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.

Headache: an ophthalmological problem?

Sir,

Headache is a common symptom in the general population[1,2] and accounts for between 1% and 3% of all attendances at primary care facilities.[3] Patients complaining of headaches are often regarded by doctors in accident and emergency departments as inconvenient and inappropriate referrals, in view of the amount of time spent assessing them and the large percentage of cases where no definite or treatable diagnosis is made. There are no previous studies considering patients who present with headache to a hospital ophthalmic casualty department which, in view of the association between headaches and eye disease, may be a more appropriate referral destination than general accident and emergency departments.

All new patients who presented at Liverpool's St Paul's Eye Hospital casualty department over an eight-week period were studied prospectively. Full ophthalmic examination was undertaken. The general practitioners of patients who did not have a diagnosis made at initial presentation were contacted six months after the patients' casualty visit in order to gain further information.

A total of 63 patients with headache as the main presenting symptom were identified out of 986 new patients (6%). Thirty one patients were self-referrals (49%), 29 had been referred by general practitioners (46%) and three by opticians (5%). Symptoms had been present for less than one week in 38% of patients. Twenty patients had associated ocular symptoms, for example diplopia and decreased vision (32%).

A definite diagnosis was made at the initial visit for 30 patients (48%); Table 1. In a further 14 patients (22%) a diagnosis had been made by the end of the study, six months following presentation: 11 patients had tension headaches and three had migraines. An ocular cause for the headache was found in 12 patients (19%); all these patients presented with ocular symptoms accompanying their headaches. The incidence of serious pathology (any condition that if left undetected or untreated may be life- or sight-threatening) was found to be 19% (12 patients; Table 1).

The proportion of patients presenting at the eye hospital casualty department complaining of headaches (6%) was much higher than the 1% to 3% which has been found previously.[3] The incidence of serious pathology found in the present study (19%) was also much higher than the 0.3% to 5% reported previously.[4] In the present study, ocular disease was not a cause of headache in any patient who did not have ocular symptoms at presentation. We suggest that any patient who presents in general practice with headache and ocular symptoms should be referred to an ophthalmologist as the underlying cause will, in a large percentage of cases (60%), be ophthalmologically related. All patients with serious conditions had ophthalmic symptoms and therefore a referral to a hospital eye casualty department was more appropriate than patients waiting for a hospital ophthalmology outpatient appointment. Patients with headache alone are inappropriate referrals to an ophthalmic casualty department as their underlying pathology, if any, is likely to be non-ophthalmological and a referral to another specialty, for example neurology, may be more beneficial.

N P O'Donnell

Ward 8z Link
Ophthalmology Department
Royal Liverpool University Hospital
Prescot Street
Liverpool L7 8XT

Table 1. Main diagnosis made at initial hospital visit for 30 patients, and conditions considered to be serious.

Diagnosis	No. of patients
Migraine	6
Convergence insufficiency	5
Cranial nerve palsies[a]	5
Systemic hypertension[b]	3
Sinusitis	3
Retrobulbar neuritis[a]	2
Decompensated exophoria	1
Episcleritis	1
Iritis[a]	1
Propine related	1
Raised intraocular pressure[a]	1
Temporal arteritis[a]	1

[a]Condition considered to be serious. [b]Two of these cases considered to be serious.

References

1. Waters WE. The Pontypridd headache survey. *Headache* 1974; **14:** 81-90.
2. Hasotia P. Evaluation and treatment of headache. Practical approach to a common symptom. *Postgrad Med* 1986; **79:** 75-84.
3. Fodden DI, Peatfield RC, Milson PC. Beware of the patient with headache in the accident and emergency department. *Arch Emerg Med* 1989; **6:** 7-12.
4. Dhopesh V, Anwar R, Herring C. A retrospective assessment of emergency department patients with complaint of headache. *Headache* 1979; **19:** 37-42.

Hormone replacement therapy

Sir,

Hormone replacement therapy is underused in the United Kingdom despite its known benefits,[1] and despite the development of hormone replacement therapy clinics in general practice.[2,3] A study was undertaken to investigate women's use of hormone replacement therapy in a general practice setting in which women could attend their own general practitioner or a practice-based clinic.

The study took place in 1993 in a four-partner practice serving 6849 patients. All 171 women in the practice who were currently using hormone replacement therapy, or who had used it during the 12 months before the study, were sent a questionnaire and an explanatory letter. Their ages ranged from 34 years to 82 years. In total, 137 women (80.1%) returned completed questionnaires: 59.9% of these women had attended the hormone replacement therapy clinic, the other 40.1% had obtained therapy from their own general practitioners.

The women's most frequently cited initial source of information about therapy (some women gave more than one response) had been the media (56.2%), followed by the general practitioner (49.6%) and family and/or friends (38.0%). This confirms previous findings that the media is the most common source of information about hormone replacement therapy.[4,5] The treatment of vasomotor and/or psychological symptoms was stated as the main reason for starting hormone replacement therapy by 75.2% of women. The use of hormone replacement therapy mainly to treat menopausal symptoms has been found elsewhere.[4-7]

Of 220 women in the practice who had had a hysterectomy, 59 (26.8%) were using or had used hormone replacement therapy in the 12 months before the study; 11 of these 59 women had started therapy because it had been recommended after their hysterectomy. These results confirm previous findings that oestrogens are underused in women who have had a hysterectomy[8,9] and suggest that this may be a result of lack of advice postoperatively.

Heavy or irregular bleeding was one of the most common reasons stated for discontinuing therapy (13.6% of 22 respondents) and was the most common reason for trying more than one preparation (16.0% of 50 respondents). Tibolone was used by 32 of 78 women with an intact uterus (41.0%) in order to avoid the return of cyclical bleeding. Women's concerns about problematic bleeding should be investigated further as these may influence the future use and development of hormone replacement therapy regimens.

Therapy had been discontinued by 22 respondents (16.1%) at the time of the study, clinic attenders and non-attenders being in similar proportions, suggesting that the clinic in this practice did not affect compliance with hormone replacement therapy. As long-term compliance with therapy is an important factor in the prevention of osteoporosis and cardiovascular disease,[10] the effects of such clinics on compliance warrants further study.

P-J ROBERTS

Seven Brooks Medical Centre
Church Street
Atherton, M29 9DE

References

1. Barlow DH, Brockie JA, Rees CMP. Study of general practice consultations and menopausal problems. *BMJ* 1991; **302:** 274-276.
2. Coope J, Roberts D. A clinic for the prevention of osteoporosis in general practice. *Br J Gen Pract* 1990; **40:** 295-299.
3. Roberts P-J. Reported satisfaction among women receiving hormone replacement therapy in a dedicated general practice clinic and in a normal consultation. *Br J Gen Pract* 1995; **45:** 79-81.
4. Hunt K. Perceived value of treatment among a group of long-term users of hormone replacement therapy. *J R Coll Gen Pract* 1988; **38:** 398-401.
5. Roberts P-J. The menopause and hormone replacement therapy: views of women in general practice receiving hormone replacement therapy. *Br J Gen Pract* 1991; **41:** 421-424.
6. Kadri AZ. Hormone replacement therapy — a survey of perimenopausal women in a community setting. *Br J Gen Pract* 1991; **41:** 109-112.
7. Wren BG, Brown L. Compliance with hormonal replacement therapy. *Maturitas* 1991; **13:** 17-21.
8. Spector TM. Use of oestrogen replacement therapy in high risk groups in the United Kingdom. *BMJ* 1989; **299:** 1434-1435.
9. Seeley T. Oestrogen replacement therapy after hysterectomy. *BMJ* 1992; **305:** 811-812.
10. Coope J, Marsh J. Can we improve compliance with long term HRT? *Maturitas* 1992; **15:** 151-158.

Haemophilus influenzae vaccine: maximizing uptake

Sir,

In the context of recent controversy concerning the possible adverse effects of vaccination,[1] it is important to keep in mind the benefits of immunoprophylaxis. This year we have seen two children with *Haemophilus influenzae* type b (Hib) meningitis that could have been prevented by vaccination.

A child aged three years from a travelling family presented with rapid onset of fever, vomiting and a decreased level of consciousness. Despite full intensive care management, including vigorous colloid resuscitation and treatment with cefotaxime, steroids, mannitol and inotropes, the child declined inexorably and died within 24 hours of admission to hospital. Cerebrospinal fluid and blood cultures confirmed *H influenzae* type b as the causative organism; the child had not received Hib vaccination.

An infant aged five months presented with a short illness suggestive of bacterial meningitis; lumbar puncture confirmed the diagnosis, and *H influenzae* type b was subsequently cultured from the cerebrospinal fluid. Following stabilization and transfer to the regional paediatric intensive care unit, cranial computerized tomography was performed, revealing cerebritis, a unilateral subdural effusion and increased ventricular volume. He went on to develop recurrent seizures, and although he has survived the illness, severe neurological deficits have resulted. He had missed all routine primary vaccinations because of a succession of minor upper respiratory tract infections.

Following the introduction of the routine Hib conjugate vaccine programme in October 1992, 93% of infants in the United Kingdom have been vaccinated and the number of invasive *H influenzae* type b infections has fallen by more than 90%;[2] thus, we estimate that more than 50 deaths and 130 episodes of serious neurological sequelae are being prevented annually.[3]

Vaccination could have prevented both of the cases described. Although achieving high vaccination uptake is problematic in certain groups, such as travelling families, a directed approach has been demonstrated to be effective.[4] A health visitor can establish rapport with families, obtain consent from the mother (who is usually the prime decision maker) and administer vaccines in the family home. The second case highlights the dangers of postponing vaccination because of minor illness; Department of Health guidelines warn 'no child should be denied immunization without serious thought as to the consequences, both for the individual child and to the community'.[5]

Although epidemiological studies may throw up hypothetical risks of vaccination, as in a recent study suggesting a link between inflammatory bowel disease and measles vaccination,[1] the tangible benefits of preventing catastrophic illness should always be held firmly in mind.

R BOOY
S C MARRIAGE
H DAVIES

Paediatric Infectious Diseases Unit
St Mary's Hospital
Praed Street, London W2 1NY

References

1. Thompson NP, Montgomery SM, Pounder RE, Wakefield AJ. Is measles vaccination a risk factor for inflammatory bowel disease? *Lancet* 1995; **345:** 1071-1074.
2. Anonymous. Invasive *Haemophilus influenzae* infections: changing patterns. *CDR Weekly* 1994; **4:** 227-228.
3. Booy R, Hodgson SA, Slack MPE, *et al.* Invasive *Haemophilus influenzae* type b disease in the Oxford region (1985–91). *Arch Dis Child* 1993; **69:** 225-228.
4. Moreton J. Hib: educating parents and professionals. *Health Visitor* 1992; **65:** 266-267.
5. Department of Health. *Immunization against infectious disease.* London: HMSO, 1992.

Warfarin in stroke prevention

Sir,

The stimulating review article by Sweeney and colleagues concerning the use of warfarin in non-rheumatic atrial fibrillation places a responsibility on general practitioners to consider seriously treatment of carefully selected patients.[1] I performed a baseline audit of patients with non-rheumatic atrial fibrillation in our group practice.

The practice comprises eight full-time partners and one part-time partner with a total list size of 14 300 (average list size 1700 for each partner) and is situated in a small market town. An anticoagulation service is organized in the practice with blood samples being sent to the district general hospital 15 miles away. The practice is fully computerized and paperless (Exeter system) with continuous archive facilities.

On 1 April 1995 computer analyses were performed searching for: patients