LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Use of benzodiazepines

Sir,

In view of the adverse publicity surrounding their use, it seems surprising that benzodiazepines are still prescribed on long term prescription for so many patients.[1,2] Few studies have looked either at patients' views on this subject or the attitudes of doctors themselves.[3-4]

In October 1991, a study was undertaken in an inner city London practice of patient and general practitioner attitudes towards long term benzodiazepine use in order to examine why a group of patients were still receiving regular repeat prescriptions for benzodiazepines.

A questionnaire was sent to the 54 patients identified on the practice computer as receiving regular repeat prescriptions over the past six months, except those taking them for epilepsy. There was a 74% response rate. Of the 40 respondents, 20 were aged over 75 years and 15 were between 61 and 75 years; 29 were women and 11 were men. Thirteen respondents were on nitrazepam, 11 were taking temazepam, seven were on diazepam and the others were on combinations of these and other benzodiazepines. Respondents were asked to tick responses to questions regarding reasons for taking benzodiazepines, knowledge of side effects and attempts made to stop taking benzodiazepines. A questionnaire was also sent to each of the four practice partners asking them to tick appropriate responses to a series of questions on prescribing and monitoring of long term benzodiazepines.

The general practitioners indicated that they prescribed benzodiazepines mainly as short term hypnotics and anxiolytics, with one doctor indicating that she did not initiate any new repeat prescriptions. None believed they should be prescribed for all patients with significant persisting insomnia or anxiety. Two agreed they should seldom be prescribed on repeat prescription and two that they were often inappropriately but unavoidably prescribed in the long term for selected patients. All four doctors believed they had encouraged all or most of their patients who were having repeat prescriptions to reduce or stop their medication on more than one occasion, and had furthermore advised all or most of them regarding specific side effects. Three of the partners thought that few of the patients would be willing to try reducing or stopping their medication.

Interestingly, 28 patients (70%) stated that their general practitioner had never suggested stopping their medication. Asked for reasons for continuing to obtain repeat prescriptions, 11 answered that it was because their doctor thought they should continue and eight because their doctor had never suggested they stop. The majority (70%) stated they were unable to sleep without their medication hence could not stop taking it. Twenty two patients (55%) had not heard of any possible side effects, and of those who had, eight answered that they had heard about these from their general practitioner. Only five associated benzodiazepines with addiction, despite the general practitioners giving this as their most frequently warned of risk. Nine patients said they would prefer to stop taking their medication if they were told of any risks.

The study shows a considerable gap between the general practitioners' perceptions of what they had told the patients and the patients' perceptions of what they had been told by the doctors. The general practitioners may not have been doing what they thought, or the patients may have forgotten or disregarded the doctors' advice, perhaps as a result of feeling reluctant to face the possibility of coping without their medication. But it is also conceivable that the doctors may have decided that these particular patients could never be motivated to stop their medication and hence gave up on them without consistently trying.

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Diagnosis of hypertension

Sir,

The difficulties associated with the diagnosis of mild to moderate hypertension have recently been highlighted in the literature.[1-5]

A study has been carried out to investigate the peripheral vascular effects of a new angiotensin converting enzyme inhibitor. Between May 1990 and May 1991 four east London practices referred patients with mild to moderate hypertension (World Health Organization classification 1–11, systolic blood pressure 160–200 mmHg, diastolic blood pressure 95–115 mmHg[6,7]) recorded on at least three consecutive occasions over a period of at least three months to the thermographic and blood flow unit. This followed the recommendations on blood pressure measurement issued by the British Hypertension Society.[8]

Thirty six patients were referred; 19 were newly diagnosed and untreated and 17 were being treated with various antihypertensive drugs.

The investigation protocol stipulated use of a random zero sphygmomanometer (Hawkley and Sons Limited), with blood pressure recorded as the mean of three readings taken at five minute intervals after the subjects had been seated for 15 minutes in a quiet room. All 17 of the treated patients were found to be normotensive and agreed to come off therapy. Subsequently, eight patients required treatment and for nine patients blood pressure remained below 160/95 mmHg (mean 155/86 mmHg) for a mean of four months while recordings at their general practice consultations gave higher values (mean 179/110 mmHg), which would have indicated treatment was required. These patients remained untreated because of the lower readings at the blood flow unit. However, using either method, only two

subjects remained normotensive at two year follow up. Over the same observation period, six of the 19 untreated patients remained normotensive, the remaining 13 requiring therapy.

A blind comparison in 25 of the patients' between blood pressure measurements recorded by a random zero sphygmomanometer and a mercury in glass sphygmomanometer showed close agreement when recorded simultaneously at the clinic but not with recordings made in the practices on or about the same day (mean values: in the clinic, random zero sphygmomanometer 153/90 mmHg versus mercury in glass 147/87 mmHg; in the practices, mercury in glass sphygmomanometer 170/100 mmHg).

While a number of factors including repeated observations may influence blood pressure recordings,[9,10] this experience reinforces the argument of Jackson and colleagues[4] that with a persistent diastolic pressure of less than 110 mmHg and in the absence of end organ damage, the period of observation before antihypertensive therapy is initiated should exceed the presently recommended three months.[11]

Nothing is gained by premature treatment, and the possible perception of poor health and the consequent reduction in the quality of life[12] in asymptomatic patients should be considered before treatment is initiated.

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Yellow card reporting

Sir,

The United Kingdom's yellow card scheme, in operation since 1964, has proved to be one of the most successful spontaneous adverse drug reaction reporting systems. It was the only scheme to identify serious cardiac arrhythmias associated with terodiline.[1] However, it is widely accepted that there is underreporting of adverse drug reactions.[2]

In 1991 the Committee on Safety of Medicines received 20 272 reports.[3] Sixty per cent of all yellow cards come from general practitioners,[2] hence general practice research is exceptionally well placed to study the subject.

A study was undertaken in a practice in Wolverhampton to determine how many adverse reactions an actively aware doctor could report in one month (the doctor looking for evidence of reportable reactions and also completing yellow cards).This was compared with the existing reporting rate for the west midlands region. During November 1991, a clinical diary was kept by a general practitioner in his vocational training year and a high level of awareness of adverse reactions was maintained. Over the same period the West Midlands Centre for Adverse Drug Reaction Reporting monitored the total number of general practitioner completed reports received and the number of general practitioners reporting reactions.

Of the general practitioners in the west midlands region (approximately 2790) 96 sent yellow card reports to the west midlands centre during the study period (nine general practitioners completed two yellow cards each, three general practitioners each made three reports, and the trainee sent four cards). By active surveillance, the trainee was able to detect four significant reactions using the criteria as set out on page 10 of the *British national formulary* (September 1991). The trainee conducted 361 consultations during the study period and therefore a reportable reaction was detected, on average, once in every 90 consultations. A mean of 1.19 yellow cards was received from each general practitioner who reported an adverse drug reaction in the region which, considering the trainee's total of four yellow cards, gives a general reporting rate of 30% among those who completed a card.

Lumley and colleagues studied 100 general practitioners and found that only 13% of yellow cards which could have been completed actually were.[4] It therefore appears that general practitioners in the west midlands report more reactions. This may be attributable to the presence of a local regional monitoring centre.

This study illustrates that increased doctor awareness could result in an improved adverse drug reaction reporting rate. Actively promoting awareness of the scheme among trainee general practitioners would mean that report of adverse drug reactions using the yellow card scheme is learned along with the other skills of general practice.

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Sex differences in morbidity in children

Sir,

The paper by van den Bosch and colleagues (September *Journal,* p.366) is interesting and important, particularly in relation to moderately serious and not serious illnesses in younger children.

A longitudinal study was carried out between 1985 and 1992 of children in our practice in Gorseinon, Swansea, in which 109 children aged 0–15 years with asthma and a matched control group of 109 non-asthmatic children were followed up.[1]

The presence of bronchitis, upper