examined if their findings were replicable in primary care settings in Edinburgh.

The study was carried out in two general practices in Edinburgh for five consecutive days in August and September this year. As in Aberdeen, the Hospital Anxiety and Depression Scale (HADS) questionnaire was given to patients waiting to see their doctor. GPs, blind to the questionnaire results, rated each participant on a scale of 0–3 for anxiety and depression.[3] Their case notes were subsequently searched for any diagnosis of depression, antidepressant prescriptions, and indication for prescription. The GP rating of anxiety was an addition to the Aberdeen study, attempting to determine whether the presence of anxiety had any impact on how GPs diagnose depression.

Unfortunately, the response rate was very low, possibly attributable to the practice receptionists approaching the patients rather than ourselves. In the first practice there were 48 participants out of a possible 278 (17%). In the second practice only 12 took part from an eligible 500 (2.4%). Of that 60, 20% had probable depression detected by the HADS questionnaire, suggesting preferential participation from people with depression. No case of inappropriate prescribing of antidepressants was detected. Ten per cent of the population studied were rated as mildly depressed by their GP (95% CI = 0.04 to 0.35) but were not found to be depressed on the HADS questionnaire. All patients with depression were also anxious so we could not assess whether this had an impact on treatment.

These findings, despite the low response rate, are in keeping with those from Aberdeen and reinforce their concerns about Scottish Government targets to reduce antidepressant prescribing.

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Osteoporosis

In reference to recent discussions on osteoporosis diagnosis presented in the *BJGP*, it was felt that it would be of interest to the reader to report the findings of a single practice audit undertaken as part of an F2 rotation.

As previously stated by Alun Cooper, the consequence of a fragility fracture places a great burden on the individual as well as the health and social care services.[1] In an effort to gauge fracture risk and thereafter appropriateness of treatment, a raft of guidelines have been published and assessment tools designed. However, it appears that there is poor compliance with these tools and anecdotally the consensus within the practice was that GPs do not feel entirely confident identifying at-risk individuals, in comparison to the honed skills of cardiac risk stratification.

With this in mind, and while discussing the Direct Enhanced Service criterion for osteoporosis, we felt it would be of benefit to audit the rate and appropriateness of investigation and management in female patients identified as suffering a fragility fracture. As an adjunct to this, retrospective analysis was undertaken regarding the identification and recording of the osteoporosis risk factors, outlined by the National Osteoporosis Guideline Group (NOGG), in the patients' clinical records.

Fifty-one female patients aged over 65 years were identified as having suffered a fragility fracture. It was found that 30% of the sample was receiving bone-sparing therapy; yet only 6% of the whole cohort and 12.5% of those between 65–74 years had undergone DEXA investigation. The clinicians have clearly undertaken some element of risk stratification. However, although documentation of commonly asked data such at alcohol and smoking status approached 100%, documentation of influential risk factors such as parental fractures was 0%, and liability to fall was 24%. Further to this, although some patients suffered from conditions that relate to secondary osteoporosis, no causal links were commented upon the notes.

Though the NOGG guidelines state that 'the final decision to assess BMD or to initiate therapeutic intervention lies with the clinician',[2] it would appear that risk stratification tools, such as the FRAX®, would have a clear benefit in acting as a prompt and ensure full documentation of risk.

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Correction

In the letter: Thornber M. Copying referral letters. *Br J Gen Pract* 2009; **59(568):** 869. The third paragraph reads: 'Thirdly there is ... However, the extra ... has been shown to be minimal' the word 'shown' should be 'found'. This has been corrected in the online version.

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