

# Letters to the Editor

## A change of government and its effect on the NHS hospital outpatient service

We reported an apparently intractable defaulting rate from new consultant clinic appointments, close to the national average (May/June 1997, page 340). Between May 1994 and January 1997, 127/1,123 (11.3%) appointments were not kept, with a non-significant fluctuation of rates between 9.8% and 13.6% in different periods sampled. This did not change materially between January 1997 and 1st May 1997 with 11/121 (9.1%) defaulters.

However, the last five months have seen a sharp fall to 11/178 (5.6%) defaulters. This is significantly different from the combined previous experience ( $\chi^2 = 5.43$ ,  $p < 0.02$ ), but was an apparently spontaneous change.

Can anyone suggest a likely cause?

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## Wegener's granulomatosis from infancy to adolescence

Editor – An article addressing age-related variations within a single disease (July/August 1997, pages 396–400) should not omit childhood and adolescence. Wegener's granulomatosis does present throughout the age spectrum and this needs to be highlighted, not only to physicians caring for the elderly, but also those who care for the young. Infants as young as three months have been reported with Wegener's granulomatosis<sup>1</sup>. I currently care for an eight-year old boy with the disease which presented at the age of four with severe

anaemia and progressed to respiratory disease that has required ventilation. Treatment including pulse intravenous cyclophosphamide, prednisolone and Co-trimoxazole has controlled his disease. These children enter adulthood with a legacy of such treatment, and adult physicians then take on their late management. Physicians, whether covering the paediatric, adult or elderly spectrum all need to be aware of Wegener's granulomatosis, however rare it might be in certain age groups.

## Reference

- 1 Dillon MJ. Vasculitic Syndromes. In: Woo P (ed). *Paediatric Rheumatology Update*. Oxford: Oxford University Press, 1990.

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## In response

I thank Dr Venning for raising a very important point that has not been adequately mentioned in the article, mostly because we did not identify any paediatric patients in our series.

Although we did not specifically consult individual paediatricians in the process of data collection, the source of data we used monitors all hospitals including paediatric departments, hence it is unlikely that we missed any younger patients with a diagnosis of Wegener's granulomatosis (WG) during the period under study.

In a study by Rottem *et al* comparing childhood onset with adult onset WG, treatment related permanent morbidity occurred in 22% of childhood onset illness compared to 45% of adult onset, but cyclophosphamide related malignancies were less likely in childhood onset patients (0% vs

11%). However, since morbidity and mortality are still considerable<sup>2</sup> a close long-term follow-up should be kept of successfully treated children with WG as they enter adult life.

## References

- 1 Rottem M, *et al*. Wegener's granulomatosis in children and adolescents: clinical presentation and outcome. *J Pediatrics* 1993;122:26–31.
- 2 Dillon MJ. Systemic vasculitis. (Review). *Clinical and Experimental Rheumatology* 1993;11 (Suppl 9):S19–S21.

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## Cardiological examinations

Editor – During examination of the cardiovascular system it is useful to note the effects of inspiration and expiration on several variables including the splitting of the second heart sound, and the intensity of the heart murmurs. These phenomena are related to the effects of increasing and decreasing intra-thoracic pressure. By decreasing intra-thoracic pressure during inspiration, right-sided filling increases, and consequently right-sided murmurs increase in intensity, left-sided murmurs decrease in intensity, and in normal subjects, the second sound becomes more widely split. The situation is reversed during expiration when intra-thoracic pressure increases.

This manoeuvre is widely practiced by both students preparing for their final MB examinations, and by those preparing for the clinical part of the MRCP examinations. However, the technique used by the vast majority of such students and doctors is uniformly incorrect. The clinical information thus obtained is of no use, and in some cases may lead to errors in diagnosis. Most physicians and trainee physicians ask the patient to 'breath in', and at the end of the inspiration, to 'stop'. The auscultatory findings thence obtained



are said to be those 'in inspiration' and when asked the significance of such findings the examiner replies: 'the right-sided murmurs are louder in inspiration'. Clearly this is incorrect since, when the breath is held in inspiration, intra-thoracic pressure increases, venous return to the right heart decreases, and right-sided murmurs will decrease in intensity. Thus the conclusions drawn are the exact opposite (ie an increase rather than a decrease in

intra-thoracic pressure). The error is then repeated with the breath held in expiration, with erroneous conclusions being drawn about left-sided murmurs.

The technique is one of the mainstays of cardiovascular examination and yet is incorrectly applied by many physicians and students. The confusion appears to arise as a result of mistaking the words 'during inspiration/expiration' for 'in inspiration/expira-

tion'. Despite advances in the application and availability of cardiovascular imaging techniques, a detailed history and examination are the cornerstones of diagnosis. It is a great shame to witness the widespread misuse of a basic physiological manoeuvre in the interpretation of physical signs.

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## Erratum

### Model for the organisation of a community-based rehabilitation service

The above-titled report was published in the previous issue of the *Journal* (Vol 31, No 5 pp 503-5, September/October 1997). The part of Figure 1 concerned with funding (see shaded rectangle) was inadvertently missed out and the complete Figure has therefore been reprinted below.

**Fig 1.** A proposed model for a multi-agency community-based rehabilitation team and its interface with hospital and primary care services

