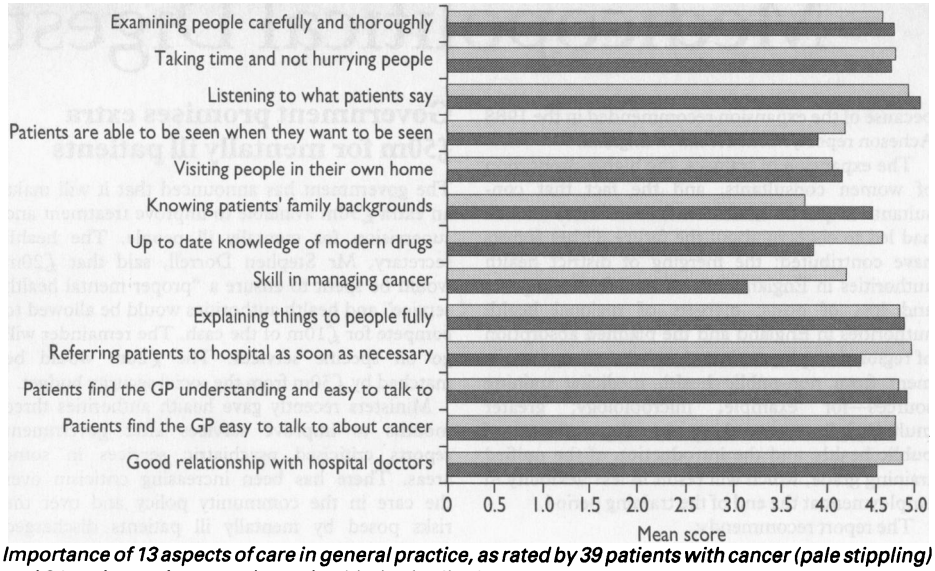

Importance of 13 aspects of care in general practice, as rated by 39 patients with cancer (pale stippling) and 34 registrars in general practice (dark stippling)

primary care and patients regarding the fulfilment of optimum follow up.

The trainees in general practice showed an awareness that follow up does not influence survival, and their view of the usefulness of skill in the management of cancer may be the more rational approach. But for patients entrenched in the system of hospital follow up, specialist knowledge and clinical examination are the sources from which reassurance is derived.

The present system of follow up in breast cancer maintains the myth that lives are thereby saved and emphasises to the patients that the doctor is actively seeking to find a recurrence. Little wonder that women value skill in cancer and fast track referral to hospital oncology services. Is this the way to build up coping strategies or to rehabilitate and empower women? If we are to develop a follow up programme flexible enough to meet individual patients' needs these issues need to be addressed.

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Nurse triage may reduce workload in accident department

EDITOR,—We read the editorial by Andrew B Bindman[1] and the two articles by Jeremy Dale and colleagues[2,3] on triage in accident and emergency departments with interest. With the ever increasing number of patients presenting to accident and emergency departments, a stricter triage system and, perhaps, a new approach to deal with the problems are needed. As Bindman suggests, there can be no gold standard for determining the appropriateness of visits, and accurate triage guidelines are impossible to develop.

At Liverpool we now have a new, amalgamated ophthalmic primary care department, which has replaced the ophthalmic accident and emergency department and caters for all ophthalmic accidents and emergencies as well as providing a service for patients with less urgent needs. Such an amalgamated unit would certainly reflect the philosophy of the report of the royal commission on the NHS quoted by Dale and colleagues.[4] Given general practitioners' low level of undergraduate training and postgraduate experience in specialties such as ophthalmology, traditionally the primary care in such branches is provided almost entirely by accident and emergency departments.

A recent audit showed that only 15% of patients attending our ophthalmic department were true emergencies. In our triaging system a short nursing history is supplemented by some objective tests, such as assessment of visual acuity and measurement of intraocular pressures, to increase the accuracy of triage. If the triage nurse deems the problem to be non-urgent the patient, whether self referred or referred by a general practitioner, is either seen by a doctor on the same day (if staffing permits) or given an appointment for a primary care clinic. A nurse practitioner can be of immense help in reducing the workload and waiting times in an accident and emergency department. We believe that a prospective study is warranted to elucidate the effectiveness of nurse practitioners in these departments.

In both of Dale and colleagues' studies most of the workload was shared among the senior house officers. A better mix of staff, with more senior medical staff, might contribute to a more efficient primary care setting. It is interesting to learn that employing a general practitioner in an accident and emergency department resulted in reduced rates of investigations, prescriptions, and referrals. Such a move in specialty accident and emergency departments has the potential to improve the quality of primary care in the community for patients with problems that would be otherwise referred to hospital specialists.

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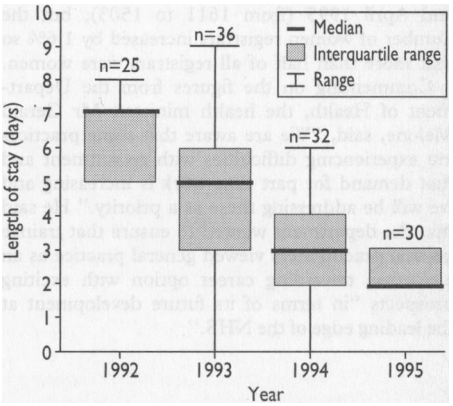
Strengths of carotid endarterectomy were understated

EDITOR,—We take issue with some of the statements that Wendy Taylor and Georges Rodesch make about carotid endarterectomy in their article on interventional neuroradiology.[1] They state that one of the advantages of carotid angioplasty over surgical removal of the plaque is that general anaesthesia is unnecessary. Most carotid endarterectomies are performed under general anaesthesia in Britain, though the operation can be done under local anaesthesia and this is common in the United States and South America. The authors also state that there is a 1-2% risk of complications with angiography. While angiography is unavoidable with carotid angioplasty, many centres in Britain are happy to undertake surgery on the basis of Duplex scanning alone.

The authors state that the patients' stay is shorter with angioplasty than with surgical endarterectomy but do not give any figures or references for this statement. At Guy's Hospital we have analysed the length of stay of patients having carotid endarterectomies over the past four years. The figure shows that the median length of stay has fallen from seven days in 1992 to two days in 1995.



Length of stay after carotid endarterectomy, Guy's Hospital, 1992-5

Four of the 123 patients developed complications: all four had strokes, which were permanent in two. No deaths occurred. A recent survey of a broad range of surgeons by the Vascular Surgical Society showed much lower complication rates than those quoted from the European and North American symptomatic carotid endarterectomy trials.

One further point not alluded to in the article is the considerable residual stenosis and the clinical consequences of this after balloon angioplasty.

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