

4. Axon ATR. The role of acid inhibition in the treatment of *Helicobacter pylori* infection. *Scand J Gastroenterol* 1994; **29** suppl 201: 16-23.
5. Logan RPH, Gummert PA, Schaufelberger HD, et al. Eradication of *Helicobacter pylori* with clarithromycin and omeprazole. *Gut* 1994; **35**: 323-326.
6. Goddard A, Logan R. One-week low-dose triple therapy: new standards for *Helicobacter pylori* treatment. *Eur J Gastroenterol Hepatol* 1995; **7**: 1-3.
7. Bell GD, Powell KU, Bolton G, Richardson PDI. Clinical and pharmacoeconomic evaluation of management strategies for duodenal ulcer disease. *Br J Med Econ* 1993; **6**: 45-58.
8. Phull PS, Ryder SD, Halliday D, et al. The economic and quality-of-life benefits of *Helicobacter pylori* eradication in chronic duodenal ulcer disease — a community-based study. *Postgrad Med J* 1995; **71**: 413-418.
9. Powell KU, Youngman PR, Bell GD, et al. A general practice study of *Helicobacter pylori* eradication treatment in patients using long-term ulcer healing therapy. *Br J Clin Res* 1995; **6**: 21-29.
10. Phull PS, Halliday D, Price AB, Jacyna MR. Is the 'absence of dyspeptic symptoms' a useful test to assess *Helicobacter pylori* eradication? *Gut* 1995; **36** suppl 1: a12.

Unexpected side effect of *H pylori* infection cure

Sir,

Ever since we have had the means at our disposal to cure *Helicobacter pylori* induced duodenal ulcer, I have been assiduously looking for patients whom I can attempt to persuade to take the unpalatable triple therapy or antibiotic/omeprazole treatment. One such patient had been using antacids and H₂-antagonists for at least 20 years and when I saw him on another matter I took the opportunity of checking his C¹³-urea breath test. This was reported as showing an excess of exhaled labelled carbon dioxide (28 units ml⁻¹ compared with a normal value of less than 5 units ml⁻¹).

After a four-week course of omeprazole 20 mg at night and amoxycillin 1g twice daily his chronic indigestion was cured. The patient attacked his garden with vigour and was able to put in a seven-hour day instead of having to stop every 15 minutes to chew antacids. The result is the most intractable case of plantar fasciitis (sprain of longitudinal plantar fascia in the foot) that I can remember seeing. I wonder if other general practitioner colleagues have noted unusual late onset side effects of *H pylori* infection cure?

RICHARD HARDING

89 East Parade
Heworth
York YO3 7YD

Counselling and psychotropic drug prescribing

Sir,

We welcome the interest from Jenkins and Hemmings (letter, December *Journal*, p.691) in our paper (September *Journal*, p.467) that explored the relationship between counselling and psychotropic drug prescribing. There are some points that we would like to make in response.

Their assertion 'many studies have shown reductions in the prescribing of psychotropic drugs after counselling interventions with individual patients' refers to one randomized controlled trial¹ in which only 54% of patients who were randomized to counselling were followed up and accounted for in the analysis at six weeks. As referenced in our paper,²⁻⁴ there is a paucity of evidence from randomized controlled trials about the effectiveness and cost-effectiveness of counselling in general practice. The trials that have been performed show a transient, but not sustained, reduction in prescribing costs in patients randomized to counselling.

The main impetus to our study was to examine the commonly cited assertion that provision of counselling in general practice reduces prescribing costs.⁵ The results clearly show that this cannot be assumed. What is needed is an unbiased evaluation of the effectiveness and cost-effectiveness of counselling in general practice in the United Kingdom. Considering the huge growth in this intervention since the introduction of the 1990 contract for general practitioners,⁶ evaluation in the form of randomized controlled trials with longer-term follow up would be a sound investment.

TOM FAHEY

Department of Social Medicine
University of Bristol
Canyng Hall
Whiteladies Road
Bristol BS8 2PR

JOHN FLETCHER

Department of Public Health
and Primary Care
University of Oxford
Radcliffe Infirmary
Oxford OX2 6HE

References

1. Boot D, Gillies P, Fenlon J, et al. Evaluation of short term impact of counselling in general practice. *Patient Educ Counselling* 1994; **24**: 79-89.
2. Earll L, Kinney L. Clinical psychology in general practice: a controlled trial evaluation. *J R Coll Gen Pract* 1982; **32**: 32-37.

3. Catalan J, Gath D, Edmonds G, Ennis J. The effects of non-prescribing of anxiolytics in general practice. 1: controlled evaluation of psychiatric and social outcome. *Br J Psychiatry* 1984; **144**: 593-602.
4. Robson M, France R, Bland M. Clinical psychologist in primary care: controlled clinical and economic evaluation. *BMJ* 1984; **288**: 1805-1808.
5. Audit Commission. *Report on prescribing*. London: HMSO, 1994: 21-22.
6. Pringle M, Lavery H. A counsellor in every practice? [editorial]. *BMJ* 1993; **306**: 2-3.

Warfarin for elderly patients

Sir,

I read with interest the results of Seamark's audit (letter, October *Journal*, p.563) stimulated by Sweeney and colleagues' review of the use of warfarin in patients with non-rheumatic atrial fibrillation.¹ The identification of at risk patients can be made in several ways and Seamark has illustrated the time-consuming nature of identifying such patients by audit (up to 20 hours of doctor time).

However, an alternative strategy might exist. Although systematic screening of all patients would be time consuming and unlikely to be cost-effective, screening of patients aged 75 years and over would conceivably be straightforward. This has the obvious advantage of existing infrastructure (the statutory annual health assessment for patients in this age group) and the further justification that atrial fibrillation is more prevalent in this age group, the corresponding opportunity for therapeutic benefit thus being greater than in younger age groups.

To assess the potential value of such a strategy, I performed a computer search for patients who were receiving repeat prescriptions for digoxin or whose records were coded with the diagnosis of atrial fibrillation, in my former training practice (five partners, list size approximately 12 000 patients). A total of 93 patients were identified, 52 (56%) of whom were aged 75 years and over. Of the 93 patients, 30 (32%) were found to be not receiving anti-thrombotic therapy (aspirin or warfarin) and of these 30 patients, 18 (60%) were aged 75 years and over. After allowing for treatment contra-indications, it was found that nine of the 18 patients could be considered as potentially suitable to receive warfarin.

A suggestion for this strategy is that those patients aged 75 years and over not receiving any anti-thrombotic treatment for their atrial fibrillation, and who should be considered for treatment, could be identified by assessment of patients' pulse rates and rhythms at screening sessions for