General Practice Research Database provides detailed anonymised data

EDITOR,—Congratulations are due to Nicky Pearson and colleagues on their creation of a database of local morbidity data by aggregating the computerised medical records of general practitioners in Somerset.[1] I wish to point out, however, that a large database already exists—namely, the General Practice Research Database, which is owned by the Department of Health; the Office of National Statistics (formerly the Office of Population Censuses and Surveys) is its custodian and operator.

The research database comprises anonymised medical records from general practice on over 3.5 million patients; the records cover about 6.5% of the population of England and Wales and come from around 550 practices.[2] The earliest continuous records date from 1987 and most extend back to 1991, giving over 15 million patient years of observation, with considerable longitudinal value. The data are patient based and include detailed information on prescribing and medical history, including information received by the practices from hospitals. As with the Somerset scheme, the data have been recorded as part of general practice rather than as a special exercise and are subject to a range of quality checks before being loaded into the research database. Several studies have shown the data to be of good quality.[3-5] The database is updated annually.

Data can be provided down to the smallest area that does not permit identification of the individual practice. Thus many health authorities are able to obtain data for commissioning purposes or for research. Because the database holds both therapeutic and diagnostic data at the level of individual patients, more detailed analysis is possible than with the Somerset scheme. Additionally, the General Practice Research Database can provide regional and national baselines for comparative purposes. Use of the database avoids the delay, trouble, and expense incurred in imitating the Somerset morbidity project. The difficult task of finding general practitioners willing to undertake additional work is rendered unnecessary.

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1 Pearson N, Brien JO, Thomas H, Ewings P, Gallier L, Bussey A. Collecting morbidity data in general practice: the Somerset morbidity project. *BMJ* 1996;**312**:1517-20. (15 June.)
2 Hollowell J. The general practice research database: data quality. In: Eames M, ed. *Measuring morbidity and health: what information can general practice deliver?* Hatfield: University of Hertfordshire Press, 1996.
3 Jick H, Jick SS, Derby LE. Validation of information recorded on general practitioner based computerised data resource in the United Kingdom. *BMJ* 1991;**302**:766-8.
4 Jick H, Terris BZ, Derby LE, Jick SS. Further validation of information recorded on a general practitioner based data resource in the United Kingdom. *Pharmacoepidemiol Drug Safety* 1992;**1**:347-9.
5 Van Staa TP, Abenhaim L. The quality of information recorded on a UK database of primary care records: a study of hospitalisations due to hypoglycaemia and other conditions. *Pharmacoepidemiol Drug Safety* 1994;**3**:15-21.

Small children may consume perfumed body sprays after mistaking them for soft drinks

EDITOR,—Cheap perfumes have long been misused as a source of alcohol. Generally they contain 70-80% alcohol by volume, which equates with being 120-140° proof. This high alcohol concentration is necessary because a non-toxic volatile agent is needed to deliver the scent. There have been reports of children

Fig 1—*Distinguishing potentially dangerous perfumed body sprays from soft drinks at first glance is difficult (the body sprays are in the two containers labelled "Tropical")*

consuming mouthwashes, which have a lower but not inconsiderable alcohol content. Consumption of perfumes has not generally been a problem owing to their unpalatable nature.[1] Recently, several perfumed body sprays that bear a remarkable resemblance to soft drinks have come on the market: they have a fruity aroma, and there are fruit motifs on their containers (fig 1). A 2 year old child was seen in our department after consuming the full contents of a 125 ml bottle of perfumed body spray. The child required admission and came to no harm.

The presentation of these perfumed body sprays is a legitimate marketing strategy and has been adopted for several toiletries. Nevertheless, because of the inherent risks it would be prudent for manufacturers to supply these products in childproof containers. At the very least the products should bear a warning label indicating their high alcohol content and danger to children.

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1 Hornfield CS. A report of acute ethanol poisoning in a child: mouthwash versus cologne, perfume and after-shave. *J Toxicol Clin Toxicol* 1992;**30**:115-21.

Blood culture is poor method of confirming pneumococcus as cause of childhood pneumonia

EDITOR,—S K Obaro and colleagues suggest that culture of pneumococci is a reliable method of diagnosis in pneumococcal pneumonia.[1] A recent audit of the investigation and treatment of community acquired pneumonia carried out in our department has shown that the investigation of children is difficult and the diagnostic yield of current tests is low.

In a retrospective study of children admitted with a diagnosis of pneumonia over one year we identified 42 cases, 28 of which were cases of lobar pneumonia. Most of these cases would be expected to be due to pneumococcus. Blood from 32 of the 42 children was cultured, but only one of the cultures was positive for pneumococcus.

A wide range of antibiotics was used to treat the pneumonia. Ten children with lobar pneumonia were treated with cefotaxime and eight with penicillin. The remaining children received a variety of aminopenicillins. Amoxycillin was the most commonly used oral antibiotic. This trend towards use of broad spectrum antibiotics has been documented throughout Britain.[2] Although resistance to penicillin is rising in Britain, it is still relatively uncommon, and we agree that penicillin remains the drug of choice for empirical treatment of lobar pneumonia.[3] There is no evidence that pneumococcus has been superseded as the main cause of lobar pneumonia. In most cases, however, the aetiology is never determined.

Our audit suggests that blood culture is a poor method of confirming that pneumococcus is the cause of childhood pneumonia. Young children cannot produce sputum. Detection of antigen in urine or serum, measurement of the titres of antibodies to the commonest serotypes, and use of the polymerase chain reaction are probably the way forward if we wish to have more rational, narrow spectrum prescribing.

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1 Obaro SK, Monteil MA, Henderson DC. The pneumococcal problem. *BMJ* 1996;**312**:1521- 5. (15 June.)
2 Davey P, Bax R, Newey J, Reeves D, Rutherford D, Slack R, *et al.* Growth in the use of antibiotics in the community in England and Scotland in 1980-93. *BMJ* 1996;**312**:613. (9 March.)
3 Johnson A, Speller D, George R, Domingue MWG. Prevalence of antibiotic resistance and serotypes in pneumococci in England and Wales: results of observational survey in 1990 and 1995. *BMJ* 1996;**312**:1454-6. (8 June.)

Unnecessary words creep in

EDITOR,—Once again—this time in Alexander Dorozynski's news article about French bishops easing the Vatican's ban on the use of condoms—the *BMJ* journal refers to the HIV virus.[1] How can such inaccuracies be stopped? Should all doctors write to their MP parliament, or is it a matter for the GMC council?

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1 Dorozynski A. French bishops ease ban on condoms. *BMJ* 1996;**312**:462. (24 February.)

⁂We regret our misguided reference to the HIV virus, and we apologise to our readers, the BMA association, the WHO organisation, and the DoH department.—EDITOR

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.