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

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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.

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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.

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Authors' response

Like a previously published Cochrane review,[1] our synthesis of the international literature on community maintenance for treating opiate dependence[2] supports the effectiveness of methadone and buprenorphine in reducing illicit opiate use and promoting retention in treatment. Our study adds to the Cochrane review by focusing on how effectiveness is influenced by the setting in which maintenance treatment is delivered, by the intensity of treatment, and by the provision of additional medical and psychosocial services.

To date, research primarily relates to patients receiving maintenance treatment in outpatient clinics. Recently, community maintenance has been extended to general practice in a number of countries including Australia and France.[3] Although high-quality evidence is sparse, our review suggests that treatment with methadone or buprenorphine in general practice could be effective in patients who meet criteria of sufficient clinical stability and when provided by primary care physicians who have appropriate training. However, in an era of evidence-based medicine, there is a need for randomised controlled trials that properly evaluate community maintenance of opiate dependence in general practice. This is particularly true for conditions such as drug misuse, in which pharmacological treatment is only one component of effective therapy.

Our review has highlighted the daily doses at which methadone and buprenorphine are effective. Trials have suggested that the minimum effective daily maintenance dose may be 50 mg for methadone and 8–16 mg for buprenorphine. Higher doses of methadone and buprenorphine appear to be more effective at enhancing treatment retention and reducing illicit opiate use. Higher doses of buprenorphine have been shown to attenuate heroin craving, but the evidence relating to methadone is more equivocal.[4,5]

We and other authors have noted the issue of underdosing of methadone in the UK in our review and other publications.[2,6,7] A recent survey of prescribing practices of general practitioners in Scotland revealed that only 58% of GPs used methadone doses in the recommended range.[6] We believe that underdosing of methadone in the UK has been recognised for some time now, but that the difficulty lies in how to change clinical practice. UK guidelines need to clearly reinforce the message that higher doses of methadone are more effective. As guidelines alone are unlikely to change clinical practice, various strategies to disseminate and implement guidelines need to be explored.

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MeReC Bulletin

The *MeReC Bulletin*[1] arrived (Benzodiazepines and and newer hypnotics) and automatically I took down my sackcloth and prepared myself for an evening of penance and self-mortification (what else does a GP do now there is no 'out of hours?').

There, as expected, in the summary was the comment about inappropriate prescribing — GPs behaving badly again!

But as I was collecting the ashes from the grate I wondered when I last prescribed inappropriately. How often do we as GPs hand out benzodiazepines on a whim, without dire warnings of addiction, tolerance and side effects? How often when signing repeat prescriptions for the elderly on sleeping tablets do we make a QALY-fied decision to continue? 'I balanced all, brought all to mind, … In balance with this life, this death'.[2] Are patients stupid? Do they take these drugs thoughtlessly or do they crave the extra hour of sleep and escape from the realities they find themselves in? In the consulting room, benzodiazepines are a drug of desperation — of the patient for relief and of the GP to help that person to have some sort of tolerable existence.

Could we do better — obviously. But are we inappropriate — no. Information handed down from august bodies seems to lack connection with reality. Pharmacokinetically they are correct. However benzodiazepines are only prescribed psychosocially.

This lack of connection is also shown in the advice about co-proxamol. The intention seems pure — reduce avoidable deaths — no-one would argue with that. But how sensible is the thinking behind it? The MHRA consulted openly about co-proxamol[3] — as many as three patients had the temerity to reply — although I suspect that patient views are irrelevant in this situation. The MHRA advise the use of paracetamol as first line[4] with the addition of ibuprofen. Both are standard drugs of proven worth. Paracetamol is regarded as effective, but a recent *Bandolier* article[5] finds that, for osteoarthritis, there is no evidence that paracetamol is better than placebo. It is well know that NSAIDs cause