

Hepatitis B transmission within families <i>Nigel Masters</i> 301	Quality or inequality in health care? <i>William W Fulton</i> 303	GPs' response to request for information <i>Caroline Whitehead and Lalage D Sanders</i> 305
Failure to keep primary care appointments in Saudi Arabia <i>Sulaiman Al-Shammari</i> 301	Standardized patients in general practice <i>Ross J Taylor</i> 303	Reports from inner city practices <i>Stefan Cembrowicz</i> 305
Assessment of cognitive impairment in the elderly <i>Graham Worrall</i> 302	General practitioners and work in the third world <i>C Andrew Pearson; C E Morris</i> 304	Request for back issues of the <i>Journal</i> <i>G K Prusty</i> 305
Which antidepressant? <i>P Freeling, et al.</i> 302	Cryptorchidism — a significant risk factor for testicular cancer <i>Nicholas Brown</i> 305	

Hepatitis B transmission within families

Sir,
Hepatitis B virus carriage is prevalent in certain groups in the UK.¹ At our health centre hepatitis B carriage has been opportunistically screened in Asian patients both at the dental and medical clinics over the last five years. This has resulted in the testing of 307 of the 565 Vietnamese refugees registered with the practice. Of those treated 49 (17%) were carriers of the hepatitis B virus; 21 (6%) had high infectivity levels.

Family spread of hepatitis B virus disease has been described² but the Department of Health guidelines for administering hepatitis B vaccine do not directly address this important area of potential disease transmission. The family tree shown in Figure 1 illustrates that individuals can be at risk despite the hospital based perinatal intervention programme. The mother eventually cleared the disease but she had already infected her first three children at their birth. Her youngest son should be offered active immunization to protect against the small risk of intrafamilial spread. The route of family transmission is uncertain but exudative skin lesions and nail biting have been implicated in one detailed study.³

Such family tree serology testing can be time consuming and difficult in primary care but it can lead to the rational use of hepatitis B vaccine for individuals at risk.

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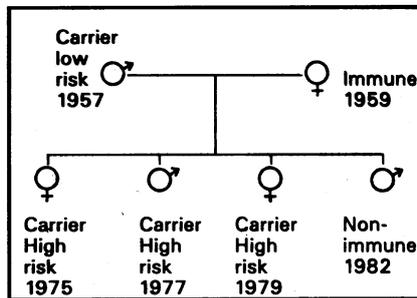


Figure 1. Example of a hepatitis B family tree, showing date of birth and current status.

Failure to keep primary care appointments in Saudi Arabia

Sir,
Patients who fail to keep their appointments at clinics are a source of puzzlement and frustration to doctors. This behaviour may also lead to inefficient utilization of public health facilities and unnecessary delays in assessing patients.

An audit of defaulters at primary care clinics in Saudi Arabia was carried out at King Khalid and King Abdulaziz University Hospitals. These clinics work five days each week and are open to citizens of all nationalities. An average of 600 patients are seen daily of whom only 25-30% are seen by appointment. All patients aged over 12 years who were given appointments over a period of four weeks were included in the study and followed up for three months after the first visit. A data form was used to collect information on the characteristics of the patient and the appointment. The form was completed at the end of the three month study (March-June 1990). A random sample of defaulters were selected and their reasons for defaulting determined by telephone. The significance of the various factors governing default was determined by the Chi-squared test.

A total of 3292 patients were included

in the study and among these patients the default rate was 29.5%. Morning appointments were better kept than those in the afternoon (non-attendance rate 26.3% versus 31.8%, $P < 0.01$) and poor attendance was more common towards the weekend (27.4% on day one versus 34.0% on day five, $P < 0.01$). The defaulters were more likely to be aged over 65 years (31.0% versus 27.6%, $P < 0.001$), and highly educated (31.6% versus 23.9%, $P < 0.001$). The main reasons for defaulting among 150 defaulters were transport difficulties particularly among women who were not allowed to drive, unclear appointment details and forgetfulness. The patients' sex, nationality, marital status, the distance travelled to the clinics, the severity of the initial diagnosis or the time interval between follow-up appointments had no significant effect on whether or not patients defaulted.

The results of this audit show that primary care clinics in Saudi Arabia are different from British or American primary care. Only 25-30% of the patients were seen by appointment and of these nearly a third failed to attend. One aspect of the service which may reinforce this high default rate is that patients who do not have an appointment simply turn up and wait their turn, thereby causing delays for those with genuine appointments who do not get preference. This shortcoming has now been corrected. It is of interest to note that the characteristics of the defaulters in the present study, such as age and ethnicity corroborated some previous studies among Caucasians,^{1,2} though not all.^{3,4}

In order to reduce the default rate of patients in Saudi Arabia, public health awareness must be improved, with the emphasis on the advantages of keeping appointments with primary care doctors. Special education is required, particularly among elderly people and those who have a hearing disability. Communication skills, teaching and training have been added to the continuing education programme of the medical team but it is too

early to evaluate the effect of this change on patient behaviour.

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Assessment of cognitive impairment in the elderly

Sir,

The paper by Illiffe and colleagues, (January *Journal*, p.9) once again raises questions about our ability to detect cognitive impairment in elderly patients.

Using the mini-mental state examination, Illiffe and colleagues found the prevalence of cognitive impairment to be 4.6% in a sample of patients aged 75 years and over, with possible impairment in a further 10.5%. Of concern is the finding that only one of the four medical records of the patients with mini-mental state examination scores of less than 11 (which indicates severe impairment) contained a record of dementia. Also, dementia was noted in only four of the 239 patient records studied. Despite the low prevalence of dementia found on formal testing, the general practitioners had apparently still failed to detect most of the cognitively impaired patients.

This study seems to confirm the finding of previous studies of cognitive impairment in the elderly in the community which claim that formal testing of cognitive function would reveal many more cases of impaired function than doctors or nurses suspected.^{1,2} However, more recent work has suggested that health care workers may not be failing to detect as many demented elderly persons as previously thought.^{3,4}

A consensus seems to be emerging about which of the many short functional testing tools is most appropriate — most workers seem to feel that either the short portable mental status questionnaire or the mini-mental state examination are the best screening tools for busy general prac-

tioners to use.^{5,6} However, the question of the number of impaired patients being missed is far from settled. A further complication is that prevalence rates are much affected by the cut-off points and diagnostic criteria used when administering the various tests for dementia.⁷

In a review of prevalence studies of elderly patients in the community I found rates ranging from 1.3%⁸ to 33.0%⁹, because of the widely different methods used and the very different populations studied. Illiffe's result falls between these extremes. The only consensus seems to be that prevalence rates increase with age, with the rate doubling every five years.¹⁰

The clinic where I work has recently completed a survey of the cognitive function of all 233 persons aged 70 years and over living in our small rural Canadian community. The instrument used was the Canadian mental status questionnaire (a local version of the short portable mental status questionnaire). The prevalence of severe cognitive impairment was 2.1%, and moderate cognitive impairment 6.4%, giving a total impairment of 8.6%. When former members of the community who are now in institutions were also tested, the prevalence of severe or moderate dysfunction rose to 11.6%.

In our study, physicians had noted the presence of dementia in the charts of all five patients found to be severely impaired by the test instrument. However, of the 15 patients who were found to be moderately impaired on testing, nine had been noted as 'neurologically normal' at a regular medical check up, and two men had been certified fit to drive a motor vehicle. It seems that doctors have difficulty detecting moderate degrees of impairment, although severe impairment is easily found.

In the light of Illiffe's results, and those of my own study, I think there is a place for the use of short screening tests on our elderly patients; we can hardly afford not to evaluate them for dementia.

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Which antidepressant?

Sir,

We write in response to the views expressed by Matthews and Eagles (March *Journal* p.123) on the choice of antidepressants in general practice. The article was entitled a 'discussion paper' but no opposing views were offered. Our recommendations would be quite different.

We would first point out that depressed patients treated by general practitioners show different features to those seen by psychiatrists.¹ The best evidence that antidepressants are effective in general practice patients comes from placebo-controlled trials of tricyclic antidepressants.^{2,3} Second generation antidepressants have rarely been tested adequately in general practice samples, and for some, overall evidence of efficacy is not very good. In addition, like all other drugs, they produce side effects, and it can take several years before the full picture of these emerges. With drugs of new chemical and pharmacological classes particularly, careful and extensive evaluation is needed before their place can be secure.

In their concluding paragraph, Matthews and Eagles recommend the first line use of trazodone, mianserin, lofepramine, fluvoxamine and fluoxetine by general practitioners. Most of these produce considerable adverse effects. Priapism is a well documented effect of trazodone which contraindicates its use in men. Nausea and vomiting occur with fluvoxamine and fluoxetine. Matthews and Eagles provide a particularly detailed defence of the record of mianserin in producing blood dyscrasias without reference to the Committee on Safety of Medicines' recommen-