

# Letters

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## Authors' response

We thank Bahri and Hilton<sup>1</sup> for their interest in our paper.<sup>2</sup> We can assure them that there was no upper age limit in our study. That said, we were aware that studies like ours, involving waiting room screening, may offer a less popular mode of recruitment to older people (relative to recruitment by GP).<sup>3</sup> The latter method would clearly not have been appropriate in our study, but the option to take home materials may have helped to minimise this effect. Bahri and Hilton's inappropriate extrapolation of our statistics ('this suggests that almost no participants were over the age of 65 years') is wholly incorrect. In fact, 204 (23%) of participants were aged ≥65 years.

We share Bahri and Hilton's second concern regarding why there was an age difference in recognition of depression. We have a report in preparation that examines the issue of age with regard to prevalence of significant depressive symptoms, their recognition, and treatment. Others have found that differences may be explained in part by factors such as severity of symptoms. Thompson *et al* 2001, found that once adjusted for severity, age was not a factor associated with detection.<sup>4</sup> The relationship of age to the recognition of depression is also a concern at the other end of the spectrum. Bower *et al* 2000, found that recognition of psychiatric morbidity was most likely among patients in the 40–49 year age group when compared with aged 18–29 years.<sup>5</sup> Lecrubier 2007, commenting on findings from the Psychological Problems in General Health Care study (where detection in the age group 18–24 years was found to be low) speculated that GPs might have a low index of suspicion for younger patients.<sup>6</sup>

We did not set out to answer the complex question of what caused the

increase in antidepressant prescribing. Instead we sought to test the hypothesis that the increase in antidepressant prescribing was due to inappropriate GP prescribing. This hypothesis was rejected and our findings complement those of Moore *et al*.<sup>7</sup> Indeed, in our discussion we cited a preliminary account of their work as providing an explanation for the rise in antidepressant prescribing,<sup>8</sup> (at the time, their full paper had not been published). We also made the point in our original paper that 'an increase in duration of antidepressant therapy would represent an improvement in practice'.<sup>2</sup>

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## Community pharmacists and the helpful GP prescriber

The RESPECT trial of pharmaceutical care researchers wondered if a detailed medical history would help community pharmacists be more active in patient medication delivery, for example by suggesting alternative drugs.<sup>1</sup> At my practice we have been providing clear reasons for the drug prescribed on our prescriptions for over 5 years now. The Clinical Indications<sup>2</sup> process provides detailed GPs' clinical prescribing decisions for the unattached community pharmacist. For the pharmacist it makes the medicine use review easy to perform with the addition of allergies and adverse drug reactions on the attached prescription slip enhancing this process. Nevertheless, it has been rare for an alternative drug to be suggested as this still requires much more detailed knowledge of the patient.

As many older patients are on numerous drugs (an average of seven in the RESPECT study) and many have failing cognition, it can be even more important in team care to indicate the necessity for medication and be able to confidently reinforce its importance. One area of communication that has worked

well has been the use of stop dates on older peoples' warfarin prescriptions, for example for DVT.

If you are not already using this process, I encourage you to get up to speed on modern medication delivery.

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## Nurse-led management of hypertension

We read the paper of Voogdt-Pruis *et al*<sup>1</sup> with interest, since we have recently reviewed the literature for nurse interventions in primary care management of hypertension. We would like to offer the following observations:

Firstly, although no previous study has reported from the Netherlands there have been reports of similar studies from Scotland,<sup>2,3</sup> and England.<sup>4,5</sup> Three of these demonstrated improvements in blood pressure control with nurse-led interventions,<sup>2,3,5</sup> while the other did not.<sup>4</sup>

The authors' conclude that their findings support the involvement of practice nurses in cardiovascular risk management. This is based on the demonstration mainly of non-inferior outcomes; however, this can only be justified by inclusion of formal cost effectiveness analysis. Few previous studies of nurse-led care in hypertension have reported cost data, and those UK studies that have done found higher costs associated with nurse involvement, due to increased time spent offsetting the expected savings on salary costs.<sup>6,7</sup> Therefore, further studies must be undertaken that include formal economic evaluation and determine whether the

increased cost of nurse-led interventions represents good value for money in terms of improvements in patient health outcomes.

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## Circumcision

The article by Anwar *et al*<sup>1</sup> in the many

senses of the word. It presented a comprehensive review of the religious beliefs behind the practice of circumcision and, I confess, educated me about the HIV risk. The debate around availability of a safe service in the UK, is obviously an important one. I feel the authors let down their argument in the last paragraph. They say it is a doctor's duty 'to carry out said decision to the best of our ability'. They appear to have made this statement on a one issue basis, without considering the wider ethics. Doctors do not automatically carry out a patients' decision — take for instance the issue of abortion.

However, while the article raises a number of points for discussion I feel that one is omitted. In the case of religious circumcision it is not the patients' decision. A baby boy is the child of parents with particular beliefs, but cannot be said to hold those beliefs at that age. As was pointed out in the article, in the UK there is no medical justification for circumcision, *per se*. There is the need for the profession to consider the possibility that if we assist in a religious circumcision then the boy, at 18, might sue us for 'the cruellest of cuts'. Not every child of Jewish or Islamic parents keeps the faith.

The authors are to be congratulated on bringing this issue to the fore and, hopefully, stimulating further debate.

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The essay on circumcision in the January 2010 issue of the *BJGP* was very interesting.<sup>1</sup> Certainly as far as the Jewish relationship to the topic is concerned it was well informed and demonstrated much insight. However, there is one aspect of the Jewish tradition that was not mentioned and that is the considerable grasp of the genetics of haemophilia displayed in the laws relating to circumcision. If a mother is unlucky enough to lose two sons from failure of the penile wound to stop bleeding, then the commandment to