LETTERS TO THE EDITOR

PERCUTANEOUS ENDOSCOPIC GASTROSTOMY IN A MILITARY HOSPITAL

From Major RW Crabbe, RAMC

Sir, Maj Salam and Lt Col Melia claim that Percutaneous Endoscopic Gastrostomy (PEG) should be considered the the treatment of choice for long term enteral feeding (1). However, in their article they fail to mention the fact that Percutaneous Gastrostomy (PG) has been safely carried out under fluoroscopic guidance since 1983 (2). The latter procedure avoids the hazards of endoscopy, has a similar morbidity and is likely to be cheaper to perform, especially in experienced hands. In addition, tubes can easily be placed in the jejunum to lessen the risks of aspiration in appropriate patients (3). The endoscopic route may be impossible in certain patients such as those with head and neck malignancy and upper oesophageal obstruction.

These considerations suggest that PG and not PEG be considered the procedure of choice when creating a feeding gastrostomy.

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3. HO CS, YEUNG EY. Percutaneous Gastrostomy and transgastric jejunostomy. *AJR* 1992; **158:** 0251-0257.

From Lt Col WMA Melia, RAMC

Sir, Thank you for the opportunity to respond to the letter of Major Crabbe.

Percutaneous gastrostomy (PG) has indeed been used in the last decade and complements percutaneous endoscopic gastrostomy (PEG). However the serious morbidity with PG may be greater: there is particular concern, recently highlighted in a presentation (L Elliott) to the Radiology Section at the Autumn meeting of the British Society of Gastroenterology, about displacement of the PG tube into the peritoneal cavity with resulting peritonitis. PEG should be within the capacity of any experienced endoscopist while PG is less widely available, dependent as it is on an interested interventional radiologist. Furthermore a recent audit revealed that endoscopy during the PEG procedure in stroke patients detects unsuspected peptic ulcers in 18%; the incidence of all asymptomatic disease was 37% (1). PEG tubes can also be placed in the duodenum to lessen the risk of aspiration in selected patients.

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A SUCCESSFUL ASTHMA AUDIT IN GENERAL PRACTICE

From Major G Wheatley, RAMC

Sir, I would like to present the findings of a recent asthma management audit carried out in general practice. It is of interest as it shows that such an audit is feasible in a military practice of high patient turnover, and that it can produce a beneficial change in management practices.

Asthma was chosen as it represents the most commonly encountered chronic disease in Army general practice, and it has previously reported that care can be improved by a systematic approach to management (1).

The practice, of around 3500 patients, was situated in a large Germany urban centre. General practitioners in the practice met in April 1993 to formulate standards of care for asthmatic patients, which were based on the then recently published British Thoracic Society guidelines (2). The practice morbidity register for asthma was updated, by reviewing the names on all prescription scripts for drugs used in asthma over the preceding three months.

A sample of 38 names were taken from the register in May 1993; three sets of notes were unavailable, and of the rest 20 patients had made a consultation for asthma in the practice in the past year. These notes were then examined to see how the patient's asthma had been managed in the practice over the previous 12 months. The second audit took place in February 1994, when a random sample of 53 names from the asthma disease register had their notes examined. Of these, 49 sets of notes were available, 21 had one or more consultations for asthma in the last year, 18 of which were in our practice. The characteristics of the samples are in Table 1, and a comparison of the findings in Table 2.

After the first audit in May 1993 the doctors were broadly satisfied with the results. Both patients admitted to hospital for acute severe asthma had been treated with nebulized salbutamol and oral steroids prior to admission.

Table 1

	May 1993	February 1994
Males	6	7
Females	14	11
Age range	13 mths-43 yrs	17 mths-35 yrs

Table 2

	May 1993	February 1994
No. of hospital admissions:	2	1
No. of oral steroid courses:	4	1
No. on prophylactic drugs:	11 (55%)	15 (83%)
No. treated with antibiotics	2	0
Over 8 year olds with recorded peak flow:	7 (54%)	7 (70%)

Out of 20 patients, 11 were on prophylactic medication (one on sodium cromoglycate, 10 on inhaled steroids). However, it was felt there was room for improvement, in both increasing the amount of prophylactic inhaler use (particularly cromoglycate for children) and reducing the amount of antibiotics used. To help uncover those who needed prophylactic medication two measures were encouraged: the use of specific questions to assess morbidity developed by Jones *et al* (3), and the regular measuring of peak expiratory flow rate.

In each of the areas measured in Table 2, which can be regarded as measures of quality of care, the later audit performs better. Specifically, the proportion of patients using prophylactic inhalers increased – the later audit found a total of 15 patients, 11 using inhaled steroids and four using cromoglycate. This increase in proportion using inhalers (from 55% to 83% or an increase of 18%) is similar to the 19% reported elsewhere after the opening of a nurse-run clinic (1). Thus closing the audit cycle implies that the standard of asthma care in the practice has improved, making the effort involved worthwhile.

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2. British Thoracic Society and others. Guidelines for the management of asthma: a summary. *Br Med J* 1993; **306:** 776-82.
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PART TIME STUDYING AND FITNESS FOR ROLE *J R Army Med Corps* 1994; 140: 160

From Maj NK Cooper, RAMC

Sir, Previous to the publication of the above letter Major JDC Bennett admirably demonstrated his classical erudition by pointing out to radiological and otolaryngological readers of a more exalted journal that the plural of the fourth declension noun meatus is meatus (*J R Soc Med* 1994; **87:** 245).

I trust that he in turn will not consider me pedantic if I remind him that the Editor's note to his latest letter could be summarised as "Mens sana in corpore sano", as well as mentioning that, in addition to the specialised Diplomas which he cites, each new RAMC medical officer is now partially qualified to sit the examinations for the Society of Apothecaries' Diploma in the Medical Care of Catastrophes (DMCC) by virtue of their attendance of the PGMO course.

However, the practical skills necessary to gain the DMCC do require a modicum of physical fitness for their acquisition.

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WAR SURGERY EXPERIENCE

From Lt Col MPM Stewart FRCS, FRCS Orth, RAMC

Sir, I read with interest Major Vasallo's informative article (J R Med Corps 1994; 140; 146-153) in which he highlights the experience which the International Committee of the Red Cross (ICRC) has accumulated in recent years in dealing with war wounds.

In these days of a continuum of specialist training of between 5 and 6 years, there is much to commend an inclusive period of 3-6 months with the ICRC, in order that military trainees acquire first hand, the principles of war surgery. At present, ICRC surgical practice differs little from that established by our military surgical forbears. ICRC surgical doctrine, however, may prove to be fundamentally different; if we are to forge closer links with the ICRC, we must guard against any erosion of our traditional military approach of echeloned care for our wounded in war, and the substitution of a policy which lays emphasis on civilian concepts of triage and treatment which are expedient (1).

In the meantime, what have we to offer in terms of our own military surgical experience? The Orthopaedic Unit of the Queen Elizabeth Military Hospital has dealt with over 90 major penetrating missile wounds to the limbs alone, in 70 servicemen injured in peacekeeping missions

Table 1
Penetrating missile wounds of limbs in 70 soldiers

	Fragment (n+43)	Bullet (n+27)
Site	No.	No.
Upper limb	24	16
Lower limb	37	14

or training exercises during the last 12 months (Table 1). In the delayed closure of wounds, reconstruction and rehabilitation of these limbs there has been the opportunity to maintain, and to instruct in, the skills of war surgery. With the proposed concentration of the medical services' efforts, and aeromedical evacuees in a TriService hospital, we should endeavour to ensure that our own accumulated, and ongoing experience in dealing with war wounds is not forgotten.

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