to create an altered outcome of depression, regardless of research trial group or professional status of carer. This is not surprising, however, given the natural remission of depressive symptoms coupled with the Hawthorne effect. It would have been useful to report findings on longer-term follow-up, when an environment of heightened awareness of depression had decreased.

A more central question in practice is that of the 'natural' management of depressive symptoms by primary care professionals, especially in the context of screening activity. Such findings, however, can only be elicited by a different methodology, which establishes the care pathways of individual patients in a naturalistic setting.[2] There is also a concern that the study (like many others) specifically excludes the elderly, where depression is known to be both more likely to be chronic and undertreated. Studies ongoing in Sheffield (Philip I, McKee K, Newton P, *et al,* unpublished ms, 1997) are attempting to understand the consequences of primary care givers (lay and professional) suspecting depression in elderly patients, and to what extent those workers would liaise with a GP, encourage prescription, make referral, or simply define sadness as a natural consequence of life circumstances. Such studies may shed light on the elements of intervention that are truly critical therapeutically, and which therefore would benefit from maximal attention in any educational input or guidelines for good practice.

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A pilot study of the role of echocardiography in primary care

Sir,

Echocardiography is an essential investigation in the assessment of patients with suspected left ventricular systolic dysfunction. There was a 2.5-fold increase in the requests for echocardiography between 1988 and 1993, with a 12-fold increase in the number of requests for assessment of left ventricular systolic dysfunction.

We assessed the role of echocardiography in a primary care setting to determine whether such a service could complement existing hospital-based echocardiography services. The service was based in the surgery of a five-partner practice in Dundee and set up in collaboration with the local cardiology department. Indications for echocardiography included a history of dyspnoea, previous or recent myocardial infarction, hypertension and cardiac murmur. Echocardiography was performed using a Hewlett Packard Sonos 1000 by an experienced echocardiography technician and two of the partners. Each patient underwent a full echocardiographic study to access left ventricular function. Following each study a formal report was produced and a treatment recommendation was made by the medical staff. The main echocardiographic diagnoses are summarized in Table 1. Twenty-two patients had their treatment altered as a result of echocardiography and eight patients were commenced on an angiotensin-converting enzyme inhibitor.

This is the first reported use of echocardiography in primary care. Primary care based echocardiography is a potential way of complementing hospital-based echocardiography services as the majority of requests here were for the assessment of left ventricular function. A key issue is the quality of the images obtained and their interpretation. GPs willing to run an echocardiography service should be trained in accordance with the British Society of Echocardiography.

This pilot study demonstrates that it is possible to set up and run a primary care based echocardiography service. It is essential that operators are fully trained and that there is collaboration with the local cardiology unit on locally agreed guidelines. Further work is required to evaluate the cost-effectiveness of such a service, the validity of assessments, and whether primary care echocardiography is a suitable alternative to open-access echocardiography.

Table 1. Main echocardiographic diagnosis.

Diagnosis	Number
Left ventricular systolic dysfunction	14
Left ventricular hypertrophy	16
Aortic valve disease	
aortic stenosis	1
aortic sclerosis	10
aortic incompetence	2
Mitral valve disease	
mitral stenosis	1
mitral incompetence	10
Normal echocardiography study	29

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HRT use

Sir,

Townsend (January *Journal*[1]) has established that the present use of HRT is over 20% for women aged 40 to 64 years in Britain. This huge increase in expense and workload must be a cause for concern as most of the prescriptions are patient-led and are reaching the well-fed, exercising, and non-smoking classes 1 and 2, rather than poorer women who are more likely to smoke and less likely to eat well.[2]

All the evidence on risks and benefits is derived from observational studies and, until the results of large randomized controlled trials are published, we will have to make decisions using the insufficient evidence now available.

We should target the vulnerable groups who have risk factors such as early menopause, fragility fractures, adverse family history, and long-term use of high-dose corticosteroids. A dedicated clinic is preferred by patients,[3] and referral within the practice, with bone density estimation only where the result makes a difference to the decisions on treatment, is economical and feasible.

Prevention cannot be cost-effective: a fracture prevented at the age of 60 may still occur years later at a greater cost to the NHS. Yet the postponement of disability could greatly improve the quality of life of the individual. Every woman needs counselling about the menopause.

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