

## LETTERS

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**Note to authors of letters:** Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

### GPs and counselling

Sir,

After family and friends, people are much more likely to contact their general practitioner regarding a personal or emotional problem than any other professional agency.<sup>1</sup> To be able to give patients the time they need, to hear what they are really saying, to pick up the cues they are giving and to respond adequately may be beyond even the most empathic general practitioner owing to perceived external pressures, such as constraints of time.

Seven consecutive surgeries undertaken by the author in one week were recorded on audiotape and the content of the consultations analysed and divided into four categories: clinical only — a consultation involving opening and closing comments and a clinical core; clinical and social — as for a clinical only consultation but with a social dimension, such as discussion regarding children, family or work; counselling skills used — as for a clinical only or clinical and social consultation but involving the use of basic counselling or listening skills; and counselling in surgery time — as for a consultation where counselling skills were used but involving a definite counselling section in the consultation (a counselling 'loop'). Inevitably, there was some overlap between these categories, but they were intended to provide a framework for analysis.

The results of the analysis are shown in Table 1. It can be seen that adding a social dimension to the consultation increased the length by 30%. Actually providing

counselling in surgery time increased the consultation length by 212%. Despite this, the mean face to face consultation length for all 106 patients was 7.0 minutes.

There is no doubt that general practitioners have a mandate from society and from their patients to listen and be available for a deeper human relationship if required. For this mandate to be fulfilled, general practitioners must feel confident enough to allow patients to use the consultation as they wish. The results presented here suggest that general practitioners who wish to address more than purely clinical issues may not be as constrained by time factors as they might feel.

The counselling 'loop' within the normal consultation<sup>2</sup> seems a useful concept. Using such a 'loop' in the consultation involves several presuppositions. First, general practitioners must accept the mandate to listen and feel that a counselling dialogue is part of their remit. Secondly, they must have the ability and confidence to use basic counselling skills. Thirdly, anxiety about the appropriate use of time could be reduced by the awareness that such an approach will not necessarily affect overall surgery lengths appreciably. In addition, in this cost conscious age, it is worth noting that brief counselling by the general practitioner is as effective as prescribing anxiolytic drugs for some conditions.<sup>3</sup> If such a counselling 'loop' emerges within a consultation, it may be an end in itself, or it may be exploratory. In the latter case the patient may be followed up later by the general practitioner or referred to another member of the primary health care team

such as the practice counsellor<sup>4</sup> or to the community mental health team.

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### Effectiveness of quinine for night cramps

Sir,

Night cramps occur commonly, especially in elderly people, and can be painful. Quinine is a remedy that has been used since 1940. Evidence for its efficacy in recent trials has been conflicting, some showing benefit<sup>1</sup> and others failing to do so.<sup>2,3</sup>

A randomized, double-blind, crossover trial, using quinine sulphate tablets (300 mg per day), and a matched placebo was designed. Patients from two practices, in Poole and Southampton, were selected on the basis that they received regular repeat prescriptions for quinine tablets. Most patients had not been taking quinine every night and some had been taking less than 300 mg per day. There were 28 patients in the study — 17 women and 11 men — and their mean age was 67 years (range 51 to 82 years). After a period of three days, during which the patients did not take any quinine, patients were allocated to take either placebo tablets or quinine tablets, one at night for 30 days. This was followed by a period of three nights without treatment, and then the patients exchanged treatment for the next 30 days. Patients were asked to fill out a diary card, on which they recorded the number of nights with cramp.

**Table 1.** Analysis of consultation type and length.

	Type of consultation			
	Clinical only	Clinical and social	Counselling skills used	Counselling in surgery time
Number of patients seen	73	16	10	7
Mean length of face to face consultation (minutes)	5.7	7.4	8.4	17.8
% increase in consultation time versus clinical only	—	30	47	212

Of the 28 patients originally recruited, 25 completed the two parts of the trial, and filled in the diary cards successfully. Two of the three patients that dropped out did so because of severe cramps during the placebo period. The order in which the treatments were given played an important part in the results (Table 1). Patients who started with quinine, and then went over to placebo, experienced more nights with cramp during the placebo period (65%) than those who started with placebo (37%). The test for carry over is significant (Mann Whitney  $W=247.5$ ,  $P<0.05$ ). However, the difference between the two treatments in the first period alone is not significant.

**Table 1.** Overall percentage of nights in each period in which cramp was experienced by the 25 patients.

Treatment	% of nights with cramp		
	1st period (n = 750)	2nd period (n = 750)	Both periods (n = 1500)
Quinine	27	14	20
Placebo	37	65	51

n = total number of nights.

Although the trial appears to have shown that quinine is beneficial overall, in that there is a significant difference between the proportion of nights with cramp while on quinine and placebo (20% versus 51%, confidence interval 0.185 to 0.395,  $P < 0.01$ ), the carry over effect renders the cross over design of the trial invalid. This carry over effect suggests that withdrawal of quinine induces cramps. This is totally unexpected, and has not been reported before. Such an effect is difficult to explain. The lack of significant difference between the two treatments during the first period, suggests that quinine is not an effective treatment for cramps, in the dosage used. It has been suggested that quinine is more effective for night cramps at a higher dose,<sup>2</sup> but this runs the risk of more side effects. Apart from the unusual effect reported here, there would also be the risk of cinchonism. This can, in severe cases, lead to deafness, optic atrophy and cardiac dysrhythmias. Furthermore, the half life of quinine has been variously reported as seven, 11 and 19 hours,<sup>2,4,5</sup> so it is possible that it can accumulate, if taken every night. Fortunately, there were no side effects recorded in this study.

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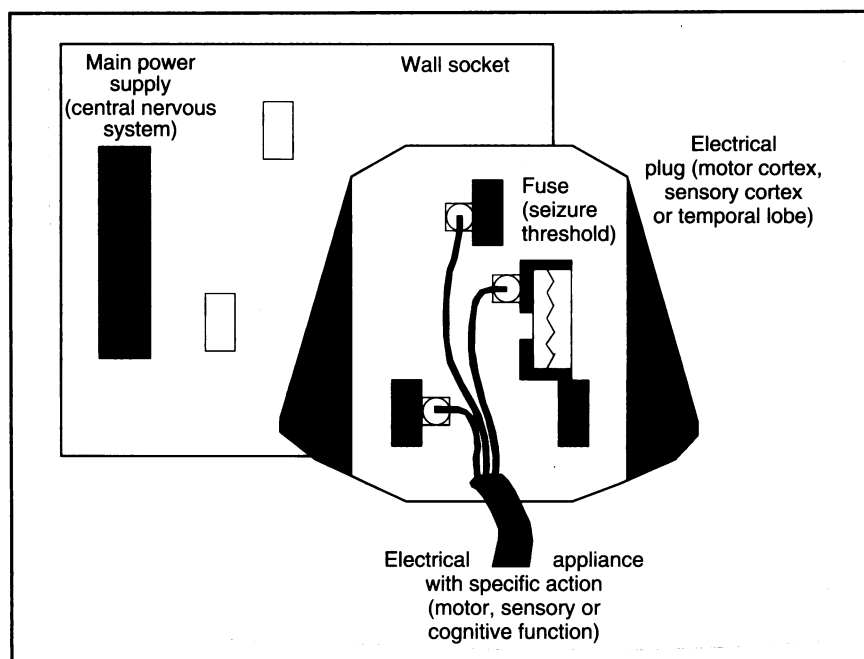
**Defusing the explanation of epilepsy**

Sir,  
Doctors may experience difficulty when describing the nature of seizure disorders, as anxious patients seldom grasp the neurological details on which doctors base their explanations. The resultant confusion may increase the patient's concerns instead, leading to non-compliance and dissatisfaction. While working at a national centre for children with epilepsy, I came to realize that a helpful comparison was needed to explain seizure disorders successfully. This would involve a familiar, recognizable household object, particularly something which could be seen and touched, and which would lend itself to a description of epileptic seizures. Over time, I found a standard electrical plug to be the most suitable comparison. This concept is echoed by Oliver Sacks in *The*

*man who mistook his wife for a hat*, in which he talks of a mechanistic neurology with similarities to capacitors and fuses.<sup>1</sup>

A simple comparison can be drawn between seizure activity in the brain and the conduction of current through an electric plug, thus providing an analogy which is readily comprehensible to patients and straightforward for the doctor to explain. The main power supply (central nervous system) may suddenly generate an excessive burst of electrical current (neuronal discharge) which is then conducted to the plug in the wall socket (lobe or cortex) (Figure 1). Here, it exceeds the capacity of the fuse (seizure threshold) which leads to an alteration in the flow of current (seizure) and a subsequent malfunction or cessation in the action of the appliance (motor, sensory or cognitive function). The fuse is clearly the weakest portion of the circuit and is thus especially sensitive to any excessive bursts of electrical current. This correlates closely with our understanding of low seizure thresholds, and how individuals may be predisposed to having seizures.

Patients often have queries about the aetiology of epileptic seizures, the determinants of their severity and the role of medication in their treatment. The aetiology of seizure disorders can be clarified by demonstrating to patients how they may have been born with a weaker fuse leading to an innate predisposition to epilepsy, or how they may have started life with an appropriate fuse which was later weakened by pathological processes. The analogy can also be expanded to



**Figure 1.** Diagram comparing seizure activity in the brain and the conduction of current through an electrical plug.