

excision or mastectomy for breast cancer is probably at least 20%,<sup>2</sup> and mild discomfort may be experienced even more commonly. The pain is usually a late onset phenomenon, developing anything from a few months to several years after treatment.

This problem is frequently encountered in both hospital and general practice, and failure to recognise the syndrome can lead to much anxiety for the patient and often fruitless and unnecessary investigations.

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## Management of sinusitis

### Is a self limiting condition

EDITOR,—The second summary point in the review on diagnosing and managing sinusitis states that "acute sinusitis should be treated with decongestants and antibiotics for 10-14 days."<sup>1</sup> Such proposals should be founded on clinical trials, but no such trials are mentioned. As far as I know, only three randomised placebo controlled clinical trials of antibiotics in acute maxillary sinusitis have been published; two of them were performed in general practice.<sup>2,4</sup>

The first trial was done in an ear, nose, and throat clinic.<sup>2</sup> Double blinding was incomplete; after 10 days a slight but significant effect of the three antibiotics used was noted. The authors concluded that "the general impression is that therapeutic outcome differs so little among the groups that factors other than the treatment outcome must be more important for the consideration of treatment choice e.g. pharmacokinetics, administration, dosage, treatment cost, number and types of side effects." The trials in general practice were done in the 1970s with doxycycline<sup>3</sup> and ampicillin<sup>4</sup>; there was no clear difference between the effect of antibiotics and placebo.

Acute maxillary sinusitis in primary health care can thus be managed as a self-limiting disease: antibiotics should be considered only for patients at risk or for sinusitis that persists for more than five days.

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### Sinusitis and rhinitis, or rhinosinusitis?

EDITOR,—Kathryn Evans's comprehensive review of sinusitis considers chronic sinusitis to be an infective condition and one that should be distinguished from rhinitis.<sup>1</sup> The distinction between rhinitis and sinusitis is an artificial one. Nasal mucosa is contiguous with sinus mucosa, and pathology of one can be expected to affect the other.<sup>2</sup> The same aetiological classification should be considered for chronic sinusitis as for chronic rhinitis.<sup>3</sup> Consequently, while chronic sinusitis

may be due to infection, with or without predisposing factors, it may be due solely to allergy, structural abnormalities causing epithelial opposition with secondary neurogenic oedema,<sup>4</sup> or a large group considered together at present as "other" disorders. This group includes mucosal hyperreactivity, whether intrinsic or resulting from environmental agents and idiopathic causes, as may also affect the lower respiratory tract. In particular, as well as in the thickened bronchial mucosa of people with asthma, eosinophils have been demonstrated in nasal mucosa from patients with non-allergic, non-infective rhinitis and in sinus mucosa from patients with chronic sinusitis with and without polyps. Of the first 800 patients in our series undergoing endoscopic sinus surgery for chronic rhinosinusitis, 325 (41%) had concurrent intrinsic lower respiratory tract disease, of whom 194 (60%) had asthma. All these conditions may predispose to infection but often cause chronic sinonasal symptoms and abnormalities in computed tomograms without infection.

We do not distinguish rhinitis from sinusitis and we diagnose patients with more than eight weeks of sinonasal symptoms as having chronic rhinosinusitis. This is a spectrum of disease, ranging from predominantly rhinitis to predominantly sinusitis with or without polyposis. Not all patients will present with purulent rhinorrhoea, and we do not advocate routine use of antibiotics. The recurrence of mucosal pathology in 23% of non-polypoid cases of chronic rhinosinusitis after restoration of normal sinus ventilation and mucociliary clearance with medical treatment and functional endoscopic surgery<sup>5</sup> suggests that factors other than infection are solely responsible in many cases.

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## Clinical guidelines

EDITOR,—Gene Feder focuses on the controversies regarding the development and implementation of and adherence to clinical guidelines.<sup>1</sup> A considerable problem arises when more than one guideline exists for the same clinical activity. Guidelines on the interval at which cervical screening should be carried out are an obvious example.

In 1988 a health circular on cervical screening issued by the Department of Health and Social Security suggested that all women aged 20 to 64 should be invited for screening and that they should be recalled at least every five years. Although the circular expired on 31 December 1992, the computers of most family health services authorities are still set to recall women every five years and a large proportion of general practitioners screen women at five year intervals when previous smears have yielded no abnormality.

A report of the Intercollegiate Working Party on Cervical Cytology Screening in 1987 recommended three yearly screening.<sup>3</sup> Guidelines produced under the auspices of the National Coordinating Network also suggested three yearly screening in women between 20 and 64.<sup>4</sup> Recommendations of the

intercollegiate working party are largely followed in hospital practice. Contradictory advice about the interval for screening leaves many women confused and is unlikely to improve compliance with the screening programme.

In the absence of a national consensus an agreed policy is needed, at least at district level, on such basic issues. All concerned need to be made aware of the existence of such a policy; only then can adherence to it be monitored.

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## Treatment for oesophageal achalasia

EDITOR,—The fact that a patient with a huge air filled oesophagus due to achalasia, reported on in *Minerva*, died after seven months from rupture of the oesophagus having declined surgery is regrettable.<sup>1</sup> He might have been simply and effectively treated by peroral balloon dilatation of the cardia.<sup>2</sup>

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## Measuring visual acuity in general practice

### Agreement is needed on what constitutes acceptable primary ophthalmic care

EDITOR,—J C Pandit's short paper on the measurement of visual acuity in general practice apparently shows the inadequacies of general practice in reaching acceptable standards of care.<sup>1</sup> The real issue, however, is what should be expected of ophthalmological assessment in primary care. This issue will not be resolved by confrontational or adversarial attitudes between primary and secondary care. Perhaps the Royal Colleges of Ophthalmologists and General Practitioners should agree on what constitutes acceptable primary ophthalmic care and how this may be achieved. What standards should be met, and what skills should a general practitioner have? When should these skills be taught, by whom, and in what setting? Should the system change to permit direct referral to ophthalmologists by optometrists?

General practitioners' confidence in dealing with eye problems has been shown to be low,<sup>2,3</sup> but why this is so and how confidence could be improved are not known. A recent review discussed how general practitioners may improve detection and treatment of visual failure and suggested that change may be brought about by more formalised training and more delegation to others.<sup>4</sup>

A study from Nottingham found that general practitioners measured the visual acuity in only a tenth of patients with eye problems,<sup>2</sup> making it difficult to interpret the importance of Pandit's findings. Measurement of visual acuity, although