Preventive care of elderly people

Sir,

I was disturbed to read Dr Fox's reply (letters, February *Journal*, p.80) to Dr Tulloch's editorial.[1] He states that in his practice the general practitioners do not engage in screening, but rely upon information from home helps and other carers to tell them of problems. Such practice amply justifies the fears expressed in Dr Wilkinson's letter (February *Journal*, p.84) that skills acquired during our training may not be put to use once established, leading to the eclipse of medically qualified general practitioners, and their replacement by paramedics. I therefore support Dr Tulloch in advocating better training in preventive care of elderly people.

The records for 1984 of my clinic for patients aged over 70 years at Woodside health centre in London showed a reduction in the consulting rate in one year in this age group from 6.6 consultations per patient per year to 3.8. Of 176 elderly patients screened at the clinic preventive care was possible for 8%: two patients were complying with treatment incorrectly. Three patients had developed speech defects as a result of multi-infarct dementia, and when tested for mental status revealed a need for increased care. Three patients had defective hearing aids requiring attention. One hypertensive patient was developing renal failure and was helped by angiotensin-converting enzyme inhibitors and referral to a dietician for a low protein diet. One patient with a low haemoglobin concentration was found to have macrocytosis, confirmed as pernicious anaemia. The patient was able to live a normal life once vitamin B_{12} deficiency had been corrected by cyanocobalamin injections. One patient who had suffered several falls was found to have numerous empty sherry bottles under the bed. He was socially isolated and depressed. Following introduction to a social club, and having been given antidepressant therapy for three months, no further falls were reported. A 77 year old man who insisted on doing everything for his wife, who had been discharged home with renal failure, was put on small doses of propranolol to reduce the effects of stress; this proved remarkably effective. A 94 year old housebound woman was reported to have foot deformities following a visit by the health visitor; these were corrected by surgical boots that improved mobility considerably. A 68 year old woman was caring for her 74 year old sister who had rheumatoid arthritis and was failing to cope. On examination she was found to have a refractory anaemia/myeloid dysplasia for which she was treated; extra assistance was also provided.

The informative network of home helps and other carers referred to by Dr Fox is useful, but full reliance on it for preventive care is misplaced and a reminder of earlier times when the needs of the elderly were neglected.

M KEITH THOMPSON

28 Steep Hill
Stanhope Road
Croydon CR0 5QS

Reference

1. Tulloch AJ. Preventive care of elderly people: how good is our training? [editorial]. *Br J Gen Pract* 1991; **41**: 354-355.

Eye care in general practice

Sir,

The survey by Featherstone and colleagues (January *Journal*, p.21) is interesting as it suggests ways of increasing the quantity and quality of eye care in general practice. It focuses on an area in which many general practitioners feel unsure of themselves.

The resources available to general practitioners can be divided into 'internal resources' and 'external resources'. Internal resources include the training that they receive at medical school, during vocational training or by subsequent attachment to ophthalmology outpatient departments, while external resources have traditionally consisted of ophthalmological opinion either at a local district hospital or perhaps in a community setting.[1]

One readily available resource that was not mentioned by Featherstone and colleagues is the optometrist who has had three years of university training followed by a supervised preregistration year in clinical practice. Optometrists are skilled at ophthalmoscopy, which is now mandatory at every eye examination, and most have access to good equipment including tonometers, slit lamps and visual field measuring instruments. Optometrists are well placed to identify and assess eye changes among diabetic patients,[2,3] and to provide regular assessments of patients with chronic eye conditions. Indeed, they initiate more positive referrals for glaucoma, for example, than any other professional group.[3,4]

Perhaps because of the retail aspect of their practice, optometrists' clinical skills and training are often underestimated by their medical colleagues and therefore this resource is often not utilized. Many patients are exempt from eye examination charges including children under the age of 16 years, or under 19 years if in full time education, patients on income support, patients registered blind or partially sighted, diabetic patients and patients with glaucoma as well as patients aged 40 years or over who are close relatives of a person with glaucoma.

Ideally general practitioners should increase their knowledge of eye conditions and skills in management. However, there is undoubtedly a good case for increased use of existing resources rather than expecting large numbers of general practitioners to undertake training to become confident in managing the 34 eye conditions listed by Featherstone and colleagues.

P ADLER

50 High Street
Stotfold
Hertfordshire SG5 4LL

M A VINCENT

Stotfold Health Centre
Hitchin Road
Stotfold
Hertfordshire

References

1. Dart JKG. Eye disease at a community health centre. *BMJ* 1986; **293**: 1477-1480.
2. Burns-Cox CJ, Dean-Hart JC. Screening of diabetics for retinopathy by ophthalmic opticians. *BMJ* 1985; **290**: 1052-1054.
3. MacKean JM, Elkington AR. Referral routes to hospital for patients with open angle glaucoma. *BMJ* 1982; **285**: 1093-1095.
4. Harrison RJ, Wild JM, Hobley AJ. Referral patterns to an ophthalmic outpatient clinic by general practitioners and ophthalmic opticians and the role of these professionals in screening for ocular disease. *BMJ* 1988; **297**: 1162-1167.

Sudden infant death syndrome

Sir,

I was interested to read Dr Riley's letter (March *Journal*, p.130) commenting on the factors associated with sudden infant death syndrome and the discussion of its possible prevention, which referred to a previous letter by myself and Dr Brown.[1] While agreeing that our statement 'the infant should be kept in the parents' room at night' was contentious, I cannot agree that there is no evidence to support it.

The risk of sudden infant death syndrome among the Asian community seems to be considerably lower than for England and Wales as a whole.[2,3] In the study by Kyle and colleagues the risk was approximately halved in those of Asian background, independently of other known risk factors.[3] A recent investigation in Birmingham looked for socio-