set with no effect on lifestyle accounting for 41.5% (*n* = 32) and a further 9.1% (*n* = 7) of patients declining surgery. Other ocular pathology including macular degeneration 14% (*n* = 11) and glaucoma 5% (*n* = 4) accounted for relatively few patients not being listed for surgery.

GPs do not generally have access to slit lamps and fundus biomicroscopy and understandably may feel out of their depth. However, we have shown that when assessing the patient with cataract it is important to assess the effect on the patient's lifestyle and their willingness for surgery before referral, and would encourage all GPs to do this to reduce the number of patients referred prematurely for their cataract operation.

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# Should GPs be prescribing more vitamin D?

The problem of rickets and osteomalacia among the immigrant community living in Britain was first highlighted in 1962.[1] More recent studies suggest that this problem persists.

Lawson and Thomas found suboptimal vitamin D levels in 20–34% of toddlers of Asian origin.[2] Shaw and Pal found that 85% of patients of Asian origin attending Birmingham antenatal clinics were vitamin D deficient in winter months[3] and Datta *et al* found that 50% of non-white patients attending antenatal clinics in South Wales had low vitamin D levels.[4]

Although supplementation of infants from racial groups is recommended, a previous study found that this occurred in less than 5% of infants.[5] The problem is complicated by recent NICE guidelines, which do not recommend vitamin D supplements for pregnant women.[6]

We undertook a postal and face-to-face questionnaire among practices in the Thames Valley area and Lambeth (this London area was chosen as their PCT has a policy of encouraging vitamin D supplementation of infants with dark skin).

Practices were asked whether they prescribed vitamin D supplements to pregnant women of Asian or African–Caribbean extraction and their infants. They were also asked to state if the approximate percentage of Asian or African–Caribbean patients was above or below 8%.

There was a 71.2% response to the 73 questionnaires sent out. In addition, 11 practices were asked face to face. Thirty-eight (67.9%) practices stated that their population was above 8% Asian or African–Caribbean (two practices did not specify).

Only two (3.4%) of the practices stated that they supplemented and this was for infants and not the mothers. Both of these practices were in Lambeth.

We were surprised at the low level of supplementation. It may be that in addition the health visitors in these practices are also prescribing vitamin D.

The recent CMO update has reiterated the need for vitamin D supplementation.[7]

We would recommend that a publicity campaign be started to encourage vitamin D supplementation.

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# Continuing care

A recent edition of *SAGA Magazine* follows newspaper and television campaigns providing material about NHS funding for continuing care.[1]

While applauding the media's raising of awareness about the opportunity to capture the full care costs (whether in a nursing home, residential home, sheltered accommodation or the individual's own home), inadequate coverage has been given to the requirement that the person's condition must be complex, intensive, unpredictable or unstable enough to meet the criteria for the funding from the government. Individuals may not meet the criteria laid down by the relevant strategic health authority — either by dint of their mental condition, or their physical condition, or a combination of the two — it is regrettable that families' hopes may have been raised inappropriately.

In the absence (so far) of national criteria, it would be worthwhile for GPs to obtain the continuing care criteria from their strategic health authority. They will then see the detail that describes the necessary complexity, intensity, instability or unpredictability of a patient's condition.

From time to time, families pursue their case about their relative stating that the patient's GP has assured them that the criteria are met. While this may sometimes be a robust opinion, regrettably it is not always so. The task of the local panels assessing applications, and the subsequent review panels at strategic health authority level (the 'second bite of the cherry') is therefore made more complicated, if after careful and sympathetic consideration, the individual's condition falls short of fulfilling the criteria.

As chairman of two Strategic Health Authorities' Review Panels, I recognise that people will only hear what they

choose to hear, or want to hear: GPs' opinions may have been more equivocal than families state! But it would be greatly appreciated if GPs could make the time to obtain and read the Continuing Care criteria, so that they are in a position to give as informed a view as possible regarding this important matter. We have a shared task, to ensure that those who are eligible for the full funding of their care are enabled to obtain this help as speedily and as easily as possible.

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## Prescribing to substance misusers

I must strongly disagree with Stephen Willott's opinion[1] that it is 'good news' that there has been an almost threefold increase in the number of GPs seeing opiate users.

If there had been an increase in the proportion of substance misusers seeing GPs and having specific treatment (from someone) that would be good news.

The possibility of a real increase in the number of misusers would most definitely be bad news, whether or not they were seeing their GP!

Again, increase in proportion treated (regardless of numbers) would be good news, but that they are treated by inexperienced non-specialists would not necessarily.

An increase in the number of GPs seeing these patients, even if the total patients stays the same, would imply that they are being more thinly spread across non-specialist care, and this suggests to me that their care is being dumped on inexperienced GPs who do not have the support to manage them well.

This would most definitely not be good news for the patients or the community.

It is also quite possible that they are indeed being dumped without the provision of any local enhanced service support, and this would be bad news for the GPs involved, who are doing it for free, as well as without support.

I don't know where Stephen works, but here in our part of Wales we have very poor availability of service, partly related to rurality, but the hospitals do tend to discharge such patients with instructions to get scripts from their GPs for tomorrow's doses, with no thought as to the effects of this on GP services or quality of care, and the fact that we have no contract to provide such services. Furthermore, when informed of their duty to continue prescribing, the hospital staff seem to think it is okay just to dump it for GPs to sort out, when we don't even have access to a suitable dispensing chemist for some of these drugs nearby, let alone education and an LES for the service.

Could Dr Willott influence this service provision problem at all to improve care of these patients?

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## Mental health screening may prove effective in primary care

A recent study by the MaGPIe Research Group[1] demonstrated high GP recognition rates (70.3%) of mental health problems. The findings may, however, be biased by the fact that GP case identification was based on a historical 12-month observation period whereas the final diagnosis (CIDI) was a present state assessment (within 1 month). This could lead to an overestimation of GP recognition rates. The conclusion that there is little gain from screening due to high detection rates may therefore be erroneous.

In a study using a composite screening questionnaire[2,3] we found that 43% of patients had high screening scores. Among patients with high screening scores we found an NNT (number needed to test) of 5, indicating that feedback on high scorers has the potential to identify 20 new cases per 100 cases. The effectiveness of feeding back high scorers' results on depression and anxiety scales is supported by a systematic review by Gilbody and colleagues.[4] A clinically useful description of this high score group could provide us with suggestions for making rational use of rating scales in general practice. While there is little evidence to support routine mental health screening, case-finding seems most promising.[5]

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## Impact of obesity

The Counterweight Project Team documented the obvious in their paper 'The impact of obesity on drug prescribing in primary care':[1] physical activity and weight loss produce better health and save money of the tax payers.

In the US, CDC has estimated that a sustained 10% weight loss will reduce an overweight person's lifetime medical costs by $2200–5300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke and high cholesterol.

This does not take into account other resources consumed by problems such as orthopaedic related issues.