

review, 56 of which were acted upon (26.9%).

The finding that 44% of patients were receiving drugs likely to cause adverse reactions in elderly people is a cause for concern, in view of the numbers of elderly people admitted to hospital as a result of their medication.¹⁻³ It is also noteworthy that for 71% of the potential adverse drug reactions identified by a surgery-based medication review, symptoms likely to arise from the drug were being experienced by the patient.

The study has shown that a pharmacist can make a useful contribution to both the medication review process and adverse drug reaction monitoring for elderly patients in the community. As the differences between the two groups of patients in terms of numbers of recommendations made and reports of drugs likely to cause adverse drug reactions were not statistically significant, there is no need for a pharmacist to undertake visits routinely to patients aged 75 years and over; review of the notes would seem to be sufficient.

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Treating acute asthma

Sir,

Patients commonly present to general practitioners with acute asthma associated with respiratory tract infection. The British Thoracic Society guidelines condemn the use of antibiotics in the absence of bacterial infection, and are unclear about the best dose, length of course and method of stopping oral steroids in such situations.¹

A postal questionnaire, checked for face validity, was sent to all 205 general practitioner principals in Bath District Health Authority in March 1993 and a reminder sent to non-respondents four weeks later. Respondents were asked to outline their management of case histories of an adult and a child presenting with acute asthma associated with respiratory tract infection. The cases were constructed in such a way that they could be managed

according to British Thoracic Society guidelines in a general practice setting, without admission to hospital.

Replies were received from 185 doctors (90.2% response rate) of whom 83.2% stated that there was an asthma clinic in their practice and 36.7% reported that they had a special interest in asthma.

Of 179 respondents, 93.3% reported that they would prescribe oral steroids to the adult with acute asthma associated with respiratory tract infection, and of 169 respondents, 87.6% reported they would prescribe oral steroids for the child. With one exception the oral steroid of choice was prednisolone. The modal initial dosage of prednisolone was 40 mg for the adult and 30 mg for the child. The modal duration of treatment with prednisolone was five days for both the adult and the child (Table 1).

Of 167 respondents, 89.2% stated that they would not tail off the course of steroids if the course lasted five days or less, but 46.7% stated that they would tail off the prednisolone if the course lasted between five and 14 days.

Oral antibiotics would have been prescribed for the adult by 66.5% of 179 responding general practitioners and for the child by 58.0% of 169 respondents.

There is some evidence that a 10-14 day course of prednisolone is required to produce maximal response in adults and hence a five day course may represent undertreatment in adults.² A study by O'Driscoll and colleagues suggests that tailing off steroid therapy is unnecessary if the course of treatment is less than 10 days, providing that inhaled steroids are continued. The prescription of antibiotics is contrary to the British Thoracic Society guidelines which are based on hospital studies suggesting that oral antibiotics offer little benefit in acute asthma management.¹

These findings suggest that there is a need to evaluate the common practice of

prescribing oral antibiotics in asthma attacks associated with respiratory tract infection in general practice. Clarification of the duration of oral steroid therapy and the need for tapering the course of oral steroids would also be welcome.

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GPs and minor surgery

Sir,

I agree with Dr Kneebone on the training of general practitioners in minor surgery, in that well conducted and organized training courses are necessary to improve the practical skills of general practitioners (editorial, *March Journal*, p.103). However, as well as a sound foundation of basic surgical principles and stitchcraft, I feel that emphasis should also be placed on improving anaesthetic skills.

Correctly used local anaesthetics can provide excellent surgical anaesthesia. However, nerve and field blocks require anatomical and pharmacological knowledge, together with practical skills, to ensure safe administration of local anaesthetic in the correct dose and at the correct anatomical site. Only when so

Table 1. Doctors' reported length of oral steroid therapy for a child and adult presenting with acute asthma associated with respiratory tract infection.

No. of days of oral steroid therapy	No. of GPs reporting length of treatment for	
	Child	Adult
1	6	3
2	13	9
3	43	36
4	8	8
5	60	59
6	1	6
7	9	27
9	1	1
10	1	7
11+	0	2
Until peak flow returns to normal	3	3

done can local anaesthesia provide the surgical anaesthesia necessary for the wide range of minor surgery undertaken in general practitioners' surgeries.

Does not the general public deserve to be treated by a medical profession capable of alleviating the pain of minor surgery effectively and consistently? By incorporating the training of local anaesthetic skills into minor surgery courses, perhaps the quality of the surgical treatments offered to the public can be further improved.

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Sir,

We appreciate and welcome the editorial on training general practitioners in minor surgery (*March Journal*, p.103) and would like to widen the perspective. General practitioner training is only part, although an extremely important part, of a whole: patients not only require the skills of the general practitioners, but also high quality care through supporting services. This includes nurse input for patients' preparation, post-operative support and longer term care. In addition, the appropriate environment which provides safe standards for infection control and sterilization of equipment must not be overlooked.

Minor surgery must be considered within a total context of skilled doctors and nurses and the back up support that ensures patients' safety and a satisfactory outcome of care.

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Testing for depression

Sir,

Dr Wright (*March Journal*, p.132) is correct when he says that mental health screening questionnaires are rarely used by general practitioners. A postal survey of 171 general practitioners (one in two principals in Sheffield) produced a response rate of 81% (139), representing 40% of all general practitioner principals in Sheffield in May 1992. Of these 139

general practitioners, only 29 (21%) had ever used any kind of psychometric questionnaire. Of these, 45% used this type of questionnaire only once a year or less, and only 7% used a mental health questionnaire more than once a month (fewer than 2% of all respondents). The reason given for using such questionnaires was for help with diagnosis in 55% of cases.

This may have implications for post-graduate training, since general practitioner trainees are unlikely to use diagnostic questionnaires on a regular basis if they do not see trainers using such screening instruments. In my 1993 study of general practitioner detection of psychological distress, a cohort of 19 general practitioners with a database of more than 4000 patients used the 12-item general health questionnaire. In qualitative feedback data, no general practitioner found any faults with the questionnaire, several commenting on the fact that they felt that it had helped patients to present symptoms of anxiety or depression during the consultation. Perhaps continuing medical education courses could contribute to familiarizing general practitioners with the advantages and limitations of simple screening questionnaires, to the benefit of our patients and ourselves.

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Sir,

I found much of great interest in Wright's paper 'Should general practitioners be testing for depression?' (*March Journal*, p.132). We need to be careful about adopting too slavishly the diagnostic categories of our psychiatrist colleagues; in general practice the picture is never as simple as the rating scales make it look.

However, far more worrying is the problem of labelling patients who might wish at some time in the future to obtain life insurance. It has come to my notice that some life insurers, on seeing that a potential client has been reported by his or her general practitioner as having suffered from a depressive illness in the past, have loaded their premiums or even denied the client life insurance altogether.

For this reason we need to be careful, perhaps noting sadness, grief, or loss as the problem presenting, not depression as the diagnosis made. Certainly I think our patients would welcome this. Perhaps we ought to listen to their sadness and become more effective at helping them with grief and loss. Skilled counsellors

can be helpful in assisting general practitioners in this work.

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Sir,

I read with interest the article by Wright (*March Journal*, p.132). I would like to reinforce the view that, in medicine in general and in psychiatry in particular, questionnaires and tests should only be used as adjuncts to enhance the diagnostic accuracy of the clinician and the results of questionnaires should not be relied on when deciding on the diagnosis of depression.

All physicians should realize the importance of the doctor-patient interview, and the empathic relationship that develops as a result, which is essential if the doctor is to gain an insight into a patient's thought processes. In the assessment of depression and suicide risk, this is particularly important. The doctor should observe the frowns, groans, expressions and titubations which develop and change as the interview progresses. A general practitioner is usually the first point of contact for a depressed patient seeking help, advice, assurance and comfort, and to ask the patient to complete a self-administered questionnaire at the first consultation may not be helpful. In addition, it may not be possible to expose the direct and indirect communication of suicide intent,¹ if patients are asked to declare their intent to a blank sheet of paper or a computer.

The prevalence of psychiatric illness in general practice is substantial² and the great majority of this morbidity comprises affective disorders.³ Although all potential cases should perhaps have the benefit of specialist advice,⁴ at present general practitioners have to deal with the bulk of identified psychiatric morbidity themselves. The issue of how psychiatrists can collaborate most effectively with primary care medical services therefore continues to be of immediate concern. The defeat depression campaign of the Royal College of Psychiatrists and the Royal College of General Practitioners, which aims to improve the recognition and management of depression by improving the skills of the doctor in the clinical interview,⁵ is a step in the right direction.

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