Extracutaneous referrals have recently exposed a growing interest among general practitioners, psychologists, and community psychiatric nurses for specialist counselling services.

In our experience accurate data on extracutaneous referrals can be collected rapidly, are relatively simple to analyse, and give procedure specific details and the possibility of case by case validation. A crude statistic on extracutaneous referrals can be interpreted in a variety of ways. It is most useful when regarded as one piece of a jigsaw of evidence concerning services and interpreted in a context that includes clinical advice. Extracutaneous referrals offer purchasers an easy way to tap into the local general practitioners' and hospital consultants' "bush telegraph" concerning the range and quality of clinical services and the views of patients as interpreted by their doctors. Extracutaneous referrals should therefore be recognised as valuable nuggets of audit information. Rather than being a foe to the accountant, each extracutaneous referral can be a friend to the purchaser of better quality health services.

Measles data are reliable

Editor,—Nigel Higon claims that the only source of data on measles cases which has remained consistent before and after the measles-rubella campaign is statutory notification and that numbers of notified cases have shown little decline.1 As he admits, numbers becomes less reliable than cases confirmed by saliva testing, but this service was not widely available before the campaign. The saliva assay, however, was extensively piloted in 18 districts of the United Kingdom between October 1991 and October 1994.1 During this pilot 36-38% of patients with measles tested were IgM positive,2 suggesting recent infection, compared to only 4% of patients tested since the campaign. Since November 1994, saliva samples have been tested in over 50% of notified cases and the proportion that is IgM positive has fallen with time (table).

In addition, measles cases confirmed by serology, isolation, or antigen detection have been reported to the Communicable Disease Surveillance Centre by laboratories in England and Wales for over 20 years. Unlike notifications, the number of laboratory reports has fallen dramatically, from 224 cases reported with sample dates between 1 January and 31 May in 1994 compared with only 52 in the same period of 1995. Many of the 1995 cases occurred during late 1994 and early 1995, when the full effect of the campaign had not been felt—only four cases have been reported with sample dates during May 1995.

Both data sources clearly indicate that measles transmission has been substantially reduced by the vaccination campaign, in particular in 5-16 year olds—the age group targeted.3 Small numbers of measles cases are still being confirmed in preschool children and in unvaccinated adults, and at least four recent infections seem to have been contracted abroad. A comprehensive surveillance programme for measles is now established and will allow us to monitor the longer term effects of the measles-rubella campaign and to define future vaccination policy in England and Wales.

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Treatment of children with asthma

Entrust parents with "crisis pack" of steroids

Editor,—In their excellent and comprehensive account of treating asthmatic children John Rees and John Price rightly emphasise the importance of "partnership in management" and "self management plans," including "an agreed action plan of what to do...if the child has an acute asthma attack."1 However, in the subsequent part of the article dealing with acute severe asthma, the principle of partnership with parents seems to extend only as far as giving four hourly relief medication (dose not specified) and calling a doctor if there is no improvement. The adjacent paragraph refers to the need for a large dose of a β stimulant bronchodilator and considering starting oral prednisolone, treatment that most readers will interpret as restricted to a doctor rather than a parent. Surely any parent who is fit to be entrusted with the overall care of a child is also fit to be entrusted with these forms of treatment, which can be started early in an attack and can often obviate the need for any medical involvement. There are often difficulties and delays in seeing a doctor, even in Britain, and the increasing number of families taking holidays abroad and in remote places is a strong argument for us trying to increase families' self reliance and reduce dependence on doctors.

For the past 10 years I have given a "crisis pack" of steroids to all the parents of asthmatic children on my list. If sufficient time is taken to supplement good written information, most families develop the confidence to use short courses of oral prednisolone very judiciously. Obviously, the concept of self reliance could be taken too far, and parents need to be told to seek medical help if the crisis pack is not working. In these circumstances, I prefer to give parents free access to our paediatric ward, as calling the general practitioner is unnecessarily onerous and only leads to delay in admission.

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Managing the complications of childhood arthritis

Editor,—I agree with Aideen Landers that the recommendations for ocular slit lamp screening are confusing.1 The most important points to emphasise are that children with juvenile chronic arthritis are at greater risk of developing asymptomatic chronic anterior uveitis than the normal population and that irreversible complications may be prevented if the uveitis is detected early by slit lamp examination and treated effectively. Landers cited the guidelines for slit lamp screening issued by the working party of the Royal College of Ophthalmologists and the British Paediatric Association,1 but unfortunately these guidelines do not seem to take into account two key questions.

Firstly, how quickly can irreversible visual impairment occur, and how soon after the onset of chronic anterior uveitis? This should determine the frequency of screening for at risk children. Irreversible complications are likely to occur if the chronic anterior uveitis is untreated for longer than six months (this is based on case report evidence only). Annual screening would not seem sensible for any child with arthritis.

1 Landers A. Ocular slit lamp screening. BMJ 1995;311:784. (8 June.)