turers and general practitioners of the demands being put upon the pharmacist, together with promotion of greater awareness among the general public of pharmacists' skills and responsibilities.

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Primary care services for problem drug users: PSALT and DrugNet

Sir,
We were pleased to read the editorial by Wilson and colleagues on improving methadone maintenance in general practice for problem drug users (September *Journal*, p.454). We have followed with interest their previous general practice work with problem drug users in Glasgow, although we are still confused about their budget allocation. In the editorial Wilson and colleagues state that 'the costs to the practice [are] considerable' and have previously reported that each patient receiving methadone maintenance costs the practice approximately £2000 each year.[1] We have challenged this amount[2] as we believe that the actual annual cost is nearer to £1000 per patient. We re-emphasize this point because we share the hope of our colleagues in Glasgow that similar projects in other parts of the United Kingdom will be established. An overestimation of the costs may dissuade other general practitioners or family health services authorities from providing high-quality, effective care in general practice to drug-dependent patients. As an extension of this, we would like to outline two initiatives introduced by West Glamorgan Health Authorities.

The primary care substance abuse liaison team (PSALT) has been established to offer formal primary care services to problem drug users. PSALT is managed by a project board and primary care is provided by three general practitioners located throughout West Glamorgan. PSALT has a shared-care philosophy and patients eligible for PSALT care can be referred by local drugs projects or by the secondary care sector. It is on this latter point that the second initiative, the DrugNet project, is being developed. Essentially, DrugNet is a computer project and, in the first instance, computers with custom designed software will be installed at the practices of the PSALT general practitioners and three local substance misuse street agencies. Shared care will be supported by a West Glamorgan register and the core system will eventually be expanded to include other partners such as the community drugs team, probation service and social services. The collection of local data will allow the audit of the shared-care model and support the design of proactive strategies against substance misuse.

Our initiatives in West Glamorgan support high quality primary/shared care for problem drug users, with a particular emphasis upon service audit. Although both initiatives are still developing, we would be willing to correspond further with anyone who is interested in such initiatives.

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References

1. Wilson P, Watson R, Ralston GE. Methadone maintenance in general practice: patients, workload and outcomes. *BMJ* 1994; **309:** 641-644.
2. Morgan GP, Willson A. Methadone maintenance in general practice [letter]. *BMJ* 1994; **309:** 955-956.

Open-access echocardiography

Sir,
We were interested to read the editorial by Colquhoun and colleagues (October *Journal*, p.517) on how echocardiographic services should be delivered for the investigation in general practice of patients with suspected heart failure.

One of us (M C) has examined secondary prevention of coronary heart disease. Thirty six patients with proven previous myocardial infarction without heart failure were referred to a general practitioner open-access echocardiography service at the Western General Hospital, Edinburgh, over approximately six months. All patients offered this service readily accepted the invitation and attended.

Results showed that 22 of the 36 patients had satisfactory echocardiographs which indicated that they required no further medical treatment or investigation. Twelve patients were shown to have asymptomatic impaired left ventricular function requiring therapy with angiotensin-converting enzyme (ACE) inhibitors. One patient was shown to have aortic valve disease requiring diuretic therapy. One patient was shown by electrocardiography, prior to echocardiography, to have atrial fibrillation requiring warfarin and digoxin therapy.

In light of such clinically significant pathology being found, we would suggest that it would be worthwhile that open-access echocardiography services be available to all general practitioners.

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Headache: not an ophthalmological problem?

Sir,
In his letter (October *Journal*, p.562) O'Donnell suggests that any patient who presents in general practice with a headache and ocular symptoms should be referred to an ophthalmologist as the underlying cause will, in 60% of cases, be ophthalmologically related. This is, unfortunately, based on a fundamental epidemiological flaw, that of the floating denominator. What O'Donnell has found is that 60% of those who attend a specialist emergency eye clinic with those symptoms are found to have ophthalmological problems. What is not known is the baseline number of patients from which these patients come. Without any knowledge of the prevalence of headache and ocular symptoms in general practice, his assertion does not hold up.

O'Donnell then suggests that patients with headache alone should not be referred to the ophthalmic casualty department but to another specialty, such as neurology. This statement is even less likely to be of benefit. There have now been between 30 and 50 studies of the prevalence of somatic symptoms in general practice and in the community. Headache is invariably among the most common somatic symptom, and prevalences in both