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