

GP obstetrics: safe but endangered

SIR,—I enjoyed Dr David Jewell's resumé (14 September, p 711) on the present state of obstetrics in general practice but felt that (numerically at any rate) he presented rather too pessimistic a picture. He quotes figures for births in 1982 in England and Wales of 3.4% occurring in general practitioner maternity units and 1.1% in the home. The former, of course, relates only to births occurring in NHS type A hospitals—that is, hospitals without specialist beds—which are published annually on OPCS form SD 52 and which take no account of births which take place in GP units within specialist units, for which there are no official figures.

A reasonable estimate of the latter can, however, be obtained using Lloyd's method¹ (subsequently validated by Macfarlane²) based on item of service payments made to general practitioners for care of women during the confinement, which are detailed annually on DHSS form SBE 504. If the numbers of births in type A hospitals and in the home are subtracted from this figure the remainder must largely relate to births occurring in GP units within specialist hospitals. For 1982 that figure was 59 273 or 9.5% of all births in England and Wales. In total therefore 14% of births were the responsibility of general practitioners.

Though numbers of births in type A hospitals are still falling inexorably, in 1982 only 109 out of 257 specialist maternity hospitals in England had facilities for GP obstetricians (Kielty P, BMA conference on general practitioner maternity unit, 1983) so here should lie the potential for expansion. It is therefore ironic to note that in Marsh's survey in the Northern region³ it was doctors practising in isolated circumstances who were most likely to attend their patients at delivery or to undertake interventive procedures such as forceps delivery or induction of labour. Which simply returns us to Dr Jewell's explicit question: what is the role of the GP accoucheur in the 1980's?⁴

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- 1 Lloyd G. The general practitioner and changes in obstetric practice. *Br Med J* 1975;ii:79-82.
- 2 Macfarlane A. Variations in number of births and perinatal mortality by day of week. *Br Med J* 1979;ii:750-1.
- 3 Marsh GN. General practitioner participation in intranatal care in the Northern region in 1983. *Br Med J* 1985;290:971-3.
- 4 Bull MJV. The general practitioner accoucheur in the 1980s. *J R Coll Gen Pract* 1981;31:357-67.

Controlled trial of Iodosorb in chronic venous ulcers

SIR,—The conclusion of Mr M C Ormiston and others (3 August, p 308) that daily dressing with cadexomer iodine (Iodosorb) is a highly effective treatment for chronic varicose ulcers conflicts with our own experience.¹ In our study 42 patients who had failed to improve during six weeks on a variety of standard outpatient treatments were randomly allocated to six weeks' daily dressing with cadexomer iodine or dextranomer (Debrisan), plus a support bandage. Cadexomer iodine did not improve the healing rate and was no more effective than dextranomer.

Even the study of Mr Ormiston and others does not show cadexomer iodine to be particularly effective, and their claim that it is better than gentian violet and Polyfax relies on healing rate expressed either as absolute reduction in ulcer area or ratio of area to circumference. The results are not expressed as percentage reduction in area. This is an important omission since different ways of expressing the data can give quite different results. For example, if one patient has an ulcer of 50 cm² which decreases by 10 cm² and another has an ulcer of

10 cm² which increases by 5 cm² the mean change in absolute area for these two patients is -2.5 cm², while the mean percentage change is +15%.

Mr Ormiston and colleagues also assessed response from the proportion of subjects changing treatment. This is totally unacceptable because the study was not double blind. Even a "clinician not associated with the routine assessment of the ulcer" could distinguish between ulcers dressed with a yellow powder and those dressed with a purple paint and would be susceptible to pressures to try a new therapy. This was certainly so in our study, which incorporated an optional crossover after six weeks based on clinical assessment of progress. Planimetric measurements of ulcer size which were not known at the time subsequently showed that the clinical assessments of healing rate had been incorrect: eight of the 21 ulcers treated initially with cadexomer iodine were bigger after six weeks but only two were changed to dextranomer; conversely nine of the 21 ulcers treated initially with dextranomer were bigger after six weeks but 11 of the group were changed to the new product.

Overall, the ulcers treated by Mr Ormiston and colleagues did remarkably well: even on standard treatment 23% healed within 12 weeks. By contrast, among our 42 patients, who constituted the majority of our clinic attenders with stasis ulcers, only one ulcer healed within 12 weeks. The conclusion that this success was due to daily rather than less frequent dressing has not been proved and it is more likely that their patients' ulcers were going to heal anyway; they were certainly smaller and less chronic than those in our study, and these may be good prognostic features. Neither the study of Mr Ormiston and colleagues nor ours has shown a beneficial effect of cadexomer iodine on healing of venous ulcers. It could be argued that this was because in the one case the ulcers were healing as fast as they could, while in the other the ulcers would not heal in any circumstance, but a more likely explanation is that the contribution of topical therapy to the healing of chronic varicose ulcers is insignificant compared with alleviation of pathological mechanisms such as tissue perfusion and venous return.

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- 1 Moss C, Taylor A, Shuster S. Comparative study of cadexomer iodine and dextranomer in chronic leg ulcers. *Scot Med J* 1984;25:54.

SIR,—Mr M C Ormiston and others state that cadexomer iodine for the treatment of venous ulcers is highly effective and allows the epithelium to grow significantly faster than when a similar group of ulcers are treated with Polyfax ointment and gentian violet. They also achieved a high degree of patient compliance with dressing and bandaging techniques and we compliment them on this. However, some caution must be exercised before hospitals are encouraged to treat all venous ulcers with Iodosorb and compression bandages applied by the patient.

Firstly, the authors state that "A well applied compression bandage is the mainstay of treatment in ambulant patients." A bandage is not a reliable method of achieving graded compression, even when applied by a well trained nurse. Dale *et al* have found that the pressure applied by compression bandaging falls rapidly within three hours of application and continues to fall slowly beyond this time.¹ We no longer use compression bandaging for venous ulcers as there are much simpler and more reliable methods of achieving graded compression in the ambulatory elderly patient—for example,

below knee support stockings or shaped tubigrip.

Secondly, the overall healing rate for their 60 ulcers after 12 weeks' treatment was only 32%. In our health district we have successfully managed a large number of pure venous ulcers and 64 have been the subject to intensive investigation. These were treated with ambulatory compression therapy using tubigrip or elastic stockings, or both, to best suit the individual need of each patient. The ulcer dressings were similarly tailored. Using this regimen 80% of ulcers with deep vein damage healed in a mean time of 11 weeks and 90% of ulcers with only superficial damage healed in a mean time of 10 weeks (Lewis JD, Cornwall JV, presentation at Anglo-French Venous Meeting, 1984). Those patients whose ulcers failed to heal all had fixed ankle joints and muscle wasting.

While we agree with the authors that their suggested method of treatment may reduce demands on the doctor and nurse, we do not believe that it is the best way of treating these patients. We consider that a combination of shaped tubigrip or elastic stockings tailored to the individual need of each patient will heal the majority of venous ulcers within 12 weeks and should be the mainstay of treatment for this condition. Compression bandaging should never be considered for any ulcers of the lower limb.

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- 1 Dale JJ, Callam M, Ruckley CV. How efficient is the compression bandage? *Nursing Times* 1983; November: 49-51.

Cutaneous amoebiasis

SIR,—Mr L Turner and others (7 September, p 635) quite rightly point out the potential for misdiagnosis of this condition, particularly when it occurs after the less common abscess of the left lobe of the liver. However, there are several points that invite comment if misconceptions in diagnosis of amoebic liver abscess are not to be perpetuated.

As any doctor experienced with amoebic liver abscess will relate, classical anchovy sauce pus is far from invariable and yellow, cream, or white pus may be found. The absence of odour is said more reliably to distinguish an amoebic from a bacterial cause.¹ Too much weight should not be placed on the absence of evidence of intestinal disease because a history of diarrhoea or bloody diarrhoea is obtainable in only 50% and 40% of patients respectively¹ and only 60% have either cysts or trophozoites detectable in the stool.² Even wet mount examination of the pus or abscess wall revealed trophozoites in only 50% of some series,¹ and, of course, a Gram stain is unhelpful.

Serological confirmation cannot be entirely relied on, and the more sensitive immunofluorescence, enzyme linked immunosorbent assay, and indirect haemagglutination tests still give 5% false negative rates in the presence of otherwise proved amoebic abscess.³ Finally, applying the epidemiology of this condition to the case presented, young adult men and visitors to the tropics from more temperate climes are among the higher risk groups.¹

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- 1 Barbour GL, Juniper K. A clinical comparison of amoebic and pyogenic abscess of the liver in 66 patients. *Am J Med* 1972;53:323-34.
- 2 Knight R. Amoebic infections. In: Weatherall D, Ledingham J, Warrell D, eds. *Oxford textbook of medicine*. Oxford: Oxford University Press, 1983.
- 3 Krogstad DJ, *et al*. Amoebiasis: epidemiological studies in the United States 1971-1974. *Ann Intern Med* 1978;88:79-98.