LETTERS

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Asian patients' preferences for GPs

Sir,

Dr Ahmad and colleagues (April *Journal*, p.153) provide some interesting data about Asian patients attending a health centre in Bradford. A colleague and I have conducted a personally-administered questionnaire survey of a random sample of Asian women aged between 16 and 50 years in Leicester.[1] Twenty-two per cent of the city's population are of Asian origin or descent.[2] Of the 337 participants, 40% were born in India, 40% in East Africa, 10% in Pakistan, 2% in Bangladesh, 6% in the United Kingdom and 3% elsewhere. Fifty-eight per cent were Hindus, 32% Muslim and 10% Sikhs.

The women were asked their preferences for the gender and ethnic background of their doctor if they were seeking advice on birth control (Table 1). These views were confirmed when some alternative ways of providing contraceptive advice and services were suggested and the women asked whether they would be more likely to use them than their general practitioner or a family planning clinic. An all-female staffed clinic was preferred by 100% of Bangladeshi, 90% of Indian, 88% of Pakistani, 75% of East African and 48% of UK born women. In contrast, an all-Asian staffed clinic received support for 50% of Bangladeshi, 32% of Indian, 21% of Pakistani, 18% of East African and 5% of UK born women.

As our study related to contraception and cervical cytology services, examination by a doctor implied vaginal examination and may well have contributed to the very strong preference for a female doctor, especially among those born in the Indian subcontinent. Certainly, among Leicester's Asian women, the sex of the doctor is seen as more important than ethnic background when seeking advice on family planning. In contrast to the Bradford study we did not find great differences in sex preferences between Pakistani and Indian born women. The fact that our main differences were between those born in the Indian subcontinent and those born in East Africa or the United Kingdom emphasizes the heterogeneity of Britain's Asians, and the risk of generalizing from studies based on single centres.

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References

1. McAvoy BR, Raza R. Asian women: (1) Contraceptive knowledge, attitudes and usage. (2) Contraceptive services and cervical cytology. *Health Trends* 1988; **20**: 11-17.
2. Leicester City Council and Leicestershire County Council. *Survey of Leicester 1983: initial report of the survey.* Leicester: Leicester City and County Council, 1984.

Table 1. Asian women's preferences for sex and ethnic background of doctors providing family planning advice, by women's country of birth.

	Preference for sex			Preference for ethnic background		
Country of birth	Female GP (%)	Male GP (%)	No preference (%)	Asian GP (%)	Non-Asian GP (%)	No preference (%)
India ($n = 134$)	93	1	6	30	22	48
Pakistan ($n = 33$)	88	3	9	33	21	46
Bangladesh ($n = 6$)	100	0	0	50	17	33
East Africa ($n = 134$)	73	3	24	12	25	63
United Kingdom ($n = 21$)	62	19	19	0	33	67

Dangers of intranasal desmopressin for nocturnal enuresis

Sir,

The recent advocacy of desmopressin as an apparently successful treatment for nocturnal enuresis[1] should be noted with caution because of the potential side effects. A recent case has been noted in which a child with cystic fibrosis had a severe adverse response to desmopressin.[2] We wish to report an otherwise normal child who presented with hyponatraemia, a grand mal convulsion, and an acute confusional state associated with an apparently pharmacological dose of desmopressin.

The child, a boy of six and a half years old (weight 20.1 kg) presented with primary enuresis to the enuretic clinic. Treatments wth star charts and imipramine had been unsuccessful. Physical examination and blood pressure were normal, and two mid-stream urine specimens revealed no urinary tract infection. He was treated with intranasal desmopressin via Desmospray (Ferring), one spray in each nostril, before bed and after emptying his bladder, pending supply with an enuretic alarm.

Eight days after starting treatment he was admitted at 14.30 hours with a three hour history of headache initially, followed by vomiting, drowsiness and an episode of loss of consciousness associated with stiffness then loss of tone, eye rolling, foaming at the mouth and incontinence of urine. Subsequent to this episode he was irrational, agitated, not responding to verbal commands. He was treated initially on arrival in casualty with 5 mg of rectal diazepam. He was given a further dose as he was still unresponsive.

On admission his pupils were dilated and reacted sluggishly to light. He was confused and lashing out. His fundi were normal with no evidence of papilloedema. There were no focal neurological signs. A blood sugar level of 6.5 mM was recorded.