Doctors and pharmacists — working together

Sir,

We wish to comment on Michael Drury's editorial on improving and increasing links between general practitioners and community pharmacists (March *Journal*, p.91). It is not entirely true to say that hospital drug information services are available only to hospital doctors. These services, organized at district and regional levels, have long provided a service, usually an enquiry answering service, to general practitioners and community pharmacists.

Limited publicity for regional services is given in the *British national formulary*. At the South Western Regional Drug Information Centre approximately 15% of our enquiries came from the community in 1990, and we are increasingly being called upon for advice on PACT (prescribing analyses and cost).

Professor Drury's observation that it is time that general practitioners had access to an information and advisory service on medicines and prescribing is undoubtedly correct. However, we do not agree that it should be provided by either the community pharmacist or the drug information pharmacist. One possible scenario is that the local community pharmacist and general practitioner liaise and are jointly supported by the drug information service.

However, the future funding of such a service is a crucial issue. While district health authorities have in the past funded their own district drug information services, it is unlikely that after April 1991 self governing trusts and directly managed units will be willing to fund an expanded service to primary care professionals from their own budgets. The regional health authorities now have new responsibilities for monitoring prescribing issues in hospital and in primary care so some may see the need to fund such a service, perhaps provided by the regional drug information centres. General managers in family health services authorities may also be convinced of the need for such a service as a contribution to the 'Improving prescribing' scheme and therefore provide funding. There is, however, the question of where the funding would be allocated in some of the family health services authorities which contain two or more district health authorities. It is unlikely that one single pattern of funding will emerge.

There is no doubt that hospital drug information pharmacists are enthusiastic to help general practitioners and community pharmacists, and it is likely that such enterprises will prove beneficial to patient care. Unfortunately, before significant progress can be made the funding issue needs to be pursued and clarified locally.

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Community care for people with mental handicap

Sir,

I was greatly encouraged to read the editorial on community care for people with mental handicap (January *Journal*, p.2). In particular, I would agree with the point about the trivialization of significant medical problems in comparison with the more gross but untreatable mental handicap.

Dr Howells comments on the limited opportunity for general practitioners to meet people with mental handicap. This fact combined with the small amount of time usually given to undergraduate teaching about mental handicap (I myself have half a day to cover the entire subject for each intake of medical students) leaves the average general practitioner with a very limited grounding in the subject. In my own district there are a few practices which are very active in making referrals, while others are never heard from.

Also of importance is the fact that, while general practitioners might expect to have approximately six patients per 2000 with severe mental handicap in their practices, the number with all degrees of mental handicap including the mild and moderate ranges would be much higher. The needs of this more able group are in many ways just as difficult to address, as their communication skills, while superficially adequate, are often insufficiently sophisticated to convey a full picture of their psychiatric or medical distress.

I have been conducting a study over the last three years on people with mental handicap who present at my clinic with depressive illness. Perhaps one of the most interesting findings about this group is that on the whole the features with which they present are towards the more severe end of the spectrum. It could be, therefore, that as with medical problems in general, those with less severe depressive illnesses are going unnoticed. It was also of interest in my sample of 34 people that about one third of the referrals came from general practitioners and, although it is hard to make judgements on the basis of a small number, general practitioners seemed no more likely than other sources of referral (social services settings, schools and family) to identify the presenting problem as depression. At present I am also in the early stages of planning a whole population survey on the prevalence of depressive disorders in people with mental handicap and would be most interested to hear any comments from readers about this.

Finally, it is of note that Dr Howell's editorial was brought to my attention by a general practitioner colleague, who works part time with me as a clinical assistant, a good illustration of the benefits of dialogue between consultant and general practitioner.

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Management of myocardial infarction

Sir,

We read with interest the editorial by Dr Clifford Kay on the management of myocardial infarction in the community (March *Journal*, p.89) and applaud the objectives of the study to be carried out by the Royal College of General Practitioner's Manchester research unit.

We have also been interested in the treatment of patients with chest pain before admission to hospital. In a recent survey we assessed 72 patients admitted consecutively by local family practitioners with a diagnosis of presumed cardiac chest pain. We found the following diagnoses: myocardial infarction 24 patients (33%); probable cardiac ischaemia (no infarction) 36 (50%); and other diagnoses 12 (17%).

Only 13 patients (18%) had been treated with aspirin before admission. This compares with 25 patients (35%) that were given parenteral opiates.

There is now excellent evidence that mortality in patients with myocardial infarction is reduced by thrombolytic therapy.[1,2] This is not yet proven in acute coronary insufficiency (crescendo angina), although there is a reduction in the episodes of ischaemic pain.[3]

Aspirin, however, has been shown to reduce mortality in both myocardial infarction[1] and crescendo angina.[4,5] In myocardial infarction the benefits of combining aspirin with thrombolysis are more than purely additive when given in the first five hours.[6]

We therefore strongly agree with Dr Kay's recommendation that the value of the simple measure of the administration of 150 mg aspirin should not be overlooked in the management of all patients presenting to their general practitioner with acute cardiac chest pain.

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Which antidepressant?

Sir,

I was interested to read the article on antidepressants by Matthews and Eagles (March *Journal,* p.123). The criteria for choosing an antidepressant — efficacy, adverse effects, toxicity in overdose and cost — could have included another, experience with the drug.

Amitriptyline may have irritating adverse effects but it has been around for a long time. It can be prescribed with confidence, in the knowledge that its efficacy is undoubted and that new adverse effects are unlikely to be discovered. The same cannot be said of some of the newer drugs. Sertraline (Lustral), for example, is being widely advertised in the general practitioner press but I would not recommend it for use by general practitioners as psychiatrists have not yet got a feel for it. I wondered why this and other new drugs such as paroxetine and amoxapine were not discussed in the Matthews and Eagles' article. Then I realized that it had been submitted in January 1990.

The article advocated the use of trazodone, mianserin and lofepramine as first line drugs. It was not stated whether this was intended to be an order of preference, but it may well have been understood as one. There are almost no adverse effects from lofepramine and it is commonly used. Trazodone is less popular, probably because of the priapism which it occasionally causes and is hard to treat. Mianserin can cause blood dyscrasias so full blood counts need to be carried out, at least initially. Overall, lofepramine emerges as the best of the three.

Fluvoxamine was suggested for depressive disorders where obsessional symptoms predominate. Fluoxetine is put in the same category but this drug is mentioned only once. I found this surprising as it has been an extremely popular antidepressant internationally and is becoming increasingly so in the UK. Over three million patients have now been treated with the drug. I am sure readers were hoping to hear psychiatrists' views of the recent adverse publicity about fluoxetine. It seems to be an effective drug which is relatively free of adverse effects. In particular it causes nausea much less frequently than fluvoxamine and many psychiatrists consider that this makes it a superior drug to fluvoxamine.

A recent television documentary suggested that fluoxetine might cause some patients to commit suicide by violent means. However, there are no controlled trials to prove that the phenomenon exists, only case reports and these can sometimes be misleading. Depressed people sometimes commit suicide by violent means and some of them are bound to be taking a commonly prescribed antidepressant. If this is a real phenomenon, there are two possible explanations for it. The less likely of the two is that there is something about the drug that gives rise to a 'side effect' of violent suicide. More likely is that patients' motivation picks up more quickly than their mood, making the chance of suicide temporarily greater. The answer may not be to stop using fluoxetine but to warn patients of this danger and monitor them particularly closely in the early phase of recovery from depression.

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Diplomatosis

Sir,

According to Dr Brown (Letters, March *Journal,* p.128) the MRCGP examination represents an endpoint assessment leading him to question the value of diplomas in core subjects like child health and geriatric medicine. He also reports that diplomas were not welcomed at a general practitioner trainee conference he attended, levelling the charge that diplomas represent nothing more than a convenient source of income to respective colleges. I think this aspersion unworthy, even anomic. He did concede, however, that diplomas were important if they represented experience and specialization. I would like to express my views as I have advocated the diploma in geriatric medicine since 1978 and am the only examiner for both it and the MRCGP examination.

The high rate of interest in the DRCOG reflects little more than its value at job interviews — it is an anachronism now that few general practitioners are involved with intra-partum care and much antenatal care is quite rightly delegated to an attached midwife. The DCH is highly specialized, and less relevant to general practice than might be supposed, since questions appear on rare diseases of childhood that are, in practice, cared for by paediatric registrars.

I would agree that diploma studies should not disrupt the general practice year or specialty attachments. However, the MRCGP examination is a wide ranging assessment in which it is highly unlikely the candidate will be asked much if anything about geriatric care, despite the fact that in the average practice 16% of patients are over 65 years old. It was only in 1980 that the first question on the elderly was asked in the MRCGP examination. Even candidates for the DGM have a high failure rate in questions on biological theories of ageing, tardive dyskinesia and emotional lability. Candidates are now better informed on rehabilitation, though many show a surprising lack of acquaintance with everyday aids and appliances, and of what is meant by enduring power of attorney, testamentary capacity, and the court of protection. From the examiner's point of view, the great advantage of the DGM is the ability to see the candidate relating to a real patient, a limiting factor in the MRCGP examination.

General practitioner principals and trainees make up a considerable proportion of the candidates for this successful diploma, for which enjoyment in participation and widespread tributes to its relevance are often expressed. The unprecedented biological trend towards longer life in developed countries makes the diploma in geriatric medicine an essential requirement for general practitioners who attend the needs of 94% of the elderly population.

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