

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.

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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.

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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