

of 445 patients who had received three or more consecutive prescriptions for one or more benzodiazepines from a practice population of 17 000 patients from three general practices.

The article illustrated the percentage age distribution for a sample of 205 of the benzodiazepine users. The age bands 60–69 years and 70–79 years contained the largest proportions of benzodiazepine users, approximately 30% and 26% respectively. However, this method of presenting such data fails to provide adequate information on the prevalence rate of different age groups. Table 1 shows the prevalence rate for each age band based on the total sample of 445 benzodiazepine users.

Table 1. Age band prevalence rates of long-term benzodiazepine users.

Age (years)	Number of benzodiazepine users per 1000 population
20–29	1
30–39	10
40–49	26
50–59	37
60–69	81
70–79	121
80–89	125
90+	29

This analysis reveals that the age band with the highest prevalence of benzodiazepine users is the 80–89 years age group. However, the 80–89 years age group accounted for only 11% of the 445 benzodiazepine users. The 60–69 and 70–79 years age groups also have relatively high prevalence rates of 8.1% and 12.1% respectively. This further emphasizes that the older age groups are relatively heavy users of benzodiazepines in relation to their representation in the general population.

Rodrigo and colleagues' reported prevalence rate of 2.2% of registered patients receiving prescriptions for benzodiazepines for more than one year and Simpson and colleagues' figure of 2.6% mask the extreme variability of prevalence rates within specific age bands. Future studies should pay more attention to prevalence rates for specific age bands.

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Reference

- Rodrigo EK, King MB, Williams P. Health of long-term benzodiazepine users. *Br Med J* 1988; 296: 603-606.

Traveller gypsies

Sir,

I am grateful to Allison Streetly for drawing attention to the outbreak of polio among travellers in the mid-1970s (letters, *February Journal*, p.83). I too cannot imagine that travellers have lower rates of infectious illness than the settled population and, as I wrote in my review (*October Journal*, p.425), a low immunization rate is still an important issue for travellers' health care.

Dr Streetly takes me to task for making 'little of the differences in culture and perspective . . . between travellers and health care providers'. This is surprising because I intended that argument to be one of the recurrent themes of the article. I discuss how recognition of traveller gypsies as an ethnic group may lead to a better understanding of their own perception of prevention and the role of health services. I also state that the most interesting development in traveller health care is the adoption of a patient centred approach starting from the concerns and problems of the travellers themselves. I stress that travellers' health visitors can help negotiate some of the cultural differences between doctors and their traveller patients, who often have their own concepts of hygiene and illness. Finally, I suggest that any health or preventive initiative should be based on close consultation with the local traveller communities, who are best placed to identify specific problems.

I fully agree with Dr Streetly that we should try to understand the health service from the 'outside in'. To this end our research programme in east London includes an investigation of travellers' own health priorities and their view of preventive procedures and health care facilities.

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Referrals by optometrists to general practitioners

Sir,

Dr Perkins concludes that general practitioners remain an effective filter between optometrists and ophthalmologists (*February Journal*, p.59). While this may have been the case during his study, I wonder if it will continue to

apply following the restriction on the availability of free sight tests.

When seeing patients under general ophthalmic services ophthalmic opticians and ophthalmic medical practitioners are obliged to refer any abnormal findings to the patient's general practitioner. This leads to an unnecessary number of patients being referred to their doctor as the examiner is unable to exercise his or her judgement. The general practitioner assesses the situation, and, as Dr Perkins has shown, a sizeable proportion of patients do not need further referral.

Since last April the entitlement to a general ophthalmic services examination has been restricted, and many people now have to pay for private examinations. The examiner is then under no contractual obligation to inform the patient's general practitioner of any findings. Obviously, the ophthalmic optician or ophthalmic medical practitioner may not know of all the relevant background information about a patient, but they could avoid sending patients with cataracts, for example, unnecessarily early to their doctor and could suggest over the counter treatment for cases such as dry eyes. If this study were to be repeated in a couple of years' time I think it likely that fewer patients would be referred to their general practitioner, and the 'filtering' would be less apparent.

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Near patient testing is within reach

Sir,

I congratulate Dr Hilton for the foresight of his review article on near patient testing (*January Journal*, p.32). What computers have done to improve patient care in general practice in the 1980s, near patient diagnostics will do to improve care in the 1990s.

Even before the advent of the white paper¹ there was an argument for producing quicker comprehensive biochemical screening to give a speedier diagnosis, to give earlier treatment and reduce the number of patient visits. Dr Hilton's example of the benefit of glucose assays in diabetic clinics points to how useful a full biochemical screen would be for a wider range of patients.

My interest is in the Du Pont Analyst which has the advantage of performing up to 16 chemistries simultaneously on a single sample in around 10 minutes, and