from the Aylesbury spatula had none; four of the smears taken with the cervix brush and the corresponding Aylesbury spatula specimens contained no endocervical cells. The remaining 44 pairs of results had endocervical cells present in both the cervix brush and the Aylesbury spatula smears. All 100 smears were adequate for screening, with the comment that the cervix brush specimens had noticeable amounts of blood present. This was also observed by the practice nurse, who said the cervix brush caused patients to bleed on contact.

Our conclusions therefore were that the Aylesbury spatula was equally effective as the cervix brush, and that on a cost basis, it was preferable.

FRAN BISHOP
DUNCAN WATNEY

Saxonbury House
Croft Road, Crowborough
East Sussex TN6 1DP

Sir,

In its paper on sampling endocervical cells on cervical smears the Cumbrian practice research group makes assumptions which are not backed by the facts (May *Journal,* p.192).

We all know that screening for cervical cancer has one major flaw; it is not reaching older women. To spend time and money on a minor aspect of technique is not sensible.

The research group is concerned about patient anxiety and inconvenience when cervical smears have to be repeated because the laboratory reports no endocervical cells, and repeat tests cost money too. However, if I get a good view of the cervix and rotate the spatula through 360 degrees I am satisfied that I have obtained a satisfactory smear. I only repeat the test earlier than usual if the smear is abnormal or cannot be interpreted. I am supported in this policy by the British Society for Clinical Cytology and the British Society for Colposcopy and Cervical Pathology in a statement quoted in the April 1990 issue of the *Journal.*[1]

Why did the research group ignore this statement? They presented the familiar idea that early diagnosis and treatment are of benefit, but that is very far from clear. Finally, they did not state that use of the cervix brush has yet to show any meaningful results in terms of mortality figures.

DECLAN FOX

Little Pubble, 2A Bunderg Road
Newtonstewart, Co Tyrone BT78 4NQ

Reference

1. McGhee MF. No endocervical cells: an update [letter]. *Br J Gen Pract* 1990; **40:** 168.

Management of weight problems

Sir,

In a recent paper on the management of weight problems (April *Journal,* p.147), the authors commented that general practitioners 'felt they had little success in achieving weight loss in patients'. This may be because, unknown to the general practitioner, the patient is also attending a private slimming clinic, and the medication and advice he or she is receiving there is undermining the general practitioner's treatment.

A few years ago, I worked in a private slimming clinic. The mainstay of the treatment was then, and still is, appetite suppressant drugs. Patients knew this, and expected to be prescribed the drugs. We asked all new attenders whether they would like us to inform their general practitioners that they were attending the slimming clinic, and what medication we had prescribed. Ninety per cent of patients did not want their general practitioner informed, presumably because they thought he or she would disapprove. Many patients had already consulted their general practitioner about their weight problem, and had not been prescribed appetite suppressants.

Centrally acting appetite suppressants do not improve the long term outlook in obesity[1] and may undermine the effectiveness of behaviour therapy.[2] However, they are advertised to the public as 'medically supervised weight loss'.

If a patient fails to lose weight despite dietary advice, enquire tactfully as to the kind of help they want, and whether they have sought help elsewhere. You may receive some surprising answers.

PETER GRAY

21 Burgess Avenue
Kingsbury, London NW9 8TX

References

1. Centrally acting appetite suppressants. *British national formulary. Number 21.* London: British Medical Association and the Royal Pharmaceutical Society of Great Britain, 1991: 150.
2. Managing obesity successfully. *Drug Ther Bull* 1989; **27:** 33-36.

Patient participation groups

Sir,

I have read with interest the article entitled 'Patient participation in general practice: who participates?' (May *Journal,* p.198) and would like to comment on some of the points made. As chairman of the Berinsfield patient participation group for some years until 1990, I can speak with some knowledge and am sorry that none of the many achievements of the group have been acknowledged or even mentioned. In the early days of the group's existence attendance at the meetings was very much higher than reported in the paper and many more local organizations were represented. Difficulties experienced by patients and their comments and criticisms of the practice were aired, and after extensive discussion, were resolved. The present degree of satisfactory relationship between doctors, nurses, receptionists and patients owes much to these early discussions. One example in particular where discussion proved valuable was the wording of a letter to women patients regarding the cervical smear test, when an earlier letter from the practice elicited a poor response because of insensitive wording.

The writers of the article in the *Journal* may not be aware of the extent to which discussions at the patient participation group meetings filter down to patients in the area. It matters not whether the representative is of social class 1, 2, 3 or 4, but whether he or she is articulate and conscientious enough to pass on what is relevant. By the very nature of things it is reasonable to accept a lower turnout at meetings now, since as I indicated earlier, many of the original difficulties experienced by patients in the practice have been ironed out. Present meetings are very useful and must continue, so that any changes in the practice may be notified to patients, particularly at the present time when there is so much concern over the future of the National Health Service.

MARGARET ALLEN

Chilterns, Thame Road
Warborough, Oxfordshire OX10 7DS

Irritable bowel syndrome

Sir,

A retrospective study of problem oriented profiles of patients with irritable bowel syndrome in my practice yielded the interesting finding of a close association with spondylosis and regional pain syndrome. Perhaps practices using a computerized problem oriented system would be able to check to see if this is merely an artefact in my recording.

I would be most grateful to hear from any practices that could assist in this matter.

JOHN GOWEN

Strand House
South Abbey, Youghal
County Cork
Republic of Ireland