

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-

dation for careful and regular blood surveillance, or of the paucity of evidence for its efficacy in general practice. The recommendation of lofepramine for the elderly may be more soundly based as it has fewer anticholinergic side effects but these side effects still do occur.

Unlike Matthews and Eagles, we believe that most general practitioners are qualified to prescribe clomipramine to their patients without referral to a psychiatrist, and that many can prescribe a monoamine oxidase inhibitor or lithium and provide the supervision that is required.

Our advice to general practitioners is based on the evidence of Hollyman and colleagues.³ Patients presenting with a probable or definite major depressive disorder⁴ should be treated initially with a first generation tricyclic antidepressant such as amitriptyline, unless contraindicated. A diagnosis of probable major depressive disorder depends upon persistent depressed mood for at least a week, preferably two weeks, together with at least four of the following symptoms: change in appetite or weight; sleep change; loss of energy; loss of interest; self-reproach; poor concentration; recurrent thoughts of death or suicide; and visible agitation or retardation. Second generation antidepressants have a place as second line treatments where side effects of first line drugs necessitate a change of regimen in spite of the disadvantages. The first generation tricyclic antidepressants are well tried, established in efficacy, have known side effect profiles and are much less expensive than second generation drugs. They are therefore much more appropriate as first line treatments.

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amitriptyline among depressed patients in general practice. *J R Coll Gen Pract* 1988; **38**: 393-397.

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Quality or inequality in health care?

Sir,

During the stimulating debate on 'Quality or inequality in health care' at the Royal College of General Practitioners' Spring meeting in Newcastle, some speakers maintained that general practitioner fundholders were drawn from the better quality practices and that fund holding would further improve the quality of the care for their patients. I was reminded of the paper by Howie and colleagues (February *Journal*, p.48) in which they reported their research which made a convincing case for relating the quality of personal family doctor care to the length of consultation.

Being by nature a 'slow' doctor myself, my work as a locum in various Glasgow practices over the last few years has been enlightening. In some 'quality' practices the consultations were at 10 minute intervals; others had five minute appointments and many extra appointments. In the former I saw 12 patients in two hours and then had time to attend to all the paper work; in the latter, mainly in the peripheral housing schemes, I saw 35 to 40 patients in three hours. I am in no doubt about the quality of care, or lack of it, in these situations.

The main difference is clearly patient demand. In practices in deprived areas where patient demand is high there are substantially fewer patients per doctor than average and therefore the doctors receive less remuneration in capitation fees. There is little time for health promotion clinics and little hope of achieving targets, so income from these activities is limited. Deprivation payments are high but do not nearly compensate, which explains why these doctors are the poorest paid in the UK.

In their paper, Howie and colleagues stated 'doctors generally feel constrained by their commitments and, although many faster doctors expressed dissatisfaction with short consultations, they did not see a change in organization as a realistic option.' The greatest differences they found between longer and shorter consultations were first in the number of psychosocial problems identified and dealt with, and secondly, in the number of other health problems identified and dealt with. My observations (only impressions and not properly researched) con-

firm Julian Tudor Hart's inverse care law.¹ It is the patients in these areas of high social deprivation,^{2,3} with the greatest demand on services and the shortest consultation times, who would benefit most from longer consultation times, where their doctors could try to help solve their problems and offer advice to improve their physical, psychological and social health.^{4,5}

The motivation of the doctors in these areas is high and they have been justly called medical missionaries. What has the new contract to offer them? What is the RCGP's role in supporting them? At the very least we must try to keep up their morale and avoid 'peripheralizing' them, like the parts of our cities in which they work.

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Standardized patients in general practice

Sir,

Rethans and colleagues are to be congratulated on their careful and thought provoking studies of the use of standardized patients (March *Journal*, p.94,97). I wish, however, that more emphasis had been placed on a most important caveat towards the end of their second paper. 'The finding that doctors perform below predetermined standards does not prove that doctors are incompetent; it should at least be tested against the hypothesis that standards for actual care are still not realistic'. In other words, an alternative interpretation of the results is that the pre-set standards of care are invalid because they fit so poorly with the actual practice of doctors who should be presumed to be competent.

In much standard setting work of this type, I suspect that even the best intentioned general practitioners cannot throw off their essentially hospital based education, traditionally so dependent on received (and frequently untested) truths. Intuitive-