Postnatal sexual problems were common among the respondents. Nearly one quarter of all the women (23.3%) reported pain and/or severe discomfort during sexual intercourse after the birth. This was most common in women who had undergone episiotomies (40.2% of 281 women), but was also experienced by women who had had stitched tears (20.5% of 375), unstitched tears (14.9% of 74), no perineal damage (10.9% of 156) and caesarean section (13.1% of 122). Dyspareunia often persisted a long time after the birth, and untreated morbidity was common, with respondents citing for example 'bad urethral pain in the first three years' and 'sore perineum scar for over two years'. Other sexual problems identified were vaginal dryness and loss of libido (usually associated with breastfeeding) (17.5% of respondents), and tiredness and exhaustion (36.2%). Consequently, half the respondents (51.7%) felt that their sex life was now 'less good' than before the birth of their child.

A total of 757 women (75.0%) reported talking to someone (either a health professional or non-health professional) about postnatal sexual health. Fifty one per cent of women (515) reported talking to their general practitioner. Such conversations were reported as being almost exclusively concerned with contraception. General practitioners may perceive talking about contraception as a clear opening gambit for women to discuss their sexual difficulties; this was, however, clearly not the case for the respondents in this survey.

There was some evidence that when postnatal sexual problems were discussed, general practitioners did not consider the problem to be serious. For example, one woman reported 'I was sore and in fact needed my episiotomy scar repaired (it had formed a ridge which was uncomfortable — this wasn't done until eight months after the birth). At the six week check the doctor said it would get better with 'use' but it wasn't until I mentioned it to a lady doctor that anything was done.'

The women in this survey were mainly white and middle class and were therefore more likely to be articulate users of health care. This raises the question of whether less advantaged women, as a result of their social, educational and cultural backgrounds, may find difficulty in raising the sensitive subject of postnatal sexual health and in persisting when their problems are not taken seriously. General practitioners can begin to address the problem of postnatal sexual health problems by asking women simple direct questions, for example 'Have you had sexual intercourse and if so is it pain free?' and 'Have you had any problems with incontinence?'[3] General practitioners can also help by informing women that vaginal dryness and loss of libido may be associated with breastfeeding and that use of a vaginal lubricant will help, and by referring women for further investigation when dyspareunia or other sexual problems do not resolve.

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References

1. Fleissig A. Prevalence of procedures in childbirth. *BMJ* 1993; **306:** 494-495.
2. Welch A, Chapple J, Beard R. *North West Thames regional annual maternity figures 1992: St Mary's maternity information system.* London: North West Thames Regional Health Authority, 1993.
3. Anonymous. New baby? How wonderful. *BMJ* 1994; **309:** 815-816.

H pylori infection

Sir,

Delaney has presented a timely and considered review of the impact of *Helicobacter pylori* infection on the management of dyspepsia (September *Journal,* p.489). This is a topic of major importance to general practitioners but which has caused considerable confusion in the past, resulting in part from the rapid rate of advance of knowledge in this field. We would like to comment on a number of points which are dealt with in the article.

First, with regard to choosing a suitable regimen for eradication of *H pylori,* standard triple therapy (bismuth plus tetracycline or amoxycillin plus metronidazole) for two weeks should no longer be regarded as the first choice of therapy. Although it has been shown to be capable of achieving a high eradication rate,[1] in practice there is a high incidence of side effects associated with this therapy,[2] with a resultant poor compliance;[3] poor compliance has been shown to reduce considerably the success of standard triple therapy for eradicating *H pylori.*[3] Although two-week dual therapies combining omeprazole with either amoxycillin or clarithromycin can achieve eradication rates of about 80%,[4,5] these have been superseded by the emergence of a new low-dose one-week triple therapy. A combination of omeprazole 20 mg twice daily, clarithromycin 250 mg twice daily and metronidazole 400 mg twice daily or tinidazole 500 mg twice daily has been shown in a number of trials (reviewed by Goddard and Logan[6]) consistently to achieve eradication rates of over 95%. This regimen is well tolerated and has a low incidence of side effects.[6] It should now be regarded as first-line therapy for eradicating *H pylori.*

Our second point concerns the cost-effectiveness of eradicating *H pylori* in patients with peptic ulceration. The theoretical financial benefits of such a policy have been calculated by Bell and colleagues.[7] General practice based studies from our own group,[8] as well as from others,[9] have shown that considerable financial savings result from a reduction in the use of acid-suppressing drugs following successful *H pylori* eradication.

Thirdly, in the management guidelines presented by Delaney it is suggested that the absence of dyspeptic symptoms should be taken as a sign of successful *H pylori* eradication although he states that evidence to support this policy is lacking. We have recently presented the results of a study which showed that monitoring of dyspeptic symptoms can indeed be a useful and inexpensive alternative to conventional tests for confirming *H pylori* eradication in patients with uncomplicated duodenal ulcer disease.[10]

Certainly more research needs to be performed but there is now good evidence to suggest that general practitioners, in consultation with their local gastroenterologists, should play an active part in the management of patients with *H pylori* infection. We entirely agree with Delaney that there are substantial clinical and financial benefits to be gained from taking advantage of the revolution in the management of dyspepsia related to infection with *H pylori.*

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References

1. Chiba N, Rao BV, Rademaker JW, Hunt RH. Meta-analysis of the efficacy of antibiotic therapy in eradicating *Helicobacter pylori. Am J Gastroenterol* 1992; **87:** 1716-1727.
2. Bell GD, Powell KU, Burridge SM, *et al.* Experience with triple anti-*Helicobacter pylori* eradication therapy — side effects and the importance of testing the pre-treatment isolate for metronidazole resistance. *Aliment Pharmacol Ther* 1992; **6:** 427-435.
3. Graham DY, Lew GM, Malaty HM, *et al.* Factors influencing the eradication of *Helicobacter pylori* with triple therapy. *Gastroenterology* 1992; **102:** 493-496.

4. Axon ATR. The role of acid inhibition in the treatment of *Helicobacter pylori* infection. *Scand J Gastroenterol* 1994; **29** suppl 201: 16-23.
5. Logan RPH, Gummett PA, Schaufelberger HD, *et al.* Eradication of *Helicobacter pylori* with clarithromycin and omeprazole. *Gut* 1994; **35:** 323-326.
6. Goddard A, Logan R. One-week low-dose triple therapy: new standards for *Helicobacter pylori* treatment. *Eur J Gastroenterol Hepatol* 1995; **7:** 1-3.
7. Bell GD, Powell KU, Bolton G, Richardson PDI. Clinical and pharmacoeconomic evaluation of management strategies for duodenal ulcer disease. *Br J Med Econ* 1993; **6:** 45-58.
8. Phull PS, Ryder SD, Halliday D, *et al.* The economic and quality-of-life benefits of *Helicobacter pylori* eradication in chronic duodenal ulcer disease — a community-based study. *Postgrad Med J* 1995; **71:** 413-418.
9. Powell KU, Youngman PR, Bell GD, *et al.* A general practice study of *Helicobacter pylori* eradication treatment in patients using long-term ulcer healing therapy. *Br J Clin Res* 1995; **6:** 21-29.
10. Phull PS, Halliday D, Price AB, Jacyna MR. Is the 'absence of dyspeptic symptoms' a useful test to assess *Helicobacter pylori* eradication? *Gut* 1995; **36** suppl 1: a12.

Unexpected side effect of *H pylori* infection cure

Sir,

Ever since we have had the means at our disposal to cure *Helicobacter pylori* induced duodenal ulcer, I have been assiduously looking for patients whom I can attempt to persuade to take the unpalatable triple therapy or antibiotic/omeprazole treatment. One such patient had been using antacids and H_2-antagonists for at least 20 years and when I saw him on another matter I took the opportunity of checking his C^{13}-urea breath test. This was reported as showing an excess of exhaled labelled carbon dioxide (28 units ml^{-1} compared with a normal value of less than 5 units ml^{-1}).

After a four-week course of omeprazole 20 mg at night and amoxycillin 1g twice daily his chronic indigestion was cured. The patient attacked his garden with vigour and was able to put in a seven-hour day instead of having to stop every 15 minutes to chew antacids. The result is the most intractable case of plantar fasciitis (sprain of longitudinal plantar fascia in the foot) that I can remember seeing. I wonder if other general practitioner colleagues have noted unusual late onset side effects of *H pylori* infection cure?

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Counselling and psychotropic drug prescribing

Sir,

We welcome the interest from Jenkins and Hemmings (letter, December *Journal,* p.691) in our paper (September *Journal,* p.467) that explored the relationship between counselling and psychotropic drug prescribing. There are some points that we would like to make in response.

Their assertion 'many studies have shown reductions in the prescribing of psychotropic drugs after counselling interventions with individual patients' refers to one randomized controlled trial[1] in which only 54% of patients who were randomized to counselling were followed up and accounted for in the analysis at six weeks. As referenced in our paper,[2-4] there is a paucity of evidence from randomized controlled trials about the effectiveness and cost-effectiveness of counselling in general practice. The trials that have been performed show a transient, but not sustained, reduction in prescribing costs in patients randomized to counselling.

The main impetus to our study was to examine the commonly cited assertion that provision of counselling in general practice reduces prescribing costs.[5] The results clearly show that this cannot be assumed. What is needed is an unbiased evaluation of the effectiveness and cost-effectiveness of counselling in general practice in the United Kingdom. Considering the huge growth in this intervention since the introduction of the 1990 contract for general practitioners,[6] evaluation in the form of randomized controlled trials with longer-term follow up would be a sound investment.

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References

1. Boot D, Gillies P, Fenlon J, *et al.* Evaluation of short term impact of counselling in general practice. *Patient Educ Counselling* 1994; **24:** 79-89.
2. Earll L, Kincey L. Clinical psychology in general practice: a controlled trial evaluation. *J R Coll Gen Pract* 1982; **32:** 32-37.
3. Catalan J, Gath D, Edmonds G, Ennis J. The effects of non-prescribing of anxiolytics in general practice. 1: controlled evaluation of psychiatric and social outcome. *Br J Psychiatry* 1984; **144:** 593-602.
4. Robson M, France R, Bland M. Clinical psychologist in primary care: controlled clinical and economic evaluation. *BMJ* 1984; **288:** 1805-1808.
5. Audit Commission. *Report on prescribing.* London: HMSO, 1994: 21-22.
6. Pringle M, Laverty H. A counsellor in every practice? [editorial]. *BMJ* 1993; **306:** 2-3.

Warfarin for elderly patients

Sir,

I read with interest the results of Seamark's audit (letter, October *Journal,* p.563) stimulated by Sweeney and colleagues' review of the use of warfarin in patients with non-rheumatic atrial fibrillation.[1] The identification of at risk patients can be made in several ways and Seamark has illustrated the time-consuming nature of identifying such patients by audit (up to 20 hours of doctor time).

However, an alternative strategy might exist. Although systematic screening of all patients would be time consuming and unlikely to be cost-effective, screening of patients aged 75 years and over would conceivably be straightforward. This has the obvious advantage of existing infrastructure (the statutory annual health assessment for patients in this age group) and the further justification that atrial fibrillation is more prevalent in this age group, the corresponding opportunity for therapeutic benefit thus being greater than in younger age groups.

To assess the potential value of such a strategy, I performed a computer search for patients who were receiving repeat prescriptions for digoxin or whose records were coded with the diagnosis of atrial fibrillation, in my former training practice (five partners, list size approximately 12 000 patients). A total of 93 patients were identified, 52 (56%) of whom were aged 75 years and over. Of the 93 patients, 30 (32%) were found to be not receiving anti-thrombotic therapy (aspirin or warfarin) and of these 30 patients, 18 (60%) were aged 75 years and over. After allowing for treatment contra-indications, it was found that nine of the 18 patients could be considered as potentially suitable to receive warfarin.

A suggestion for this strategy is that those patients aged 75 years and over not receiving any anti-thrombotic treatment for their atrial fibrillation, and who should be considered for treatment, could be identified by assessment of patients' pulse rates and rhythms at screening sessions for