that nine patients have not requested H_2 antagonist therapy since their triple therapy treatment.

These patients have been spared the discomfort of further gastroduodenoscopy, and savings have been made on further consultation time, investigations and long-term treatment with H_2 antagonist therapy. The results of our experience are encouraging and we hope to follow up these patients over a period of time.

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Consulting habits of temporary residents

Sir,

Little attention has been paid to the consulting habits of holidaymakers in the United Kingdom. It is a generally held view that temporary residents seen in general practice are not only time consuming and a source of potential stress, but are also a largely unnecessary, costly burden to the National Health Service, albeit representing a considerable source of remuneration for some general practitioners.

In August 1991 all family health services authorities in the UK were sent a questionnaire asking for the number of high and low rate temporary resident claims made by general practitioners in the past year. By December 1991 80 of the 116 family health services authorities (69%) replied. There were 622 576 high rate claims and 969 610 low rate claims and at current rates (£11.45 and £7.65 respectively), this amounts to expenditure of approximately £14.6 million per year. Total expenditure on temporary resident claims is therefore estimated to be approximately £21 million per year. Family health services authorities and regional health authorities have been unable to audit this major source of expenditure as specific records for temporary residents are not kept and they have little knowledge of factors influencing temporary resident consultation rates.

Our own recent study of temporary resident consultations during one week in peak holiday season (19–28 August 1991), found that 15 of 210 consultations (7%) with temporary residents were for repeat prescriptions only. A similar study by Perkins[1] found that 18% of temporary resident consultations were for repeat prescriptions. These figures represent an estimated cost nationally of between £1.5 and £3.8 million. Our study also revealed that 13% of temporary resident consultations were for problems associated with pre-existing conditions.

A considerable proportion of temporary resident consultations may be avoided if prospective holidaymakers were to be given specific and appropriate advice concerning their medical conditions, especially in relation to medication, prior to departure. Use of posters in the waiting room, information leaflets, opportunistic health advice from practice nurses and doctors may be sufficient. Further research into the reasons for temporary resident consultations is necessary and, perhaps, a national campaign is needed addressing the issue with the aim of reducing unnecessary consultations by holidaymakers.

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GPs and optometrists

Sir,

There has been recent interest in optometry and general practice (letters, December *Journal,* p.518). A study conducted in April and May 1991 investigated communication between general practitioners and optometrists using a questionnaire comprising closed questions. The questions were matched, that is the same issue was addressed in questionnaires sent to both doctors and optometrists. All optometrists and general practitioner trainers in the Tayside region were contacted. Questionnaires were sent to 60 general practitioners and 36 optometrists, and replies were received from 46 general practitioners (77%) and 29 optometrists (81%).

A total of 45 general practitioners 'never' or 'infrequently' replied to optometrists upon receiving the general ophthalmic services (Scotland) form noting ocular abnormality. Only one of the 29 optometrists recorded they 'often' received a written reply from general practitioners although 24 optometrists reported a desire for such feedback. Referral from the optometrist to the general practitioner was usually written — 39 out of 46 general practitioners (85%) reported that they received referrals in the form of a typed letter, a general ophthalmic services (Scotland) form, or a combination of both. Among the 29 optometrists 24 (83%) reported that they sent referrals in one or both of these forms. Referrals from general practitioners to optometrists were not written, a verbal message being sent via the patient.

The content of referral letters from optometrists was also examined. Forty two general practitioners and 24 optometrists thought that urgency of any subsequent hospital referral should be stated. The majority (35) of general practitioners felt optometrists were qualified to give a diagnosis of ocular abnormality. Most optometrists (19) wanted to refer patients directly to hospital ophthalmology outpatient clinics, and 27 general practitioners also felt that this was appropriate.

This last finding is interesting since Perkins[1] found that of 61 patients referred from optometrists, 50 required onward referral to an ophthalmologist. He concluded that 'general practitioners remain an effective filter in the referral system between optometrists and ophthalmologists'. Communication between the general practitioner and optometrist tends to be one sided: from the optometrist to the general practitioner. Space on a revised general ophthalmic services (Scotland) form to include an assessment of urgency of referral and likely diagnosis would be welcomed.

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Management of URTIs

Sir,

We were surprised that the paper by de Melker and Kuyvenhoven on the management of upper respiratory tract infection in Dutch general practice was predominantly concerned with describing the use of antibiotics (December *Journal,* p.504). More detailed considerations could have been given to advice on home remedies and the prescribing of antipyretic