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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 H_2-antagonists for at least 20 years and when I saw him on another matter I took the opportunity of checking his C^{13}-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?

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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 trial[1] 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.

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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

this age group. Although the absolute numbers of patients involved is small and only half of those patients at greatest risk could be considered suitable candidates for receiving warfarin, the fact remains (in this practice at least), that screening for atrial fibrillation in patients aged 75 years and over would identify the majority of patients who are currently at risk of stroke and who could benefit from intervention. Such a strategy is likely to be more acceptable in terms of workload implications than a systematic audit to identify at risk patients.

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Management of opiate dependence

Sir,
The editorial by Wilson and colleagues (September *Journal,* p.454) highlighted the variability of general practitioners' contact with problem drug users. We studied the contact between problem drug users (most of whom were opiate dependent) attending a community drug team and general practitioners in Trafford, Greater Manchester.[1] Of 136 drug-dependent patients who completed a questionnaire, 119 (87.5%) were currently registered with a local general practitioner. All of them were in receipt of their methadone prescription from the community drug team rather than from their general practitioner. Of the 136 drug-dependent patients surveyed, 41 (30.1%) had been removed from a general practitioner's list at some time; 36 of the 41 believed this to be as a result of their drug dependence. This can be compared with family health services authority data for the same area which showed that a mean of 0.2% per year of all registered patients had been removed from a general practitioner's list.

If more general practitioners were willing to adopt methadone maintenance programmes for their opiate-dependent patients then perhaps a greater proportion of such patients would maintain contact with a primary care team for longer periods. This would enable both their drug dependence and presentations of ill health to be addressed in the primary care setting, with the support of secondary care services should that prove necessary.

General practice based methadone maintenance clinics comparable to that described in Wilson and colleagues' editorial are now being set up across Manchester to facilitate the provision of care for opiate-dependent patients in primary care. Perhaps as general practitioners become aware of the success of such an approach, they will be less inclined to respond to their patients' opiate dependence by striking them off their lists.

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Practice list inflation

Sir,
We read with interest the study by Robson and colleagues on the audit of preventive activities using a validated measure of patient population, the 'active patient' denominator (September *Journal,* p.463). However, that interest was sparked by our concern over the issue of list inflation. Using the data given in the study, from an original sample of 2400 patients (150 patients in 16 practices) it is likely that 453 (18.9%) should not be on the practice registers and so would not attract capitation payments. Even if the 221 patients for whom no records could be found are excluded there are 232 patients (9.7%), or, taking into account and excluding the 11, 18 and 40 people that three practices erroneously included in their original samples, 163 patients (6.8%) who should be removed from the register.

List inflation is usually measured by comparing the numbers of registered patients compiled by the family health services authorities with population estimates produced by the Office of Population Censuses and Surveys. This has rightly been criticized on the grounds that it does not take into account cross-boundary flow — patients registering with a doctor in a different family health services authority area from the one in which they live. This study shows that list inflation goes well beyond cross-boundary flow. We cannot look to the current targets for health promotion activity to help encourage practices to remove patients inappropriately remaining on their lists, as the targets are not spread across the population. There is an incentive for practices to try to achieve a fine and self-serving balance whereby they remove those 'ghosts' who make practice performance on targets look bad while making no such efforts to correct their lists for other categories of patients.

The implications for a move to a procedure based on weighted capitation for allocating prescribing budgets as advocated by the National Health Service Executive are clearly enormous, especially if, as shown in Robson and colleagues' study, list inflation varies so much between practices.

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Audiotape recordings

Sir,
In their letter, Bain and MacKay raise important issues about the use of videotaped consultations for summative assessment (August *Journal,* p.443). They point out that problems of coercion, consent and confidentiality could be avoided by using simulated patients.

Another possibility would be to use audiotape recordings. As well as being less intrusive and less expensive than videotapes, audiotapes have the advantage of preserving the anonymity of a real patient, providing names are not mentioned. Although the non-verbal aspects of a consultation are missing, audiotape recordings have been used extensively for training in communication skills and are part of the degree assessment for final year medical students at the University of Sheffield.[1,2]

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