Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Which adolescents attend the GP?

Sir,

Interest in adolescent health is growing. It is recognized that adolescents make decisions about their behaviour which will have important consequences for their future health.[1] Adolescents have prominent concerns about their health[2] that they want to discuss with their doctor;[3] however, general practitioners (GPs) spend less time in consultation with adolescents than with other age groups.[4] Little is known about which adolescents use the services, and less is known about how psychiatric and psychosomatic factors influence service use.

We performed an analysis of computer records of adolescents aged 13–16 years 11 months, registered with a general practice in London. During a one-year period, 231 of 432 (53.5%) of the adolescents who were registered, attended the practice. The rates of consultation of different age bands within the group were similar, as was that of males versus females. These results differ from Jacobsen, who found significantly increased consulting in 15–19 year old females.[5] This suggests that increased consulting by females may only begin at age 17.

Among the reasons for consultation, there were no obvious episodes of serious illness. The commonest reasons for consultation were upper respiratory tract infections, asthma, general check-ups, injuries and acne. Psychiatric presenting complaints comprised 3% of presentations including depression, insomnia, enuresis, fear of carcinoma, bullying, and running away.

We looked at the relationship between the frequency of attendance and presenting complaint. Twenty-three per cent of adolescents attended four times or more (which we defined as frequent attendance) and accounted for 46% of presentations. This frequent attending was not associated with age or sex, but had differences in presenting complaints. This group had fewer upper respiratiry tract infections and significantly more psychiatric and behavioural complaints. They also had signficantly more vague complaints of a neurological, psychosomatic nature including dizziness, fainting, parasthesias, tiredness and headaches (Table 1). The vast majority of the psychiatric and neurological and psychosomatic complaints occurred in frequent attenders.

In light of our findings, the previously held view that adolescents attend primary care infrequently, and that GPs therefore have little opportunity to intervene, is not justified. Although attendance is below the national rate of 78% for all age groups, more than 50% are attending per year. A sizeable minority of adolescents attend frequently. Psychiatric and psychosomatic concerns are more prominent in this group. More research is needed to further clarify what leads these adolescents to consult, and what interventions they receive.

TAMI KRAMER
STEVE ILIFFE
ELIZABETH MURRAY
SUSIE WATERMAN

Academic Unit of Child and Adolescent Psychiatry
Imperial College School of Medicine at St Mary's
Norfolk Place
London W2 1PG

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Evidence-based approach to treating depression

Sir,

We share Dr Kernick's concern (February *Journal*) that, in order for an evidence-based approach to treating depression to be productive, the relevant study setting is

Table 1. Presenting complaints differentiating frequency of attendance.

Type of complaint (Total no. of complaints = 611)	Frequent (n = 286)	Non-frequent attenders (n = 325)	Chi-square test P value 1 df	Odds ratio (95% confidence interval)
Psychiatric (n = 20)*	17 (5.9%)	3 (0.9%)	<0.001	6.78 (1.8-21.5)
Neurologica/psychosomatic (n = 25)*	18 (6.3%)	7 (2.2%)	0.02	3.05 (1.6-11.6)
Upper respiratory tract infections (n = 79)*	27 (9.4%)	52 (16.0%)	0.02	0.5 (0.3-0.9)

*Frequent attendance is defined as four or more times in one year.

paramount.[1] However, we believe that before any future trial measuring the effectiveness and value for money of tricyclic antidepressants (TCA) and selective serotonin reuptake inhibitors (SSRIs) commences, adequate education on the application of TCAs is a prerequisite. As Kernick acknowledges, it has long been established that sub-therapeutic doses of antidepressants are of no greater value than placebo,[2,3] and that, even when antidepressants are prescribed at the defined daily dose, they are not effective in all cases.[4] A recent health authority-wide audit of general practitioners' (GPs') use of two TCAs, amitriptyline and imipramine, revealed that low-dose prescribing was indeed common place. Using Prescribing Analysis and Cost data (PACT), we calculated that the average dose for a total of 8360 prescriptions of amitriptyline was just 55 mg per day, and for 1858 prescriptions of imipramine, 65 mg per day, both of which are below consensus guidelines. Clearly, more information would have been useful in order to determine the primary reason and the context for prescribing the two TCAs.

It is correct to assume that over the years GPs will have built up their own picture of the effectiveness and relative merits of both families of antidepressants. The key message from our audit, however, is that in order for scientific evidence to complement GPs' wisdom and experience, a deeper understanding on the use of TCAs deserves consideration so that GPs deliver the correct level of treatment to the most appropriate patients.

JONATHAN KOFFMAN
PAULINE TAYLOR

Department of Public Health
Kensington and Chelsea and Westminster
Health Authority
50 Eastbourne Terrace
London W2 6LX

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Exercise on the NHS: a cost-effective exercise for older adults

Sir,

We were interested to read the review by See Tai *et al* (February *Journal*) highlighting the methodological difficulties that face those contemplating a rigorous evaluation of exercise promotion in general practice.[1] Issues of response bias, participation and adherence to a programme, randomization of subjects and blinding of assessment are common problems in all attempts to conduct randomized trials of community-based health promotion programmes. We are currently conducting a randomized trial of a community-based exercise programme for older people in Sheffield, in which we hope that these problems have been solved. The trial is a pragmatic one with the objective of evaluating the effects of offering free, local exercise sessions to a whole population — in this case, sedentary adults aged over 65 on four practice lists. We have chosen to randomize practices rather than patients, for the compelling reasons which Tai *et al* outline. Although this does lead to a loss in power, it can to some extent be compensated by collecting baseline data over a longer period.[2] The primary outcomes of our trial are mortality and hospital admissions (indentified through National Health Service routine data) so that blinding is unnecessary.

In the first year of the trial, approximately one in four of those offered exercise attended at least one session, resulting in about 300 people currently attending our classes once or twice a week.

In any trial of this sort, response bias (the *already* fit will both participate and have better outcomes) is inevitable, which demands an intention to treat (intention to exercise) analysis. Interestingly, our first year experience has been that attendance is greatest in those who are neither very active, nor very inactive. Presumably the former have other things to do, and the latter find it hard to do anything.

Importantly, the trial will measure the cost-effectiveness, as well as the effectiveness, of offering exercise to older adults. If it turns out that the benefits of exercise, in terms of avoiding expensive hospital and nursing home care, outweigh the costs, then exercise schemes may become an irresistible buy for future primary care commissioners.

RACHEL DAVEY
JAMES MUNRO

Medical Care Research Unit
University of Sheffield
30 Regent Street,
Sheffield S1 5DA

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Counselling

Sir,

I apologise for confusing Dr Hamilton (January *Journal*). I used the word counselling to describe a number of treatment interventions, often of 'proven efficacy', which are delivered by CPNs, psychologists and counsellors, all of whom claim to be working as 'counsellors' in general practice.[1]

The confusion lies in the use of the word counsellor — a word that even the most eminent authorities sometimes misuse and fail to understand in its complexities.[2]

I believe that 'proven efficacy' means what Goldberg and Cater meant it to mean, and I fail to understand how I misused it. Efficacy is demonstrated when one variety of treatment approach is controlled with another, or with a control, and the results show a difference.[3]

A recent editorial highlighted the evidence of the 'proven efficacy' of cognitive behaviour therapy,[4] which is one of many treatment approaches.[3]

Efficacy is different from effectiveness, which is perhaps a much better way of measuring outcome but requires very different methods.

GRAHAM CURTIS JENKINS

Counselling in Primary Care Trust
First Floor, Majestic House
High Street, Staines
Surrey TW18 4DG

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Resuscitation of general practice

Sir,

The informative but disturbing editorial by Dr Tony Mathie (January *Journal*) must be urgently heeded.

In 1948, the National Health Service was envisaged with the general practitioner (GP) at the centre, supported by the public health services and with consultant advice and specialist treatment readily available where needed. Now, belatedly, we wonder why we lost the high ground.

Every medical student should be trained as if he or she is to become a GP. Dare one suggest that, at the original selections of entrants, a family history of doctoring could be as important as 'A' level results? The over-emphasis on the latter will inevitably lead to a preponderance of female doctors who will opt for part-time work.

There was a time when family doctoring was a 'calling' and 'general trends in working patterns' were not suitable for such a profession. Indeed, there was a time when the GP, working in the health centre in the town where he lived, took blood samples and blood pressures when necessary during consultations. Now these tasks are too often allocated to the practice nurse at specified times.

The commuter with a computer is the poorest advertisement for general practice.

In Wales, we did have one shining example of a doctor called, not recruited, to an isolated valley community, where he devotedly served and researched for local and international benefit.

By honouring him our College shows it does know the answers.

G MURRAY JONES

58 Danybryn Avenue
Radyr
Cardiff CF4 8DD

Complementary medicine

Sir,

Dr Lewith made a number of valuable points in relation to complementary medicine and must therefore be complimented on his article (January *Journal*). There are, however, three points that deserve comment.

In his conclusion, Lewith states, 'Many of them (complementary therapies) are not readily amenable to the standard randomized, controlled clinical trial.' However, his foregoing discussion does not explain why he believes this. In fact, to determine whether therapy A is better than therapy B, the two must be compared (by conducting a controlled trial). And to ensure that one is comparing the treatments between *similar groups*, one ought to ensure that possible confounding variables are equally distributed between the groups (again, by conducting a randomized trial). We see no reason why randomized, controlled trials should not be possible in complementary medicine.[1] It is true that, for logistic and financial reasons, this methodology cannot be applied to all complementary therapies, but it should test at least the most promising ones.

Lewith advocates using surveys on patients' preferences to investigate the effectiveness of complementary medicine. This approach can be problematic. For example, a recent trial shows that the addition of several complementary treatments to a cardiac rehabilitation programme was highly valued both by patients and their spouses. However, the addition of complementary therapies resulted in no benefit to the patients in terms of mortality, morbidity, anxiety, depression and quality of life.[1] Data on patients' preferences may therefore be fashionable (and useful to those who make their living from complementary medicine), but its clinical relevance requires evidence.

Lewith cites our work (currently in press, but known to him as the editor of *Complementary Therapies in Medicine,* in which it will be published) as a basis for his statement that, in terms of published papers, things are beginning to change, with more controlled clinical trials appearing in the literature'. Our work[3] does indeed show that the number of Medline-listed 'alternative medicine' publications also indexed as clinical trial, clinical trial phases I-IV, controlled clinical trial, multicenter study or randomized controlled trial has increased, particularly over the past 10 years (35 in 1984; 72 in 1989; 211 in 1994). However, if calculated as a percentage of the total number of 'alternative medicine' publications, the level of clinical research is still pitifully low (2.8% in 1984; 4.8% in 1989; 12.8% in 1994). Our work concludes that more original Research in complementary medicine is urgently required.

Another problem with the literature relating to complementary medicine is that it may be seriously biased towards reporting studies with 'positive' results and to neglecting those with 'negative' results. A recent analysis shows that only about 1% of articles published in four complementary medicine-related journals *(Complementary Therapies in Medicine, Forschende Komplementürmedizin, Alternative Therapies in Health and Medicine, Natura Med)* are 'negative'.[4]

Furthermore, the literature on complementary medicine is highly fragmented. Fifty or more complementary medicine-related journals exist, each of which publishes very few controlled clinical trials. Our department has therefore created a review journal, *FACT (Focus on Complementary and Alternative Therapies). FACT* is strictly evidence-based and aims at summarizing and commenting on the most relevant articles from this highly diverse literature. Anybody interested should order a free copy from the address below.

J BARNES
E ERNST

Department of Complementary Medicine
Postgraduate Medical School
University of Exeter
25 Victoria Park Road
Exeter EX2 4NT

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Ethnic monitoring in general practice

Sir,

Since April 1985, all National Health Service (NHS) hospital admissions need to be ethnically monitored.[1] The merits of ethnic monitoring in general practice include audit of health provision and targeting of health needs. A recent study[2] concluded that such monitoring is acceptable to recipients of primary care in a number of practices in England. We have undertaken our own study to attempt to validate these findings in a specific inner-city practice and have found grounds for concern, so confirming the results of a New Zealand Study.[3]

Our inner-city practice list, in excess of 7000, and has a strong tradition of accepting immigrants, particularly Portuguese and Spanish. In our survey, all adult patients obliged to attend for a general health check after registration were, over a three-month period, offered a question-

naire to determine ethnic origin along with that of their parents and grandparents. They were asked if they were happy for us to collect this information, if they trusted us to 'use it properly' and if they felt it would be useful. This was then correlated with the clinicians' perception of need; for example, in booking interpreting services.

Approximately one third of the patients returned the questionnaire (102/302), but 17% (17/102) either withheld the information or expressed reluctance in providing it. A further 12% did not believe this information was being sought for clinical reasons, and, in total, 28% registered disquiet to some extent.

Our sample proved too small for rigorous analysis. The results do suggest, however, that in those groups where refugee or immigrant status may be an issue, as based upon country of origin or background, there is an increased reluctance to divulge this information: 91% (48/53) compared with 68% (169/249).

It is generally accepted that ethnic monitoring may have benefits in planning health care provision.[4] It cannot be ethical if it constitutes a barrier to health care, nor desirable if it contributes to any delay in diagnosis and treatment. Planners should be aware not only of the limits of such data,[5] but also that the acceptability of collecting this data might need further consideration before rolling out any national GP-based programme.

DAVID KEABLE-ELLIOTT
ALAN M CAMPION

Mawbey Brough Health Centre
39 Wilcox Close
London SW8 2UD

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Grandma knew which medicines were best

Sir,

An audit was carried out on HIV-affected families using the family clinic as St Mary's Hospital, where many attending adults and children emanate from other countries and cultures.

The audit included a questionnaire sent to all families where one parent originated from an African country. It aimed to gain an insight into sources of help, medications and therapies that were available to families in their countries of origin, and those available to them in the United Kingdom (UK). We also asked whether parents felt they could discuss complementary therapies and traditional medications with the medical practitioner caring for them or their child.

Results indicated that most families, when living in their own country, relied initially on the advice of an older family member if there were health concerns. Prayers and local remedies would also be used together with attendance at a local clinic when there was sickness in the family. When residing in the UK, parents often sought counselling to replace the spiritual and extended family support previously available to them in their country of origin.

Massage was popular in both the UK and country of origin, but there was greater availability of therapies such as reflexology, aromatherapy and acupuncture in the UK.

Over half of the respondents felt unable to discuss any complementary therapy with their general practitioner or hospital consultant, although many felt it would be helpful to be able to discuss their therapies with their doctor or someone else available at the treatment centre. It is of note that children were more likely to be taking Western medication to help treat their underlying HIV infection than were parents.

Increasing numbers of people are using complementary therapies and herbal remedies in many situations of serious, acute and chronic sickness.[1] Although those taking part in the audit were small in number, there was an abiding feeling that Western practitioners would not understand the role and value on non-conventional therapies. In some cases these were being used instead of Western medications. A consequence of this may be that some adults are reluctant to access health care at appropriate times.

In these days of 'customer care' and 'consumer satisfaction' (and in terms of cost), surely it is important for more medical practitioners to consider a truly holistic approach to health care when developing and delivering their services.

D MELVIN

St Mary's Hospital
Paddington
London W2 1NY

C MOORE

Merton and Sutton NHS Community Trust
Cranmer Road
Mitcham
Surrey CR4 4TP

Reference

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Corneal exposure in herpes zoster ophthalmicus

Sir,

Herpes zoster ophthalmicus (HZO) is a reactivation of latent varicella zoster virus residing in the trigeminal ganglion.[1] The trigger for the reactivation remains unclear but is followed by viral proliferation and migration along sensory nerves. The attendant inflammation causes perineuritis and vasculitis.[2] Ocular involvement in HZO occurs in about 50% of cases.[1] Involvement of the nasociliary nerve, causing the rash to extend to the tip of the nose (Hutchinson's sign) increases the risk of ocular complications. Ocular damage and visual loss can occur with isolated cutaneous involvement.

We report a case of an eighty-one year-old man with a right HZO. Initially there was no ocular involvement, but the patient had extensive scalp necrosis. Dermatological management involved regular dressings to the ulcerated area. When the ulcer had almost completely healed, the patient was discharged to the care of his general practitioner. Over a period of four years he had recurrent scalp ulceration. Visual acuity gradually dimished in the right eye but at no time did the patient experience any ocular pain. At the time of ophthalmic referral, the right visual acuity was reduced to recognizing only hand movements. The patient exhibited extensive scalp necrosis and cicatrization with upper-lid retraction and corneal exposure. The cornea was anaesthetic and vascularized. A skin graft achieved good upper eyelid function and eliminated the corneal exposure. Corneal wetting improved, but visual acuity remained at the level of counting fingers.

This case illustrates two very important aspects of HZO. First, even in the absence

of ocular involvement, corneal innervation may be reduced, thus increasing the risk of subsequent corneal damage which may be painless. Secondly, severe cutaneous damage may, in the long term, lead to corneal exposure.

Initial treatment of HZO should be aimed at controlling viral proliferation and the immune response. Within the first 72 hours of the appearance of the rash, systemic acyclovir has been reported to reduce the incidence of ocular complications and post-herpetic neuralgia.[3] The protection of an exposed cornea with or without ocular involvement is an essential part of the management of these patients. This is particularly important in cases where corneal sensation is reduced. Frequent lubrication, botulinum toxin or surgical tarsorrhaphy may all play a part. A multidisciplinary approach to such patients is essential for a good recovery from the acute phase of the disease with preservation of vision.

T POTAMITIS
J N O'SULLIVAN
V MOHAN-ROBERTS

Academic Unit of Ophthalmology
Birmingham and Midland Eye Centre
Dudley Road
Birmingham B18 7QH