

their general practitioner. Taking into consideration the points already made about possible reasons for their visit to the department and the general nature of the question asked, the figure does not seem to differ from that found in other studies.²

The study asked a vague general question about consultations with a general practitioner before the visit to the accident and emergency department and consequently got vague general data, from which no conclusions can be drawn. Perhaps more disturbing is the implied criticism of general practitioners' diagnostic ability. I hope that I am being hypersensitive after my second 120 hour week this month and that no such criticism was meant.

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- 1 Nguyen-Van-Tam JS, Baker DM. General practice and accident and emergency department care: does the patient know best? *BMJ* 1992;305:157-8. (18 July.)
- 2 Davidson AG, Hildrey ACC, Flayer MA. Use and misuse of an accident and emergency department in the east end of London. *J R Soc Med* 1983;76:37-40.

EDITOR,—Purchasers and providers will be interested in the economic implications of Nguyen-Van-Tam and Baker's findings. The study does not help in deciding whether the answer is to provide better education for general practitioners, to have more experienced doctors on duty at all times in accident and emergency departments, or to take steps to prevent unnecessary self referral. A study comparing the original general practitioner's decision not to refer with a measure of the appropriateness of the admission would be interesting.

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- 1 Nguyen-Van-Tam JS, Baker DM. General practice and accident and emergency department care: does the patient know best? *BMJ* 1992;305:157-8. (18 July.)

AUTHORS' REPLY,—The use and abuse of accident and emergency departments clearly remains an emotive, important, and controversial subject. We showed that, in Nottingham, adults with a given complaint who have seen their general practitioner before they refer themselves to an accident and emergency department are just as likely to be admitted as other attenders; thus we caution against any scepticism that may be directed towards them in the casualty department. Though Michael Dixon reasonably suggests that patients can "wind up" doctors into admitting them, it is unreasonable to assume that this occurred more commonly in one particular group of attenders in our study; thus its effect is unlikely to have altered our conclusions.

Inevitably, not all emergency admissions are appropriate, nor are they all admissions of seriously ill patients; in Nottingham, however, the decision to admit each patient lies ultimately with those firms on take and not, as R M Ridsdill Smith suggests, with a casualty officer who is playing safe. It is usually a senior house officer or registrar from the on take firm who deals with referrals from casualty, and it is perhaps easier for him or her to decline potential admissions than it is for the house officer accepting calls directly from general practitioners who might also, quite correctly, be playing safe. We remain convinced that in this particular circumstance admission rates are a reasonable proxy of ill health since the factors that may constrain their validity (many of which have been mentioned in the correspondence) apply equally well to patients referred from all sources.

The time that elapsed between the consultation

in general practice and self referral to casualty is not as relevant as has been suggested; patients can choose to reconsult their general practitioner at any time in the event of deterioration, and emergency admission can be arranged directly with on take firms. Despite any delays the patients we describe should not encounter scepticism from staff in casualty when they present.

We did not take issue with general practitioners referring patients to casualty and did not use our findings to pass judgment on those who do this. Furthermore, we did not attempt to give elaborate explanations for our findings; no criticism of general practitioners' diagnostic abilities is implied, although, as with all epidemiological studies, there are many ways of interpreting the results.

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"Barfly" injuries

EDITOR,—A new sport has joined the list of so called safe activities. "Barfly" jumping entails dressing in a Velcro suit, leaping from a trampet, and attempting to stick oneself against a Velcro wall (often upside down).

A 42 year old woman recently presented to the trauma service four days after becoming "unstuck" on the wall, while upside down, and sustaining a forced flexion injury of her neck. At presentation she complained of increasing pain in the lower part of the neck and paraesthesia of both arms. The lower cervical spine was tender on palpation, but there was no objective neurological deficit. Plain radiography and computed tomography showed an unstable compression injury of C6 and C7, with subluxation of both facet joints and fracture of the C6 spinous process. She was treated with halo traction to reduce the subluxation, and a successful posterior fusion of C6 and C7 was performed. She was discharged home on the seventh postoperative day.

When we contacted several large life insurance companies we found that if this patient had sustained a fatal injury from such an activity only half would have paid out on her life insurance policy.

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Oesophageal atresia mistaken for anorexia nervosa

EDITOR,—P D Duane and colleagues present a cautionary tale of mistaken diagnosis—achalasia mistaken for anorexia nervosa in emaciated young women—and point out that their patients lacked the distorted body image and fear of fatness so characteristic of primary anorexia nervosa.¹

Their story captures the essence of Gull's remarks at the BMA's annual meeting in 1868 when he first referred to the condition he then called hysteric aepsia,² but later called anorexia nervosa.³ He spoke of the need to diagnose medical conditions by their "cardinal facts" and said, "We avoid the error of supposing mesenteric disease in young women emaciated to the last degree through hysteric aepsia, by our knowledge of the latter affection, and by the absence of tubercular disease elsewhere." Doctors now should try to avoid the error of supposing anorexia nervosa in young women emaciated from mesenteric disease by their

knowledge of anorexia nervosa and the absence of its cardinal facts.

When Gull made his presentation to the Clinical Society and first used the term anorexia nervosa he had to deal with his audience's perception that localised oesophageal disease was the cause of the syndrome.⁴ One of his listeners remarked that "twenty years ago these cases used to be sent to Mr MacKenzie"—the English laryngologist who figured so prominently in the unfortunate affair of Crown Prince Frederick of Germany's throat cancer.

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- 1 Duane PD, Magee TM, Alexander MS, Heatley RV, Losovsky MS. Oesophageal achalasia in adolescent women mistaken for anorexia nervosa. *BMJ* 1992;305:43. (4 July.)
- 2 Gull WW. The address in medicine delivered before the annual meeting of the BMA at Oxford. *Lancet* 1868;ii:171.
- 3 Gull WW. Anorexia nervosa. *Transactions of the Clinical Society of London* 1874;7:22-8.
- 4 Clinical Society. *Medical Times and Gazette* 1873;2:534-6.

EDITOR,—P D Duane and colleagues report two cases of oesophageal achalasia in adolescent women that were mistaken for anorexia nervosa.¹ Over 14 years 38 patients with achalasia were referred to me; in two of these patients doctors incorrectly diagnosed anorexia nervosa for two years and four years respectively. Both patients, who were teenage girls, responded well to treatment.

Unlike in Duane and colleagues' cases the symptom of dysphagia had not been recognised. Neither patient had been identified as having a fear of weight gain. In both cases spontaneous regurgitation had been interpreted as self induced vomiting. No gastrointestinal investigations had therefore been performed. I agree with Duane and colleagues that barium meal examination yields more information than endoscopy when there is a motility disorder; nevertheless, as most patients with dysphagia have a physical obstruction I believe that endoscopy should usually be the first choice, particularly as it permits biopsy and temporary therapeutic manoeuvres. Endoscopy may also be helpful in achalasia. Although certain features may be equivocal, such as a hypertonic sphincter, increased oesophageal diameter, or food retention, aimless tertiary contractions in the lower oesophagus are usually a diagnostic feature. The important point is that an unexplained motility disorder should be referred for oesophageal motility studies, which in Duane and colleagues' two cases might have shown the typical findings of achalasia.

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- 1 Duane PD, Magee TM, Alexander MS, Heatley RV, Losovsky MS. Oesophageal achalasia in adolescent women mistaken for anorexia nervosa. *BMJ* 1992;305:43. (4 July.)

Value of routine ultrasound scanning

EDITOR,—Carole A Luck's study of routine ultrasound scanning shows the acceptability of routine scanning to be high and the sensitivity to be 85%.¹ But the results are to some extent biased by the inclusion of many minor renal malformations of doubtful importance, which masks the fact that only just over a third of cardiac malformations were detected. This emphasises the importance of moving away from overall figures when quoting the predictive value of various methods and reflects the weaknesses of ultrasound screening. If the