turers and general practitioners of the demands being put upon the pharmacist, together with promotion of greater awareness among the general public of pharmacists' skills and responsibilities.

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Primary care services for problem drug users: PSALT and DrugNet

Sir,
We were pleased to read the editorial by Wilson and colleagues on improving methadone maintenance in general practice for problem drug users (September *Journal*, p.454). We have followed with interest their previous general practice work with problem drug users in Glasgow, although we are still confused about their budget allocation. In the editorial Wilson and colleagues state that 'the costs to the practice [are] considerable' and have previously reported that each patient receiving methadone maintenance costs the practice approximately £2000 each year.[1] We have challenged this amount[2] as we believe that the actual annual cost is nearer to £1000 per patient. We re-emphasize this point because we share the hope of our colleagues in Glasgow that similar projects in other parts of the United Kingdom will be established. An overestimation of the costs may dissuade other general practitioners or family health services authorities from providing high-quality, effective care in general practice to drug-dependent patients. As an extension of this, we would like to outline two initiatives introduced by West Glamorgan Health Authorities.

The primary care substance abuse liaison team (PSALT) has been established to offer formal primary care services to problem drug users. PSALT is managed by a project board and primary care is provided by three general practitioners located throughout West Glamorgan. PSALT has a shared-care philosophy and patients eligible for PSALT care can be referred by local drugs projects or by the secondary care sector. It is on this latter point that the second initiative, the DrugNet project, is being developed. Essentially, DrugNet is a computer project and, in the first instance, computers with custom designed software will be installed at the practices of the PSALT general practitioners and three local substance misuse street agencies. Shared care will be supported by a West Glamorgan register and the core system will eventually be expanded to include other partners such as the community drugs team, probation service and social services. The collection of local data will allow the audit of the shared-care model and support the design of proactive strategies against substance misuse.

Our initiatives in West Glamorgan support high quality primary/shared care for problem drug users, with a particular emphasis upon service audit. Although both initiatives are still developing, we would be willing to correspond further with anyone who is interested in such initiatives.

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1. Wilson P, Watson R, Ralston GE. Methadone maintenance in general practice: patients, workload and outcomes. *BMJ* 1994; **309:** 641-644.
2. Morgan GP, Willson A. Methadone maintenance in general practice [letter]. *BMJ* 1994; **309:** 955-956.

Open-access echocardiography

Sir,
We were interested to read the editorial by Colquhoun and colleagues (October *Journal*, p.517) on how echocardiographic services should be delivered for the investigation in general practice of patients with suspected heart failure.

One of us (M C) has examined secondary prevention of coronary heart disease. Thirty six patients with proven previous myocardial infarction without heart failure were referred to a general practitioner open-access echocardiography service at the Western General Hospital, Edinburgh, over approximately six months. All patients offered this service readily accepted the invitation and attended.

Results showed that 22 of the 36 patients had satisfactory echocardiographs which indicated that they required no further medical treatment or investigation. Twelve patients were shown to have asymptomatic impaired left ventricular function requiring therapy with angiotensin-converting enzyme (ACE) inhibitors. One patient was shown to have aortic valve disease requiring diuretic therapy. One patient was shown by electrocardiography, prior to echocardiography, to have atrial fibrillation requiring warfarin and digoxin therapy.

In light of such clinically significant pathology being found, we would suggest that it would be worthwhile that open-access echocardiography services be available to all general practitioners.

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Headache: not an ophthalmological problem?

Sir,
In his letter (October *Journal*, p.562) O'Donnell suggests that any patient who presents in general practice with a headache and ocular symptoms should be referred to an ophthalmologist as the underlying cause will, in 60% of cases, be ophthalmologically related. This is, unfortunately, based on a fundamental epidemiological flaw, that of the floating denominator. What O'Donnell has found is that 60% of those who attend a specialist emergency eye clinic with those symptoms are found to have ophthalmological problems. What is not known is the baseline number of patients from which these patients come. Without any knowledge of the prevalence of headache and ocular symptoms in general practice, his assertion does not hold up.

O'Donnell then suggests that patients with headache alone should not be referred to the ophthalmic casualty department but to another specialty, such as neurology. This statement is even less likely to be of benefit. There have now been between 30 and 50 studies of the prevalence of somatic symptoms in general practice and in the community. Headache is invariably among the most common somatic symptom, and prevalences in both

settings range from 20% to 45%, depending upon exact case definition. O'Donnell cannot be suggesting that all patients with headaches should be referred to a specialist: such a practice would be of little benefit and carries the risk of iatrogenic over-investigation and illness reinforcement. Whatever it is that determines whether a general practitioner refers a patient presenting with the symptom of headache, it is unlikely to be the presence of that symptom alone.

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Sir,

I read with interest the comments of Simon Wessely regarding my letter which detailed a study of patients who presented with headache to a hospital ophthalmic casualty department (October *Journal,* p.562). He seems, however, to have misinterpreted the results and conclusions.

This was a study only of patients attending Liverpool's St Paul's Eye Hospital casualty department and thus obviously did not take into account the floating denominator. The main point that I was attempting to convey was that for patients with headache and eye symptoms or signs, if the general practitioner is considering hospital referral, an ophthalmological referral would be the most appropriate. I was certainly not suggesting that all patients with headache should have a specialist referral, and anyone with experience of general practice or the hospital service would be in agreement with this. Wessely's final point that patients with headache are only referred if there are other accompanying symptoms is a myth; there is ample evidence in the literature of such referral.

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Warfarin therapy in primary care

Sir,

Sweeney and colleagues' review of the use of warfarin in non-rheumatic atrial fibrillation highlights the potential for anticoagulation to protect patients at risk from stroke.[1] It also mentions some of the difficulties general practitioners may have in applying such research results to their practice populations.

Subsequent correspondence from Fitzmaurice (August *Journal,* p.444) raised the question of whether international normalized ratio results from different centres can be compared. The following case history from an inner city London practice, in which I was a long-term locum general practitioner, illustrates why this point is of crucial importance not only at a theoretical level but also at a practical level.

A patient aged 82 years who was on long-term warfarin therapy, feeling unable to make the usual journey to a teaching hospital anticoagulation clinic, attended the general practice surgery for her 'blood test'. A request for an international normalizing ratio measurement was duly sent via our usual pathology services, on the same day, to a different local teaching hospital. Surprisingly, as this patient's international normalizing ratio was usually maintained at about 2.5 on 5 mg warfarin daily, the result came back at 4.6, causing me to decrease the dosage slightly. However, 10 days later, at the usual hospital clinic, the patient's international normalizing ratio had fallen to 1.5, requiring further adjustment of her treatment.

A similar scenario threatened to repeat itself several months later when this patient again attended the surgery rather than the anticoagulation clinic. The result was again high at 4.7, but on this occasion I decided to repeat the test before taking further action and took two simultaneous samples, sending one to be analysed by each hospital. The results came back as 3.1 and 4.1.

If general practitioners are to pursue the evidence-based medicine recommendations of Sweeney and colleagues and prescribe warfarin with greater frequency, it is essential that standardized laboratory investigations are directly comparable. While they are not, the pace of change in clinical practice is likely to remain slow.

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Reference

1. Sweeney KG, Gray DP, Steele R, Evans P. Use of warfarin in non-rheumatic atrial fibrillation: a commentary from general practice. *Br J Gen Pract* 1995; **45:** 153-158.

Sir,

Recent studies have emphasized the need for patients suffering atrial fibrillation to be considered for anticoagulation therapy.[1] In an attempt to respond to this we endeavoured, by computer-aided search of patients' records, to identify appropriate patients out of a list size of 10 000. Several problems became apparent.

First, more than half of the patients who were potential candidates for therapy with warfarin (28 of 49) had been seen by a hospital physician within the previous two years for a variety of reasons, without clear recommendations for such treatment being given. In view of the complexity of anticoagulation, we feel that such an identification programme should not be exclusively general practitioner led.

Secondly, even with a clear protocol and computerized patient information, it was time consuming to identify and assess the patients who should be considered for anticoagulation therapy. This is because the relative contra-indications to warfarin (for example, lack of mobility and no access to a telephone) can only be elicited from a personal assessment. While time is not a problem in a research study, it certainly is in everyday general practice.

Finally, there was concern about the risk of cerebral haemorrhage as a complication of warfarin treatment. This risk has been calculated as being three major haemorrhages per 1000 patients treated with warfarin per year.[1] This is outweighed by the prevention of 31 strokes.[1] However, for an individual patient affected by cerebral haemorrhage, and for his or her family, we feel that this may be hard to come to terms with if it is perceived as a consequence of the personal enthusiasm of the general practitioner rather than part of a formal local or national policy.

Local health authority guidelines on the identification of patients with atrial fibrillation who should be considered for warfarin therapy, with a coordinated approach from both primary and secondary care, would seem to be the best way forward.

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Reference

1. Sweeney K G, Gray DP, Steele R, Evans P. Use of warfarin in non-rheumatic atrial