected socioeconomic information about every patient, irrespective of whether they consulted during the year.

The report indicates how rates based on this sample of half a million people can be applied to the demographic structure of any local population. This would give local estimates of morbidity expected in general practice and other indicators of use of primary health care. Alternatively, more sophisticated techniques such as synthesised estimation can be used.

Other potential sources could be used for planning. For example, the Royal College of General Practitioners Research Unit has continuously collected and has published clinical data, currently from over 90 practices, for many years. Also ministers have recently announced that the Office of Population Censuses and Surveys will be responsible for managing the collection and analysis of data previously obtained by VAMP.³ We are interested in developing ways in which these data could contribute and invite those with responsibility for planning primary health care services to contact us.

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- 1 Shanks J, Kheraj S, Fish S. Better ways of assessing health needs in primary care. *BMJ* 1995;310:480-1. (25 February.)
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Standardised methods of data collection are required

EDITOR,—John Shanks and colleagues discuss the advantages, for the purpose of needs assessment, of combining knowledge from general practice with that derived from data sources held centrally.¹ They suggest that health authorities and family health services authorities may need to wait for a

merger to explore the benefits. In East Sussex both authorities have been exploring this for the past two years.

The idea of providing general practitioners with census results for combination with information derived from their own systems proved impractical because their data were extremely difficult to interpret. As a result, an innovative approach was developed. The reasoning was that if data could be collected from a consultation in a standard and simple manner and indexed in relation to the person to whom they referred then it should be possible to compare values before and after an intervention and assess benefit. Furthermore, standardisation of the collection of data across many practices should allow the creation of a database about a larger population with a known denominator.

For the pilot project, asthma was chosen because of the recent publication of local guidelines. These formed the basis of a standard set of questions, developed in cooperation with staff from the pilot general practices. Their computer systems' software was used to construct a program that prompted for and encoded "yes/no" or multiple choice answers. This could be used during or after a consultation by anyone in the practice with appropriate access.

Unfortunately this process of standard data collection has been hindered by the current design of computer software for general practice (something that may change with the release of upgraded systems in the near future). As a result, the programs seemed to be slow and prone to error, which made them too cumbersome for the time pressured environment of the consultation. Also, use of questionnaires adds a large number of codes to a patient's record.

The software copes better with adding one or two codes per consultation, so difficulties were encountered with analysis and database management. Despite these difficulties it has proved possible to collect data, in particular from clinics operated by practice nurses.

This project has identified the need to start working with general practice computer software companies to encourage them to take account of the wider uses of general practice data, in particular for needs assessment. It may also be necessary for the rules for accrediting these computer systems to be tightened.

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Chronic diseases need to have standard definitions

EDITOR,—John Shanks and colleagues mention the value of morbidity data collected in general practice.¹ Remarkably little is known about the completeness and validity of data on health promotion and chronic diseases. The definition of asthma for the purposes of management of chronic disease has been reported to differ considerably among practices.² I found a similar imprecision in the definition of hypertension when collecting morbidity data in 20 Oxfordshire practices that subscribe to VAMP computer systems. Large amounts of time, effort, and money (£901 000 in Oxfordshire last year) are spent on recording and extracting morbidity data for the purposes of managing chronic disease and health promotion. Many general practitioners are dubious about the value of this information, primarily because the data are not yet used for needs assessment. Until there is a uniform definition of conditions such as hypertension, coronary heart disease, and asthma it will not be possible to aggregate practice

based data. Consequently, this valuable source of morbidity data will remain unexploited.

Allyson Pollock and colleagues seem to support the current orthodoxy that public health practice and general practice are mutually exclusive.³ A clinical commitment would surely enhance the credibility of public health doctors among their practising colleagues,⁴ while basing medical practice on applied epidemiological principles is now well accepted.⁵ The boundary between the practice of public health medicine and work as a general practitioner is narrowing all the time. Such developments can only benefit both specialities.

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Interventions must be effective to be needed

EDITOR,—John Shanks and colleagues suggest that conventional methods for assessing needs require adaptation for use in primary care.¹ They are right that several methods should be used, although this applies in all areas of needs assessment. An important element of needs assessment that they do not mention is whether interventions are effective: if "health need" is the ability to benefit from care then interventions have to be effective to be needed. This is a difficult field, but useful evidence does exist.

In Camden and Islington, as part of an initiative in needs assessment in primary care, we have established a series of newsletters entitled *Health Needs Assessment and Your General Practice*. They use routinely collected information, analysed by practice.

The most recent issue, on asthma, compared information collected by the family health services authority under the health promotion scheme, prescribing analysis and cost (PACT) data on the ratio of prophylactic to bronchodilator treatment prescribed, and hospital data on rates of admission for asthma. Each practice receives a customised newsletter in which its position is indicated relative to that of other practices. Although simply feeding back information may not be sufficient to change practice, the initiative has been welcomed by general practitioners locally. General practitioners and practice staff are involved in the newsletters, and feedback about the newsletters indicates that they are promoting reviews of treatment.

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Tailor data collection to needs

EDITOR,—Our experience in a fundholding practice involved in needs assessment confirms John Shanks and colleagues' views that, to inform purchasing at practice level, needs assessment should combine epidemiological data with an analysis of the views of the primary health care team, other service providers, and users.¹ We have also found that routine epidemiological data need modification to make them appropriate to the purchasing process.

With the extension of fundholding to include community nursing services, practices were allocated a budget for whole time equivalent staff based on existing provision. Team meetings at Paxton Green group practice developed a vision of nursing services that realised the wish of patients to be cared for whenever possible in their own homes and formed the basis of the contract service specification. Changing hospital and medical practice had left the district nursing team feeling that its workload was unduly heavy. Consequently, to purchase the appropriate level of nursing care it was essential to identify patients' district nursing needs.

South East Thames Regional Health Authority funded a study of district nursing, which aimed to inform the purchasing of district nursing based on patients' need.²

We combined an epidemiological study and in depth interviews with "local voices."³ Interviews were held with local providers of care (both statutory and voluntary), users, and carers. Activity and caseload data were drawn from West Lambeth Community Care (NHS) Trust's Comcare records (a computer software package for recording nursing activity data) and district nursing manual records.

We described the teams' workload, case mix, primary activities, and amount of time spent with patients. Comparisons with national and local data showed Paxton Green to have a smaller district nursing team than that expected for the practice's population. The interviews identified gaps and deficiencies in service, and many overlapped with social care. Recommendations for purchasing included the need for an extra whole time equivalent D grade nurse.

We found it possible to conduct a needs assessment study principally drawn from routinely collected and locally derived information, but additional details of patients' dependency were needed to inform purchasing decisions about skill mix. Use of a local dependency model confirmed our initial conclusions. The practice has transferred money from its planned underspend to pay for extra nursing services in 1995-6.

Our study supports the opinions of Shanks and colleagues that routinely available information collected locally can be used to inform purchasing decisions, but, to be completely effective, routine data collection must be tailored to the decisions to be made.

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