larger samples and longer follow-up times are required to substantiate our findings.

We are, however, surprised by the reference to the Nielsen paper regarding adverse effects of steroid therapy. Nielsen *et al* studied the incidence of gastrointestinal bleeding following an average dose of the equivalent of 500 mg of prednisone given over a month. Our single dose of 60 mg of prednisnone for 1 or 2 days, is less likely to have serious adverse effects.

We do agree that we did not control for antibiotic use as a potential confounder in in the analysis. There was additional benefit of steroid therapy among patients with swabs positive for streptococcus so the possible confounding role of concurrent antibiotic therapy requires further study.

Finally, regarding their concerns that the use of steroids in pharyngitis might lead to medicalisation and increased consultation rates for the condition, here in Israel we tend to encourage our patients to visit us to obtain effective treatments for their complaints, especially if these are only available on prescription.

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Consultation frequency

I was interested to read the paper presented by Bushnell on behalf of the MaGPIE group.[1] However, I have a number of concerns about the validity of the conclusions, as published.

My chief concern is that there is insufficient information about their methods, in both this and the accompanying paper.[2] The basis of this study is a measure of continuity, or 'consultation frequency' as the group refers to it. However, detail on how they determine this is missing. Measurement of continuity is fraught with methodological problems,[3] yet the authors do not seem to have adopted any of the existing instruments. The importance of this issue, and its potential influence on the findings, is not discussed at any point.

If the influence of continuity on symptom recognition was a prior research question, why was the study conducted with a sample size underpowered to detect differences? Although in their introduction Bushnell *et al* acknowledge the importance of other factors, such as severity of symptoms, in influencing recognition, no account appears to have been made for these in the final analyses. In addition, the researchers do not appear to have excluded any patients with known psychiatric disorders or in receipt of prescriptions for psychotropic medication. I assume the GPs in this study were not 'blind' to the medical records, which may have influenced reported recognition rates, even in 'unknown' patients.

We are told that the level of psychological problems recognised by GPs was collected from two questionnaires, referring to the index encounter and the previous year respectively, but only the 12 month findings appear to be reported. Does this reflect any bias that favours the presentation of positive findings?

Finally, this study relies on cross-sectional data, yet no consideration is given to the issue of causality. Although Bushnell *et al* suggest that frequency of attendance leads to improved GP recognition, the relationship may in fact run the other way.

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2. MaGPIe Research Group. The nature and prevalence of psychological problems in New Zealand primary healthcare: A report on Mental Health and General Practice Investigation. *N Z Med J* 2003; **116:** U379.
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Authors' response

Ridd has asserted that 'the basis of this study is a measure of continuity'. However, that is not something that is claimed in the paper. This paper is about the relationship between frequency of consultation and recognition of psychological problems in patients consulting a GP. Frequency of consultation was determined by counting the number of consultations with the patient during the 12 months prior to and including the index consultation. Frequency of consultation is one aspect of continuity of care, and we do not believe this reference to continuity in the discussion goes unreasonably beyond our data, or that it requires extensive explanation.

Measures of severity that are valid across the range of common mental disorders assessed in this study are not the simple matter that Ridd implies. However, severity of disorder is in fact likely to be one component of the many factors that influence the GPs clinical opinion, which is the basis of the hierarchical categories of recognised disorder in Tables 1 and 2. It is unclear what Ridd is referring to in his comment that 'only the 12 month findings appear to be reported'.

Ridd does not appear to understand the limitations of this type of cross-sectional data. We cannot tell exactly when the psychological symptoms first appeared during the previous 12 months or exactly when the GP recognised the problem. Thus we cannot look at causality (and did not intend to). The paper describes the relationships evident in the data. The data suggest that the oft-repeated assertion that GPs 'miss' 50% of common psychological disorder is an oversimplification, and that in this study, GP non-recognition of psychological problems was at a problematic level only among patients with little prior contact with the GP in the past 12 months.

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Corrections

Rymer J. Hormone replacement therapy after the menopause — where are we now? *Br J Gen Pract* 2005; **55:** 172–174.

Paragraph 12 should read '... The effect on the breast of using a progestagen containing intrauterine system is unknown', rather than '... The effect on the the breast of using an interuterine device with oestrogen is unknown'.

Walton M, Lambert M, Rahman R, Seale B. Gender-based inequalities [letters]. *Br J Gen Pract* 2005; **55:** 314.

Apologies to Runim Rahman and Ben Seale (senior information analysts at Gatehead PCT) who were not accredited alongside their coauthors.