

despite a consistently high immunisation rate, we have discovered an important group of susceptible teenagers we were not previously aware of among whom a measles outbreak remains. Despite immunisation rates consistently over 90%, of our 256 10–16-year-olds, 51 were not fully immunised. The autism fallacy accounts for five people not taking up immunisation, but 46 were new entrants to the UK after the age of 5 years old. In our area therefore, despite high immunisation rates, we are at high risk of an epidemic. Herd immunity does not apply.

We cannot afford to rest on our laurels. Having reached high immunisation rates overall is good but not good enough especially in areas of high population turnover and immigration. Measles susceptibility is an ever-present danger.

Do we need to routinely do one-third MMR at age 10–12 years old, or immunise all new entrants along with TB screening?

Petre Jones,

MRCGP, The Project Surgery, 10 Lettsom Walk, London, E13 0LN.
E-mail: petre.jones@nhs.net

DOI: 10.3399/bjgp13X670570

Are we overusing thyroid function tests?

The prevalence of hypothyroidism in the UK is 2%. It is 10 times more common in women, with incidence figures of 4.1/1000 women/year and 0.8/1000 men/year. Thyrotoxicosis is much less common, with a prevalence of 0.4%. It is also more common in women (0.77/1000 women/year versus 0.14/1000 men/year). The standard investigation if either disease is suspected is blood thyroid stimulating hormone (TSH).

Guidance from the British Thyroid Association (2006) states that TSH should be tested if thyrotoxicosis is suspected, with a normal TSH effectively ruling out hyperthyroidism, and for hypothyroidism it advises that, because the typical signs are often not present, clinical judgement is important in deciding whom to investigate.¹

We studied the yield of thyroid disease obtained from the number of TSH tests requested, in an Exeter, Devon, practice serving an urban population of 18 178. Of the 2717 patients who had TSH testing in 2012, 398 (15%) were already taking thyroxine

for hypothyroidism, and 77 (3%) were on treatment for active thyrotoxicosis or having annual TSH monitoring for previous hyperthyroidism. Thus there were 2267 patients who had TSH testing for diagnostic purposes. These tests identified 48 (2.1% of those tested) patients newly diagnosed with hypothyroidism over the past year. Ten of these were at higher risk: seven patients became hypothyroid while receiving carbimazole treatment for thyrotoxicosis, two after having a thyroidectomy, and one after radioiodine treatment. Arguably, this leaves 38/40 newly diagnosed with spontaneous hypothyroidism. There were seven new diagnoses of hyperthyroidism in the past year.

The study by Vanderpump *et al* provides demographic data on UK thyroid disease incidence and prevalence: using their data we would expect 39 new diagnoses of hypothyroidism and six of hyperthyroidism annually; remarkably close to our observed figures.² Although the high number of tests to identify each case suggests indiscriminate testing, the practice is one of the lowest in Devon for TSH testing (14th out of 108 [personal communication, Professor Chris Hyde, 2013]).

The local cost of a standard TSH test is £1.67 (to which must be added the costs of phlebotomy, transport, and clinic time). Nationally, 10 million thyroid function tests are requested each year, at a cost of over £30 million to the NHS.³

Our study shows a high ratio of TSH testing to each diagnosis of thyroid disease, which could indicate that we are testing for hypothyroidism rather indiscriminately, with significant costs to the health budget. The next question will be to find out how this can be improved.

Alexander Werhun,

GPST3 ACF, Mount Pleasant Health Centre, Exeter, EX4 7BW.
E-mail: awerhun@nhs.net

William Hamilton,

Professor of Primary Care Diagnostics, University of Exeter.

REFERENCES

1. Association of Clinical Biochemistry, British Thyroid Association, British Thyroid Foundation. *UK guidelines for the use of thyroid function tests*. London: Association of Clinical Biochemistry, British Thyroid Association, and British Thyroid Foundation, 2006. <http://acb.org.uk/docs/tftguidelinefinal.pdf> (accessed 26 Jun 2013).
2. Vanderpump MPJ, Tunbridge WMG, French

JM, *et al*. The incidence of thyroid disorders in the community: a twenty-year follow-up of the Whickham Survey. *Clin Endocrinol (Oxf)* 1995; **43**(1): 55–68.

3. *Adapted summary of UK guidelines for the use of thyroid function tests*. Liverpool: Royal Liverpool and Broadgreen University Hospitals NHS Trust. http://pathlabs.rlbuh.nhs.uk/tft_guideline_summary.pdf (accessed 26 Jun 2013).

DOI: 10.3399/bjgp13X670589

Miss Polly had a dolly

The nursery rhyme by Dr Corbett¹ repeats the mischievous myth that GPs are to blame for the pressures on A&E departments. She should consider adding this verse in the interests of balance:

*Miss Polly gave her GP stick, stick, stick,
For not doing a home visit quick, quick,
quick,
But she managed to travel to A&E,
Though it was further than the surgery!
She waited 3 hours and 59 mins
Until the nice nurse called her in,
The nurse explained it's just a cold, cold,
cold,
Just as your doctor told, told, told.*

Kevork Hopayian,

Leiston Surgery, Main Street, Leiston, Suffolk, IP16 4ES.
E-mail: k.hopayian@btinternet.com

REFERENCE

1. Corbett E. Miss Polly had a dolly who was sick, sick, sick ... *Br J Gen Pract* 2013; **63**(611): 319.

Editor's note

The poem was written by a specialty trainee in general practice during maternity leave when her baby son was ill.

DOI: 10.3399/bjgp13X670598

Reducing inappropriate ENT referrals

Cox and colleagues¹ highlight the problem of increasing numbers of outpatient referrals, many of which are thought to be inappropriate. Ear, nose, and throat (ENT) problems are common in primary care² and appropriate referral is crucial. We investigated GP referrals to the one-

stop emergency ENT clinic at St George's Hospital, London. Criteria for referral to this clinic include: otitis externa (needing microsuction), recurrent epistaxis, fractured nose (needs to be seen within 7–10 days of injury), foreign bodies in the ear, sudden unilateral sensorineural hearing loss, and Bell's palsy.

We collected prospective data on 100 consecutive primary care referrals in April–May 2013. The patients' mean age was 41 years (range 1–88 years), 24 were children aged <12 years, and 47 were male. Referrals were triaged by an ENT senior registrar or consultant and 65 were accepted.

Of the remaining 35 referrals deemed inappropriate, seven were for microsuction of wax, six patients had neck lumps or hoarse voice (2-week referral), three had otitis media (referral to paediatric/general ENT clinic), two had possible cholesteatoma (referral to otology clinic), four had tinnitus or vertigo (referral to audiology clinic), two had chronic sinusitis (referral to rhinology clinic), two had hearing aid problems (referral to audiology clinics), and nine had other conditions.

We believe that recognition of criteria for emergency ENT clinic referrals and an awareness of the many different subspecialist ENT clinics available may help GPs refer more appropriately and provide efficient care. Hospitals should keep GPs regularly updated in their acceptance criteria for the different clinics and publish this information on their websites. This is important in view of Cox and colleagues¹ findings that referral management schemes are expensive and do not seem to reduce outpatient attendance rates.

Sridhayan Mahalingam,

*Academic FY2 in Primary Care and Population Health Sciences, St George's, University of London, Cranmer Terrace, London, SW17 0RE.
E-mail: smahalingam@doctors.org.uk*

Chris Pepper,

Specialist Registrar in ENT, Division of Population Sciences and Education, St George's, University of London, London, and ENT Department, St George's Healthcare NHS Trust, London.

Pippa Oakeshott,

Reader in General Practice, Division of Population Sciences and Education, St George's, University of London, London.

REFERENCES

1. Cox JM, Steel N, Clark AB, *et al*. Do referral-management schemes reduce hospital attendances? Time-series evaluation of primary care referral management. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X668177.
2. Griffiths E. Incidence of ENT problems in general practice. *J R Soc Med* 1979; **72**(10): 740–742.

DOI: 10.3399/bjgp13X670606

The pain of pregabalin prescribing in prisons

Delegates at the RCGP inaugural Offender Health Conference have identified the demands placed on clinicians in UK prisons to prescribe pregabalin as one of their main concerns.

Pregabalin is licensed for the treatment of epilepsy, anxiety disorder, and neuropathic pain. It is frequently requested by patients with substance-misuse problems, particularly those with opioid addiction. Patients report being prescribed pregabalin for pain. They may be co-prescribed opioid substitution therapy. Many have been using heroin immediately prior to detention.

It is important for safe prescribing regimens to exist in prisons, but we believe that NICE guidelines are not being followed in the prescribing of pregabalin for the treatment of neuropathic pain by community prescribers, and that prison prescribers are inheriting inappropriate demands for this medicine from their colleagues. This places them in a very difficult position. Prison GPs are familiar with the potential for the misuse of a wide range of medicines in custodial settings. Such misuse can contribute to the culture of bullying and exploitation that exists in some prisons. It can also place prisoners at risk of direct and unpredictable harm as a result of taking prescribed and non-prescribed drugs in an unregulated way.

The RCGP Secure Environments Group (SEG) calls for community prescribers including GPs, pain clinics, psychiatrists, and substance misuse services, to rationalise the prescribing of pregabalin and to ensure that NICE guidelines are followed. The RCGP SEG does not see a major role for pregabalin in the treatment of non-neuropathic pain and we support clinicians in safely discontinuing pregabalin in prisoners who have clearly identifiable drug problems and in whom the diagnosis of neuropathic pain is questionable. Other medicines are also a cause for concern

for prescribers in prisons in drug-using patients. These include mirtazapine, clonazepam, tramadol, and gabapentin, as well as other opioids and benzodiazepines. RCGP SEG calls on community prescribers to be cautious in prescribing these medicines in patients who have a history of addiction problems. RCGP SEG calls for research into the prescribing of pregabalin in prisons and in the community, with particular consideration to age differentials, addiction histories, and the indication for the prescription.

Unexplained deaths in custody are an important issue. RCGP SEG calls for detailed toxicology reporting in such cases as well as full consideration by coroners of all prescribed and non-prescribed drugs in these tragic cases.

Marcus Bicknell,

*Chair of RCGP's Secure Environments Group.
E-mail: marcus.bicknell@gp-c84704.nhs.uk*

DOI: 10.3399/bjgp13X670615

Use of PHQ-9 scores to guide treatment decisions in primary care

Shaw and colleagues stated no changes in depression management were seen in studies they reviewed of using patient health questionnaire (PHQ-9) scores to guide primary care treatment.¹ This statement is an inaccurate reflection of the literature they reviewed and cannot go unchallenged.

The observational study conducted in Southampton practices, in the year following the introduction of the DEP3 QOF indicator rewarding the use of symptom questionnaires at follow-up of depressed patients between 5 and 12 weeks, showed that follow-up scores appeared to influence decisions to change treatment significantly.² After controlling for confounders, patients who showed an inadequate response in questionnaire-score change at follow-up were nearly five times more likely to experience a subsequent change in treatment, compared to those with an adequate response (odds ratio 4.72, 95% CI = 2.83 to 7.86).²

Shaw and colleagues downplayed the evidence of the quasi-randomised trial from the US which found that feeding back