active, Be healthy' and 'Change4life'.[2] For a medical student research project we examined self-reported exercise in cardiovascular and orthopaedic patients at Bedford Hospital. Following ethical review, Manning conducted a questionnaire survey in July 2009.

The response rate was 84% (63/75). Mean age of responders was 71 years (range 27 to 97) and 90% were white. Although 86% reported exercising regularly, only 29% complied with DOH recommendations (30 minutes of moderate exercise five times a week).[3] White patients were significantly more likely than those from ethnic minorities to participate in regular exercise (91% 51/56 versus 43% 4/7, $P<0.05$). Similarly more men than women reported doing the DOH recommended amount of exercise (50% 12/24 men versus 15% 6/39 women $P<0.05$). Comparable results have been seen in previous studies.[4,5]

Lack of awareness is a major problem in both exercise promotion and familial hypercholesterolaemia. Only one patient in our study knew how much exercise the DOH recommends. Similarly, it is estimated that 85% of people with familial hypercholesterolaemia remain undiagnosed.[1] GPs are often the first point of contact for patients with chronic diseases such as familial hypercholesterolaemia. They may have a vital role both in diagnosis of this important condition and in exercise promotion.

Serena Manning,
4th year medical student.

Pippa Oakeshott,
Reader in General Practice, St George's, University of London, Cranmer Terrace, London, SW17 0RE.
E-mail: m0603345@sgul.ac.uk

REFERENCES

1. Humphries SE, Qureshi N, Minhas R, *et al*. Identification and management of familial hypercholesterolaemia: what does it mean to primary care? *Br J Gen Pract* 2009; **59(567):** 773–777.
2. Department of Health. *Be active, be healthy: a plan for getting the nation moving*. London: DoH, 2009.
3. Department of Health. *At least five a week*. London: DoH, 2004.
4. Department of Health. *Health survey for England 2006*. London: The Information Centre, 2008.
5. The Department of Health and Human Services. *U.S. national physical activity statistics*. Atlanta, GA: Centers for Disease Control and Prevention, 2007.

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Respiratory infections

I read the themed October *BJGP* on respiratory infections with both interest and nostalgia. I would like to make two general points.

First, although Verheij's admirable leading article uses and quotes the phrase 'antibiotic revolution',[1] what struck me most in the linked papers was not how much has changed over the last 30 years, but how little things have changed. Wang *et al*'s findings of large inter-practice prescribing variations[2] closely mirror the pattern of the 1970s. And extrapolating from the data Meropol *et al*[3] present, it seems that in 2004 just over 50% of all consultations for respiratory infections (combining his figures for adults and children) resulted in an antibiotic being prescribed, a figure not very different from the 58% we reported three decades ago. If there has been a drop in the volume of antibiotic prescribing, it is as likely to be due to changing demography or consultation availability, as it is to any sustained influence of educational interventions aimed at doctors.

Second, I was struck by the fact that none of the 121 references in the four relevant articles was to papers published earlier than 1990. This is part of a now regular pattern resulting from the increased use of review articles to introduce literature reviews and meta-analyses to summarise clinical trials. Although labour-saving for the author, this trend results in the airbrushing out of apposite historical work which might illuminate the work being undertaken.

In this case, I was obviously disappointed that none of the work I and others had been associated with in earlier years to try to describe and influence the determinants of antibiotic prescribing had earned a reference, not least because it contributes to understanding why unnecessary prescribing continues.

However, a solution is at hand. The *J Health Serv Res Policy* runs a series 'Worth a Second Look', and I was recently invited to re-visit one of my apparently out-dated articles (from *J R Coll Gen Pract* 1972 entitled 'Diagnosis — the Achilles Heel'), and comment on its relevance to medicine today. The resulting paper is now available online[4] and will be available in hard copy early in 2010. For those thinking of researching in this rich field, the essay includes relevant starter references, and also a model suggesting how difficult it is likely to be to make changes to the antibiotic prescribing *status quo*.

Come to think of it, given the proven effectiveness of the QOF financial incentives in changing patterns of care,[5] why not simply debit practice incomes with the cost of all antibiotics prescribed, less whatever is deemed the necessary annual mean antibiotic requirement per patient? It could work!

John Howie,
4 Raverig Park, Balerno, Edinburgh, EH14 7DL.
E-mail: john.howie00@btinternet.com

REFERENCES

1. Verheij TJM. The antibiotic revolution should be more focused. *Br J Gen Pract* 2009; **59(567):** 716–717.
2. Wang KY, Seed P, Schofield P, *et al*. Which practices are high antibiotic prescribers? A cross-sectional analysis. *Br J Gen Pract* 2009; **59(567):** e315–e20.
3. Meropol SP, Chen Z, Metlay JP. Reduced antibiotic prescribing for acute respiratory infections in adults and children. *Br J Gen Pract* 2009; **59(567):** e321–328.
4. Howie J. Diagnosis in general practice and its implications for quality of care. *J Health Serv Res Policy* 2009 [Epub ahead of print].
5. Campbell SM, Reeves D, Kontopantelis E, *et al*. Effect of pay for performance on the quality of primary care in England. *N Engl J Med* 2009; **361(4):** 34–44.

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Antidepressant prescribing

In light of the debate concerning political targets to reduce antidepressant prescribing in Scotland,[1] we were interested to see Cameron *et al*'s paper addressing the appropriateness of antidepressant prescribing by GPs.[2] After consulting our Aberdeen colleagues, we

examined if their findings were replicable in primary care settings in Edinburgh.

The study was carried out in two general practices in Edinburgh for five consecutive days in August and September this year. As in Aberdeen, the Hospital Anxiety and Depression Scale (HADS) questionnaire was given to patients waiting to see their doctor. GPs, blind to the questionnaire results, rated each participant on a scale of 0–3 for anxiety and depression.[3] Their case notes were subsequently searched for any diagnosis of depression, antidepressant prescriptions, and indication for prescription. The GP rating of anxiety was an addition to the Aberdeen study, attempting to determine whether the presence of anxiety had any impact on how GPs diagnose depression.

Unfortunately, the response rate was very low, possibly attributable to the practice receptionists approaching the patients rather than ourselves. In the first practice there were 48 participants out of a possible 278 (17%). In the second practice only 12 took part from an eligible 500 (2.4%). Of that 60, 20% had probable depression detected by the HADS questionnaire, suggesting preferential participation from people with depression. No case of inappropriate prescribing of antidepressants was detected. Ten per cent of the population studied were rated as mildly depressed by their GP (95% CI = 0.04 to 0.35) but were not found to be depressed on the HADS questionnaire. All patients with depression were also anxious so we could not assess whether this had an impact on treatment.

These findings, despite the low response rate, are in keeping with those from Aberdeen and reinforce their concerns about Scottish Government targets to reduce antidepressant prescribing.

Anna Fletcher

Treasa O'Sullivan,
Royal Edinburgh Hospital, Morningside, Edinburgh. E-mail: osullivantreasa@aol.co.uk

Helen Cash

Anne Byrne

Stephen Lawrie

William Riddle

Richard Williams

REFERENCES

1. The Scottish Government. *Heat targets: heat target revision and additions (2008).* http://www.scotland.gov.uk/topics/health/mental health/service policy/DFMH/antidepressant prescribing (accessed 9 Nov 2009).
2. Cameron IM, Reid IC, Lawton K. Appropriateness of antidepressant prescribing: an observational study in a primary care setting. *Br J Gen Pract* 2009; **59(566):** 644–649.
3. World Health Organisation. *International statistical classification of diseases and related health problems, 10th revision, version for 2007.* http://apps.who.int/classifications/apps/icd/icd10online/ (accessed 9 Nov 2009).

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Osteoporosis

In reference to recent discussions on osteoporosis diagnosis presented in the *BJGP*, it was felt that it would be of interest to the reader to report the findings of a single practice audit undertaken as part of an F2 rotation.

As previously stated by Alun Cooper, the consequence of a fragility fracture places a great burden on the individual as well as the health and social care services.[1] In an effort to gauge fracture risk and thereafter appropriateness of treatment, a raft of guidelines have been published and assessment tools designed. However, it appears that there is poor compliance with these tools and anecdotally the consensus within the practice was that GPs do not feel entirely confident identifying at-risk individuals, in comparison to the honed skills of cardiac risk stratification.

With this in mind, and while discussing the Direct Enhanced Service criterion for osteoporosis, we felt it would be of benefit to audit the rate and appropriateness of investigation and management in female patients identified as suffering a fragility fracture. As an adjunct to this, retrospective analysis was undertaken regarding the identification and recording of the osteoporosis risk factors, outlined by the National Osteoporosis Guideline Group (NOGG), in the patients' clinical records.

Fifty-one female patients aged over 65 years were identified as having suffered a fragility fracture. It was found that 30% of the sample was receiving bone-sparing therapy; yet only 6% of the whole cohort and 12.5% of those between 65–74 years had undergone DEXA investigation. The clinicians have clearly undertaken some element of risk stratification. However, although documentation of commonly asked data such at alcohol and smoking status approached 100%, documentation of influential risk factors such as parental fractures was 0%, and liability to fall was 24%. Further to this, although some patients suffered from conditions that relate to secondary osteoporosis, no causal links were commented upon the notes.

Though the NOGG guidelines state that 'the final decision to assess BMD or to initiate therapeutic intervention lies with the clinician',[2] it would appear that risk stratification tools, such as the FRAX®, would have a clear benefit in acting as a prompt and ensure full documentation of risk.

Jonathan Evans,
Anatomy Demonstrator, University of Bristol, Bristol, BS8 1TD.
E-mail: jpevans@doctors.org.uk

REFERENCES

1. Cooper A. A fractured service: the latest advice on osteoporosis. *Br J Gen Pract* 2009; **59(562):** 239–241.
2. National Osteoporosis Guideline Group (NOGG). *Osteoporosis: clinical guideline for prevention and treatment. Executive Summary. 2008.* http://www.shef.ac.uk/NOGG/downloads.html (accessed 9 Nov 2009).

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Correction

In the letter: Thornber M. Copying referral letters. *Br J Gen Pract* 2009; **59(568):** 869. The third paragraph reads: 'Thirdly there is ... However, the extra ... has been shown to be minimal' the word 'shown' should be 'found'. This has been corrected in the online version.

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