antibodies. Hepatitis E should be considered as a case of hepatitis in patients exposed to raw meat carcasses.

Chris Jary
General Practitioner,
New Hall Surgery, Hull
E-mail: Christopher.Jary@GP-B81049.NHS.UK

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Treating addiction

The article by Strang *et al*[1] in the June edition of the Journal raises several important issues regarding what we do as GPs. I am an ex-prescriber and feel the College drive to improve treatment in this area may, on occasion, (in areas of low training take up) lead to a reduction in service. It also is ironic that it appears in the same edition as the leader by David Jewell[2] in which he talks of a GP as a generalist. I feel that as I do not have a 'diploma' in addiction and have not attended any College courses on this subject that I would 'be in trouble' should I prescribe and problems develop. I do not have this feeling in the many other areas in which I prescribe as a generalist (whether I have a diploma in that subject or not). I feel that the current trend will only make this feeling worse. I also find it interesting that those doctors who are prescribing are using lower doses than the 'experts' feel ideal — similar to other disease areas such as lipids and hypertension.

John Sharvill
General Practitioner,
Balmoral Surgery, Kent
E-mail: John.Sharvill@gp-G82036.nhs.uk

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Methadone vs buprenorphine

Your review on methadone and buprenorphine treatments casts doubt upon their effectiveness in general practice due to a lack of controlled research in the community.[1] By the same standard, we should not be able to treat diabetes, depression or arthritis in general practice. Community, rather than specialist treatment is widely regarded as preferable for chronic conditions and it is the only feasible means of treatment outside metropolitan areas. Furthermore, adequate coverage of drug using populations in treatment cannot be achieved without extensive involvement of general practice-based treatment. The quality of clinic-based care is also quite variable.[2]

Despite giving 56 references, these authors fail to cite the many peer-reviewed descriptive and comparative reports of addiction treatments in general practice.[3–8] Yet they quote a small British study of people on low methadone doses (average 43.5 mg, range = 20–80mg) and with high prevalence of heroin use (67%) which found that modestly higher doses of methadone (average increase of 14.5 mg) increased their heroin craving and lowered feelings of wellbeing.[9] This study, never replicated, stands in stark contrast to strong evidence in multiple papers that higher doses, up to 100 mg daily, are associated with less heroin use.[10–11] The authors allude to inadequacies of methadone treatment in parts of the UK yet they fail to point out the seriousness of this neglect, with average doses as low as half the usual effective daily dose of 60–120 mg, generally given without supervision.

We should all have confidence in Cochrane reviews which find that when given in sufficient doses with appropriate levels of supervision and counselling, both methadone and buprenorphine maintenance treatments are associated with major reductions in illicit drug use.[12] There are also substantial improvements in general health and other important social and economic benefits including less blood borne viral infections. For methadone this involves supervised starting doses (for example, 30 mg daily) with gradual increases as indicated clinically.[13] Buprenorphine can be equally successful in general practice settings where it can be very rewarding for those prepared to be involved in treating opiate dependent patients using these modalities.

Andrew Byrne
Dependency Physician, Sydney, Australia
E-mail: ajbyrne@ozemail.com.au

Richard Hallinan

Richard Watson

Alex Wodak

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