LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Triage of back pain by physiotherapists in orthopaedic clinics

I was interested in the article by Mr Weatherley and Mr Hourigan (July 1998 *JRSM*, pp. 377–9), particularly since our unit was one of the ones surveyed. One of the problems that they only touched on was that of dissatisfaction by general practitioners and patients with this initial consultation. We have found that about 5% of patients seen in back pain clinics are referred back by their doctors within a year and we get the impression that this rate is increased if physiotherapists do the primary assessment. Needless to say a high re-referral rate defeats the whole object of running such triage clinics. We have come increasingly to the conclusion that specialist physiotherapists are better deployed in developing their teaching role, since it is only by improving the management of backache in primary care that any significant difference will be made to the chronic morbidity resulting from this disorder.

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Nerve injury from false aneurysm

We congratulate Mr Colville and Mr Colin on their important report of a patient with median nerve complications associated with a false aneurysm of the brachial artery (July 1998 *JRSM*, p. 387). We have had occasion to treat several patients in whom there was serious damage to major trunk nerves as a consequence of injuries to axial vessels. The evolution of the nerve lesion in such cases where false aneurysm or arterio-venous fistula occurred associated with knife, missile or catheter injuries seems to be largely related to the arterial injury. Recovery was good, when the arterial lesion was treated effectively, for those nerves which were not directly involved in the sac. Recovery was poor or absent where the nerve was intimately involved in the sac as it was in the reported case.

We have no doubt that delay is harmful and that recognition and treatment of the associated nerve dysfunction should lead to early operation with a better chance of restoration of good function.

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Diagnosis of the acute red eye

Dr Anderson and his colleagues (March 1998 *JRSM*, pp. 127–8) have stated a problem faced by many managed care programmes all over the world—whether the diagnosis of a relatively common disorder by general practitioners is the same as one by a specialist using more sophisticated equipment. This is a topic of particular interest in the evaluation of a health care plan such as is used in the USA where a gatekeeper or triage examiner makes initial examination and diagnosis as well as the decision whether the patient should be referred to a specialist for further evaluation. To test the possible hazards of such an arrangement, it is necessary to study to what extent the initial and specialist diagnoses may differ for a variety of disorders. Anderson *et al.* compared the diagnosis of the acute red eye in the same patients by two different and independent groups of examiners (both ophthalmologists), one using the direct ophthalmoscope (representing the general practitioners) and the other the slit lamp (representing the specialists). The data showed good agreement between the two groups of examinations. In the few cases where the incorrect diagnosis would have led to a sight-threatening situation, follow-up slit lamp examinations had been requested.

Anderson *et al.* concluded that no harm would be done to the patient in the medical management of the acute red eye disorder if the initial examiner did not have a slit lamp available for use. Although this conclusion is indeed a correct one from the data, the implication that, for the acute red eye disorder, an initial diagnosis by a general practitioner with a direct ophthalmoscope is equivalent to one by an ophthalmologist with a slit lamp is not warranted and is probably incorrect. Anderson *et al.* did have each patient diagnosed by two different examiners, but both were trained ophthalmologists. It is the trained eye (and brain) that makes the direct ophthalmoscope a possible substitute for the slit lamp. If the initial examination had been carried out by general practitioners with direct ophthalmoscopes, and their diagnosis compared with those from a group of ophthalmologists with or without slit lamps, the results would almost certainly be different. In the USA, the poor correlations in most cases between follow-up examinations by ophthalmologists and initial direct ophthalmoscopic examinations by non-ophthalmologists have led to the jocular proposal that examinations by (non-rechargeable) battery-operated direct ophthalmoscopes be prohibited. This is the type of direct ophthalmoscope generally used by the non-ophthalmologists and rarely, if at all, by ophthalmologists.

The study by Anderson *et al.* cannot be used as the basis for allowing general practitioners to have the sole responsibility for the medical management of the acute red eye disorder. As this is a potentially sight-threatening situation, until further data are available the patient should always be referred to an ophthalmic specialist.

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Training of surgeons

In his editorial (August 1998 *JRSM*, p. 401) Mr Peter McDonald is wrong in stating that the two Bristol doctors who have recently been the subject of GMC and media attention were paediatric surgeons. The doctors concerned were trained as cardiothoracic surgeons. Adult cardiothoracic surgery formed the bulk of their practice. In this, their performance was good. These cardiothoracic surgeons also operated on children with heart disease, and in their unit rather than in the nearby children's hospital. The outcome was found to be below the current average.

There is controversy as to where paediatric operations are best performed. In another publication[1] Mr McDonald asks 'whether we see paediatric surgery breaking