Do antidepressants cause folic acid depletion?

Sir,

I was most interested to read the paper 'Do antidepressants cause folic acid depletion?' (January *Journal*, p.17). However, I was concerned to see so many methodological and theoretical errors and despite being a pilot study it hardly warranted publication.

If the authors wish to make any inferences about the use of antidepressants in general practice then it hardly seems relevant to study a group of elderly patients in an institution who have been taking these drugs for two years. Such a lengthy exposure would be most inadvisable in a general practice setting. We are not offered any diagnoses for these patients, so the reason for the prescription of the antidepressant is unclear — the treatment of low mood in chronic schizophrenia seems most probable. The group taking antidepressants were not all receiving the same drug. Amitriptyline is sometimes used as an appetite stimulant in chronic psychoses and presumably this might colour the results.

It is stated in the introduction that all the individuals in the study were receiving the same diet but in the method it is stated that some were on a 'light' diet and some eating 'normal' meals. We are not informed which patients these were, although the authors admit a different folate composition for these different diets.

In view of the age of these patients the existence of multiple pathologies is likely. However, we are only told that no history of malabsorption existed. Evidently the patients were not examined or otherwise investigated to exclude malabsorption or other pathologies. It would be interesting to have longitudinal data on the folate metabolism of these patients, to see whether this was changed in any way by the medication.

Finally, since the numbers in the study were so small, it would have been possible to publish a scatter plot of the results. It may be that only a few outlying data points are affecting the rest of the data. I note that the standard errors of the means are relatively large. How much the presented data supports the authors' conclusions is difficult to say.

It may be that a further study could iron out some of these problems, but as it stands this pilot study generates many more questions than even hinted-at answers.

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Sir,

To an extent I agree with Dr Green that our article raises problems without solving them.

I would emphasize that we were seeking the effect of a class of agent, not specific drugs, on a vulnerable group. The number of patients in the study was small as people on antidepressants are not common in institutions — a population of 600 yielded only 11 such patients.

Although their medication is not managed by general practitioners, there are patients attending outpatient clinics on long-term antidepressants. Such chronic dosage must also affect a general practitioner in his work if he is a responsible prescriber.

Breaking down the dietary data was not felt to be of benefit as the groups were already small and both 'light' and 'normal' diets were 'adequate' in folate content. The adequacy of intake is also discussed in the article.

Albeit a simple study, it was not easy to complete and may now be impossible to repeat as the population in hospitals declines by the month. Longitudinal studies are a good idea but such a study was not feasible, nor was formal clinical exclusion of a malabsorption state. Much data, including a scatter plot, was omitted to ensure brevity of presentation but it did not hide or tell any more than was given.

Generally, any pilot study is a limited affair and ours yielded a shorter duration of drug use than was expected but did allow for other factors to be controlled. We were not blind to these problems (nor were the helpful referees) but felt content to pursue the debate as the issues are important. I agree that further enquiry is indicated but suspect that to obtain enough data several groups will need to collaborate.

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Lack of training in dermatology

Dr Perkins (Letters, January *Journal*, p.36) correctly points out that hospital outpatient waiting lists are too long and could be reduced by fewer general practitioner referrals. However, the suggestion that in dermatology a definitive report could be given on the basis of a Polaroid photograph with relevant clinical details, thereby avoiding a hospital consultation, is naive.

Undoubtedly a photograph would frequently aid diagnosis prior to consultation, merely reflecting the inadequacy of the clinical description in many referrals. However, few dermatologists would be happy to treat patients like a magazine quiz and the medicolegal implications of incorrect advice on the basis of such a system would be considerable. The analogy with a cardiologist's report on an electrocardiograph is unfortunate, as such a report rarely obviates a clinical consultation.

It is general practitioners' lack of confidence in dermatology, owing to inadequate training that is the fundamental problem. Despite the fact that 60% of medical students are destined to become general practitioners, when 6% of their consultations will concern skin problems,[1] undergraduate exposure to dermatology is extremely limited and shows a wide variation. I have recently surveyed the British universities' undergraduate dermatology curricula and found the mean time allocated is nine days with a range of five to 20 days. Emphasis on the need for postgraduate education in dermatology is often the excuse for the deficiencies of the undergraduate curricula. Unfortunately, few opportunities exist nationally for postgraduate education in dermatology and its extent is difficult to define in the absence of a coordinating body.

The training of the non-dermatologist in dermatology is highly whimsical and it is only by rectifying this that waiting lists for skin problems will be reduced and the service improved.

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Reference

1. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice. Third national study, 1981–82.* London: HMSO, 1986.

Regional distribution of family practitioner services

Sir,

In a recent article Birch and Maynard (December *Journal*, p.537) state that 'the use of the RAWP formula (and the corresponding formulae in Northern Ireland, Scotland and Wales) has narrowed inequalities in hospital and community health services.'

Unfortunately, while the PARR formula has been calculated on an area board

basis in Northern Ireland for several years now, no attempt has as yet been made to implement this policy. This has led to the current situation where the Western Health and Social Services Board is estimated to be around £9 million underfunded according to the Department of Health and Social Security's own figures for Northern Ireland. While we are well aware of the relative poverty of staff and service in the hospital and community sectors which this underfunding has produced, it is obvious from the results of Birch and Maynard's paper that there is bound to be a significant hidden impact in the general practitioner services, especially in light of the view that 'the ability of patients to express needs as demands is conditional upon the availability of services'.

I am sure your readers can well imagine the impact upon their own services if RAWP had not been implemented in England and can sympathize with their colleagues in general practice in the western part of Northern Ireland.

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Thyroid disease follow-up

Sir,

We read with interest the report (News, November *Journal*, p.524) by Drs Jeremy Jackson and Peter Baxter of a framework for thyroid follow-up in general practice. Hypothyroidism is one of the few conditions which entitles a patient to life-long exemption from prescription charges. If form C-P 11 is completed by the patient and a doctor, and sent to the family practitioner committee, an exemption certificate will be granted to the patient. Some patients are not aware of this.

From the records of serum thyroxine and serum thyroid-stimulating hormone estimations carried out between June 1983 and March 1985 in the Department of Biochemistry at Northampton General Hospital, 1555 patients with hypothyroidism were identified. Of these 843 were already exempt from charges because of their age. Of the remaining 712 patients 140 were selected, as they were from eight training practices willing to cooperate, or under the care of the consultant with a special interest in hypothyroidism. We asked the doctors for permission to write to the patients — 15 patients were excluded at their general practitioner's request, and no reply was received concerning a further 15 patients.

A questionnaire was sent to 110 patients and 86 replies were obtained from patients eligible for an exemption certificate. Twelve of these patients did not have an exemption certificate. Of those who did, 46 had been informed by their general practitioner and the remaining 28 by other sources.

We recommend that informing patients of their right to free prescriptions should be included in the framework for management of hypothyroidism.

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Sex and health promotion

Sir,

Like Professor Clarke (December *Journal*, p.555) I deplore the adverse consequences of present day sexual behaviour with epidemics of sexually transmitted diseases, cervical cancer and abortion. In recognizing the need for a new primary care initiative I feel that all primary health care team members (in particular general practitioners) must warn those who are sexually active and using contraceptive measures, especially those under the age of 20 years, of the risks they run. For such initiatives to be effective all contraceptive advice and care should be centred on the primary health care team.

The organization 'Life' offers a national resource for competent pregnancy testing and advice regarding unplanned pregnancies, in addition to post-abortion counselling. The address of 'Life' is 118–120 Warwick Street, Leamington Spa, Warwickshire CV32 4QY (tel. 0926-21587/311667) and the telephone numbers and addresses of all local offices are available on request.

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Promoting better health

Sir,

With the knowledge of what has happened in the hospital service over the last few years I think it is naive to welcome the promises contained in the government's white paper with such unreserved enthusiasm (January *Journal*, p.1). Of course there are some elements in the proposals that are laudable and demand our support; it would be remarkable if there were not after all the debate. But there are others that are far from laudable. It is rightly pointed out that much of the document is vague and that much detailed work is now needed.

There is an arrogance inherent in the philosophy of the College that general practitioners can do anything, which at the best of times I find distasteful; in the current climate it is positively suicidal. I agree that general practitioners should be promoting health, improving information systems, educating, managing better and generally aiming to improve their services — but it has to be put in context. The hospital service is falling to bits. This has been acknowledged in public by the Royal Colleges of Physicians, Surgeons and Obstetricians and Gynaecologists. The services provided by the local authorities are ever diminishing and we are increasingly being asked to pick up the pieces. If we are to be able to meet the expectations of our patients and of government, and fulfil our own hopes we will need a lot more than what is on offer in the white paper. And it is not just a question of money.

There are many issues which are not thought through and as an inner city general practitioner one that alarms me is the issue of list sizes. After considerable debate it is now widely accepted that reducing list size is an important way of improving quality and moving to a more preventive approach, especially in areas of deprivation. A recent editorial in the *Journal* (November *Journal*, p.481) supported this conclusion. And yet there are several proposals in the white paper encouraging larger list sizes.

To improve the services we offer our patients is a worthy objective, but to expect us to be able to achieve it by swallowing the brave words of a government which has openly admitted that it is no longer committed to the concept of free treatment at the point of need is laughable. We must be more aware of the hidden agenda of the government, which almost certainly includes cash limiting more and more of the family practitioner services. And that would have a catastrophic effect on the quality of service to our patients.

As a local medical committee member I know that many of my colleagues share my misgivings. For our College and *Journal* to take so uncritical a line undermines the position of those who will be involved in the many negotiations which lie ahead. The College cannot afford to re-