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 audiovestibular 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 colleagues'[1] 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.

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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.

Pregbalin 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 mirtazipine, 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

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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

PHQ-9 scores to primary care physicians at diagnosis and follow-up led to significantly increased rates of remission and response, clearly showing benefit to patients.[3] They failed to point out that changes in management in the intervention arm of the trial were actually more numerous too. More patients received antidepressant treatment at baseline, and antidepressant regimen changes over the following 6 months among partial or non-responders were all more numerous in the intervention arm.[4] Although these differences in treatment changes were not statistically significant, they were all in the direction expected if feedback of PHQ-9 scores was influencing treatment,[4] suggesting the trial was under-powered to detect small but clinically significant differences in care in those cases where treatment changes were indicated.

Research in specialist practice, specifically excluded from Shaw and colleagues' review, has even more convincingly demonstrated the benefits of monitoring depression treatment with symptom questionnaires. Systematic reviews and meta-analyses in specialist psychological and psychiatric care have shown that outcomes can be improved with an effect size of between 0.1–0.3 standard deviations, being most beneficial when patients are involved in rating their own problems and receive feedback on progress, in addition to feedback to the practitioner.[5]

Now that the use of symptom questionnaires is an optional component of the QOF incentivised initial and follow-up assessments in depression, it will be interesting to see whether practices continue to use them, given the evidence that patients like them,[6] and that they can help improve patient outcomes in depression.[3]

Tony Kendrick,

Professor of Primary Care, Primary Care and Population Sciences, Aldermoor Health Centre, Southampton, SO16 5ST. E-mail: ark1@soton.ac.uk

Paul Little,

Professor of Primary Care Research, Primary Care and Population Sciences, Aldermoor Health Centre, Southampton.

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Poetry for new doctors: in memory of Dr Pat Manson

I'm a GP in Hawick, and was a colleague and friend of Dr Pat Manson, GP trainer of 23 young doctors, who tragically died last April. I have thought for some time that it would be useful and valuable to produce a little book of poetry for new doctors at the beginning of their emotionally demanding work. It would fit easily into their pockets and be a source of comfort and support. When they are often at risk of being overwhelmed by the vast amount of protocols and clinical data, this little book would serve to nourish their humanity.

I had discussed this idea with Pat and, as was his way, he was positive and encouraging about it. He was creative and loved poetry. He was passionate about teaching and motivating young doctors and he cared deeply about his patients but, as his *BMJ* obituary said, '*The wellbeing and care of his patients was the cornerstone of his professional life and he gave his time unstintingly, often to his own personal detriment … Ultimately he was overwhelmed by his own exacting standards and sadly took his own life*'.

When he died, Lesley, Pat's widow, and I felt that the booklet would be a fitting tribute to him and I approached the Scottish Poetry Library. They are keen to help produce it and we hope to give it to every new Scottish graduate this and next year. As a charity, they are contributing their experience and knowledge of poetry. Estimated production costs are £5000 for 1 year's graduates and £8000 for 2 years.

Would you like to be part of his project and help produce a poetry booklet dedicated to Pat and to the work that he loved and which he did so very kindly and well?

You can donate via this justgiving site: http://www.justgiving.com/Scottish-Poetry-Library-Poetry-for-New-Doctors, or by sending a cheque payable to Scottish Poetry Library: Poetry for New Doctors, 5 Crichton's Close, Canongate, Edinburgh, EH8 8DT.

Lesley Morrison,

E-mail: lesley@ljmorrison.fsnet.co.uk

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Correction

In the September 2012 article: Sheron N, Moore M, Ansett S, *et al.* Developing a 'traffic light' test with potential for rational early diagnosis of liver fibrosis and cirrhosis in the community. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654588, the algorithm "predicted probability (p) = exp(HA * 0.015 + P3NP * 0.447 + (PLT * –0.005) – 0.611)/(1 + exp(HA * 0.015 + P3NP * 0.447 + (PLT * –0.005) – 0.661))" should have stated "predicted probability (p) = exp(HA * 0.015 + P3NP * 0.447 – PLT * 0.005 + –0.611) / (1 + exp(HA * 0.015 + P3NP * 0.447 – PLT * 0.005 + –0.611))". The online version has been corrected.

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