

telephone number; the optician to whom the patient is referred and the reason for referral; the patient's relevant past medical history including hospital reference number (if known); and family/social history. The second side gives the patient's drug therapy and allergies; clinical history and findings, including blood pressure and urinalysis results; and the opinion required including boxes to tick when intra-ocular pressure or fundal photography are required. These details are signed and dated by the referring general practitioner. The third side is headed clinical notes and together with side four is left free for extra information, clinical notes and follow up as required.

Why should we not communicate with and utilize the skills of our ophthalmic colleagues more readily? Few general practitioners have immediate access to slit lamp examination for acute anterior eye conditions. Would it not be more appropriate to build up a better working relationship with our optometrist colleagues for urgent eye opinions than burden our local casualty department where examination may be carried out by a doctor with fairly limited skills in ophthalmology?

Harrison and colleagues have shown that properly equipped ophthalmic opticians are better able to diagnose accurately and refer patients with glaucoma than general practitioners.¹ Ocular hypertension is therefore best managed by the ophthalmic optician and, when appropriate, hospital referral arranged in conjunction with the general practitioner. Accurate and cost effective screening and follow up of the families of patients with glaucoma could also be organized by the optometrist.

Patients with more chronic visual problems, such as hypertensive or diabetic patients, could readily be referred, using the ophthalmic referral card to an optometrist. Harrison and colleagues have also shown that ophthalmic opticians have greater skills than general practitioners in the early detection of diabetic retinopathy.¹ It would, therefore, seem reasonable to refer diabetic patients to them for initial screening. Follow up, at mutually agreed intervals, could then be arranged in conjunction with the practice diabetic and hypertension clinics and any hospital ophthalmic referral be made by the optometrist and general practitioner in consultation.

Concern has been expressed that the restrictions on the availability of free sight tests deter people from using optometrists.² There are, however, important exemptions to those required to pay for sight tests. These include low income groups,

all diabetic patients, patients with glaucoma and anyone over 40 years of age with a family history of glaucoma in a parent, brother or sister — the main groups for which general practitioner-optometrist cooperation would be most beneficial.

The advantages of better communication and cooperation between general practitioners and optometrists would be: a better standard of ophthalmic care by both general practitioner and ophthalmic optician; a reduction in unnecessary hospital referrals; a shortening of waiting times for outpatient appointments; and savings to the National Health Service.

The optometrist working from our health centre has expressed support for the idea of inviting our local ophthalmologists to undertake occasional clinics in the ophthalmic suite. Such a development would allow a three way referral service for ophthalmological problems between general practitioner, optometrist and consultant ophthalmologists. This would be a helpful, cost effective service and the ophthalmic referral card could become a useful, efficient means of communication between all concerned.

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Fatal cryptosporidiosis in association with Sheehan's syndrome

Sir,

Cryptosporidiosis is a common cause of acute gastroenteritis in immunocompetent individuals, particularly in children, and of chronic, persistent, severe diarrhoea in the immunocompromised.¹⁻³ Healthy young adults may acquire infection by family contact with children and the disease in this age group may be severe.^{2,3} We report a fatal case of cryptosporidiosis in a 33 year old woman who had received thyroxine and hydrocortisone replacement therapy for Sheehan's syndrome for the previous six years.

The five month old son of the woman was admitted to hospital with a two week

history of diarrhoea; cryptosporidium oocysts were detected in the faeces and no other pathogens were present. The mother then became unwell with vomiting and diarrhoea and her partner was given general advice for gastroenteritis by a locum general practitioner. Four days later she died, following a sudden and rapid deterioration in her condition.

Post-mortem examination suggested dehydration and confirmed the features of Sheehan's syndrome, with a pituitary gland largely replaced by fibrous scar tissue. The adrenal and thyroid glands also showed severe atrophy. Cryptosporidium oocysts were detected in the faeces but no other enteric pathogens were present. A post-mortem blood sample showed an elevated urea level (10.8 mmol l⁻¹) (suggesting dehydration) and a normal cortisol level of 301 nmol l⁻¹ which indicates that there had been no response to the stress caused by the severe infection.⁴ Death was attributed to circulatory failure and no other natural disease was found.

Severe metabolic disturbance and death has been attributed to cryptosporidiosis in a small number of immunocompetent adults.³ In this case, intramuscular hydrocortisone administered for the duration of the acute, gastrointestinal illness may have prevented the fatal outcome.⁴

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Preventive care of elderly people

Sir,

In his editorial (September *Journal*, p.354) Dr Tulloch states that there is 'clear cut evidence from controlled trials that screening and functional assessment reduce institutional care significantly among elderly people'. This view is supported by four references, one of which is in Norwegian. The study by Hendriksen and colleagues¹ was conducted in