Letters

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Home blood pressure monitoring

Shah and colleagues found patients with heart failure who lived in areas of socioeconomic deprivation were less likely than those in more affluent areas to be treated with recommended beta blockers.¹ We recently investigated use of home blood pressure (BP) monitoring in stroke patients registered at a deprived inner city general practice in Lambeth. In March 2008 we sent confidential postal questionnaires, backed up by a telephone call if required, to 74 patients listed on the stroke register at an inner London general practice. We excluded 57 patients in nursing homes and four patients with severe illness because of the difficulty of completing and posting questionnaires. The questions included asking patients whether they measured their BP at home and whether they were aware of their target BP. The protocol, patient information leaflet, and questionnaire were reviewed by Wandsworth Research Ethics Committee. Data were entered and analysed using SPSS (version 13).

The response rate was 61% (45/74) of which 35 were postal and 10 were telephone questionnaires. The mean age of the responders was 71 years (range 31–94 years) and 58% (26) were male. The majority of those answering the questionnaire (69%, 31/45) described their ethnicity as white. However, 20% (9/45) described their ethnic group as black-Caribbean, a group known to have a high risk of stroke. A further four responders described their ethnicity as Indian, Pakistani, Chinese, and 'Other' respectively.

We found that only eight patients (18%) were monitoring their BP at home of whom six checked their BP at least once a week. Only two of them had been shown by a health professional how to measure their own BP. However, the majority (62%, 23/37) of those who did not use a home BP monitor believed that the use of one in the future would help them to control their BP. An important finding was that 89% (40/45) of responders were unaware of their target BP (<140/85 mmHg): 33 (73%) said they did not know, and a further four patients gave a target that was too high. Only 5/45 (11%) of patients gave the correct target BP. Regarding the potential for using IT to help monitor BP at home, 80% (36/45) had a landline, 20% (9/45) a personal computer with internet access, and 13% (6/45) knew how to use a mobile telephone for texting.

Good control of high blood pressure is effective in both primary and secondary prevention of strokes.^{2,3} However, in this study only one in 10 stroke patients knew their recommended target BP and only one in five were monitoring their BP at home. We agree with Shah and colleagues that there is potential for improvement in both uptake and access to secondary prevention of cardiovascular disease.

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Depression in general practice

The February issue of the *BJGP* devoted space to research into depression and attempted to put this work into context. Here I try to set the scene in a different way — by relating what we do in the consulting room to what is happening in the community at large. I have taken percentages from the literature and converted them to round numbers on a human scale. Suppose a part-time UK GP has 600 adults on their list, sees 200 in a month and discusses a few of them over coffee (see figure).

Each month, 15% of adults report having felt depressed and 4% consult their doctor about this.¹ So each month, in an adult population of 600, 100 feel depressed and 27 consult.

The prevalence of depression in general practice is around 10% and its diagnosis by GPs has a sensitivity of 36% and specificity of 84%.² So of the 200 patients seen in a month, depression is diagnosed in 20 of the 180

who do not have depression and in seven of the 20 who do, giving a total of 27* supposedly depressed patients. Of patients diagnosed with depression 33–43% are given antidepressants.^{3,4} So, out of 27 patients we prescribe antidepressants for 10.

Antidepressants produce improvement in 28–74% of patients compared with 16–35% on placebo.⁵ Withdrawal rates from antidepressants are 3–30%.^{5,6} So, of 10 patients for whom we prescribe antidepressants, two withdraw, three continue without benefit and five continue with benefit, of whom two would have benefited from placebo.

This account omits certain considerations such as compliance and is meant not to be statistically watertight but to give an overview. It indicates the marginal role of antidepressants, the importance of finding out what makes one depressed person consult unlike the other three who don't, and the potential value of depression screening questionnaires.

*By my choice of list size and workload I have arranged for these figures to match: that does not mean they represent the same patients.

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Film on NHS for new immigrants

The work of O'Donnell and colleagues¹

clearly illustrates how recent immigrants' expectations of the NHS are shaped by their experience of health services in their country of origin. When expectations conflict with the reality of service delivery in the UK, patients become frustrated, staff also find themselves under strain. The need to repeatedly explain the system and to cope with unhappy patients, who are having difficulty negotiating appointment and referral systems, can increase the workload.

In response to the challenge of explaining the NHS to new immigrants, I have recently worked with a small group of (mainly) asylum seeker and refugee health professionals to produce a short film, 'How to use the NHS'. The film takes the style of a conversation between two old friends. It is made in English with voice-overs in eight other languages, namely: Arabic, Farsi, Kurdish, Urdu, Sylheti, Somali, French, and Polish.

The key messages in the film cover some of the issues highlighted by O'Donnell's article, and others that my own experience suggested might be useful. For example:

- in the UK, patients receive most of their care from their (well trained) GP, not from hospital;
- most GP surgeries ask patients to make an appointment to be seen;
- patients must arrive on time for their appointment;
- interpreters can be requested for patients with little English;
- help with costs of prescriptions is available for those on low incomes;
- repeat prescriptions can be obtained without seeing the doctor, provided a few days notice is given;
- routine referrals to hospital specialists may necessitate a wait of a few weeks. This is the same for all NHS patients; and
- for advice, and out-of-hours care, NHS direct can be consulted on 0845 46 47 — the service offers interpreters.

The film was launched in Manchester in March 2008. Because we want the film to be used as widely as possible, it is