

regarded as part of the workload. Problems can arise with such a service. Patients may be unable to get through on the telephone. They may justifiably become irritated if kept waiting, especially if they are telephoning from a call box or abroad and incur unnecessary expense. A policy must be agreed for patients who fail to telephone for results. Finally, the sifting out of patients who are quick and easy to deal with means that only patients with more complicated problems attend for follow up, which increases the consultation time.

Overall our patients appreciate the service. Most of them are young, fit, and in employment, and some are prepared to travel long distances to use the confidential service provided by a genitourinary medicine clinic. Reducing the number of visits to the clinic saves them time and money. Furthermore, if follow up by telephone was unavailable resources would have to be found to see these patients in the clinic. We think that more clinicians and patients could benefit from our experience.

A J ROBINSON Consultant	E ALLASON-JONES Clinical director
C SHERGOLD Information manager	P FRENCH Consultant

Department of Genitourinary Medicine/HIV/AIDS,
Mortimer Market Centre,
London WC1E 6AU

1 Rao JN. Follow up by telephone. *BMJ* 1994;309:1527-8. (10 December.)

2 Monks A, Thin N, Trotter S, Pryce D. Report of the working group to examine workloads in genito urinary medicine clinics. London: Department of Health, 1988:20.

Phone clinic provides excellent support

EDITOR,—It is not only the United States that has implemented the idea of following up carefully defined groups of patients by telephone.¹ We have started what we call a "phone clinic" to follow up patients with cancer shortly after they have completed treatment, which aims at replacing a routine outpatient visit. We have shown that the phone clinic provides excellent support and effective medical surveillance in a defined situation in oncological follow up and has resulted in a decrease in medical outpatient attendances, which has allowed time for medical consultation targeted at patients in greatest need.²

We do not share Jammi Nagaraj Rao's view of the staff necessary for phone contact.¹ With proper planning, training, and record keeping it was not necessary for the phone clinic to be manned by senior medical staff. An experienced and trained nurse practitioner may enhance the service for patients with cancer as a high proportion of the patients need advice on support services not frequently offered by medical staff. There was no evidence of any adverse effects on medical care. Compliance and satisfaction among patients were high as none of the patients requested medical consultation.

Before too many phone clinics are established in place of routine outpatient follow up, however, we should ask whether the follow up is necessary at all. The answer will become apparent only from detailed examination of the content and outcome of routine follow up appointments; in many specialties, including oncology, the quest for this information is only just beginning.

MICHAEL BRADA
Senior lecturer in radiotherapy and oncology

Royal Marsden Hospital and Institute of Cancer Research,
Sutton, Surrey SM2 5PT

NICHOLAS D JAMES
Senior lecturer in clinical oncology

CRC Institute for Cancer Studies,
Queen Elizabeth Hospital,
Birmingham B15 2TH

1 Rao JN. Follow up by telephone. *BMJ* 1994;309:1527-8. (10 December.)

2 James ND, Guerrero D, Brada M. Who should follow-up cancer patients? Nurse specialist based outpatient care and the introduction of a phone clinic system. *Clin Oncol* 1994;6:283-7.

Side effect of quinine for nocturnal cramps

EDITOR,—Malcolm Man-Son-Hing and George Wells report a meta-analysis of the use of quinine for nocturnal night cramps in elderly people.¹ I wish to draw attention to lichenoid photosensitivity related to quinine, which is a poorly recognised but, I suspect, a relatively common side effect of this treatment. I first became aware of it in 1982, and until my retirement in 1991 I saw nine patients affected by it. All were elderly women taking quinine for nocturnal cramps. I have reported five of these cases previously.² The following points are worth emphasising: all nine patients had lesions on the dorsa of the hands (figure); none of the patients



Lichenoid photosensitivity related to quinine in 70 year old woman

initially associated the skin eruption with quinine, and most could be persuaded of the association only with difficulty; and the eruption cleared in all cases when quinine was withdrawn.

T A J DAWSON
Retired consultant dermatologist

Portadown,
Craigavon,
County Armagh BT63 5SF

1 Man-Son-Hing M, Wells G. Meta-analysis of efficacy of quinine for treatment of nocturnal leg cramps in elderly people. *BMJ* 1995;310:13-7. (7 January.)

2 Dawson TAJ. Quinine lichenoid photosensitivity. *Clin Exp Dermatol* 1986;11:670-1.

Liver biopsy

Interventional radiology teams can provide prompt analgesia and care monitoring

EDITOR,—In their editorial on whether ultrasound guidance for percutaneous liver biopsy is appropriate Guy Vautier and colleagues comment that "the biopsy is usually done in a radiology department, which means that the patient would be waiting to return to a ward without being observed."¹ We agree that it is inappropriate to leave patients unobserved after percutaneous liver biopsy, particularly because at least 60% of complications occur soon after the procedure is completed.²

We believe that observation and monitoring of patients after percutaneous liver biopsy are an integral part of the procedure. In our institution liver biopsies on thin, cooperative patients are performed in the wards by the gastroenterologists. Biopsies are performed in the radiology department on patients in whom they are likely to be difficult (because of obesity, variant anatomy, a small liver, or reduced cooperation) or who are likely to develop complications.

One of the advantages of performing liver biopsies under ultrasound guidance in the interventional procedures area of a radiology department is the presence of a dedicated nursing and radiological staff, who are well trained and experienced in monitoring and resuscitating patients. This dedicated monitoring is rarely available in busy medical wards but is vitally important in the

early recognition of complications. The presence of the patient in the radiology department ensures a rapid diagnostic evaluation (by ultrasonography or computed tomography) of any suspected complications if clinically appropriate. In our radiology department, patients who have had liver biopsies are closely monitored in the interventional radiology area immediately after the biopsy. Later they are accompanied back to the ward or short stay unit by a nurse for further observation.

The authors also state that guided biopsies require more resources than blind biopsies in terms of trained staff. We believe that a procedure in which up to a quarter of patients experience pain¹ demands appreciable clinical support. In our practice, patients who complain of pain during or immediately after liver biopsy guided by ultrasonography receive prompt analgesia. This is prescribed and supervised by the interventional radiologist and given by the radiology nurse. The choices of drug and dosage are based on the patient's body weight and clinical condition. Complications are dealt with in conjunction with the referring clinician.

We agree with the authors that certain criteria must be met when a decision is made on where percutaneous liver biopsies should be performed; these include suitable training of operators and appropriate care after the procedure. The ready availability of suitably monitored analgesia should also be considered. The implication that radiology is unable to meet these criteria is an oversimplification. The advent of dedicated interventional radiology teams has provided an environment in which pain and complications after procedures can be minimised. The inclusion of an experienced nurse in the team also allows for excellent monitoring of patients both during the procedure and immediately after. These features are particularly important in patients who are at high risk of complications.

R FARROW
Clinical fellow
D E MALONE
Associate professor
G W STEVENSON
Professor

Department of Radiology,
McMaster University Medical Centre,
Hamilton, Ontario L8N 3Z5,
Canada

1 Vautier G, Scott B, Jenkins D. Liver biopsy: blind or guided? *BMJ* 1994;309:1455-6. (3 December.)

2 Piccinino F, Sagnelli E, Pasquale G, Giusti G. Complications following percutaneous liver biopsy, a multicentre retrospective study on 68,276 biopsies. *J Hepatol* 1986;2:165-73.

Require imaging guidance

EDITOR,—We were amused by Guy Vautier and colleagues' efforts to justify the continued use of blind liver biopsies and by their assertion that "the ideal biopsy may be one that is performed in the ward by the gastroenterologist using ultrasonographic guidance."¹ We believe that this is an issue in which the advantages of one option are so self evident that there is no justification for the large scale randomised trial suggested by the authors. In our opinion all biopsies should be performed by expert operators using imaging guidance, and nowadays few hospitals do not have the required skill—in the radiology department.

In our practice liver biopsies are performed as part of a routine ultrasonography list, taking no more than 20 minutes; are as atraumatic for the patient as is possible; have caused no important complication in eight years; and, when automatic biopsy guns are used, uniformly provide diagnostic samples. Direct ultrasonographic visualisation ensures that the needle is nowhere near the gall bladder or major vessels as the needle can be watched within the liver throughout the biopsy. Our patients are never left unobserved "while waiting to return to the ward"; this is a matter of good nursing organisation.