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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Multiple concurrent childhood immunization

Sir,
General practitioners and health visitors have expressed concern that the introduction of a second injection, against *Haemophilus influenzae* type b, into the primary immunization programme for infants aged two, three and four months may adversely affect uptake. We investigated reasons for refusal of the *Haemophilus influenzae* type be vaccine during 1991 in a prospective community intervention study of the vaccine. Parental consent was usually obtained by health visitors when routine immunizations were discussed. If consent for the new vaccine was refused, a questionnaire was completed to document the reasons for refusal.

We have previously found that acceptance of the *Haemophilus influenzae* type b conjugate vaccine polyribosyl ribitol phosphate–tetanus toxoid, was high, being 97% in five randomly selected Oxfordshire practices,[1] although over the first three months of the 17-month study, acceptance was about 88%. For most of the first 202 infants for whom the study vaccine was refused, the principal reason given by the parents for refusal was that it was new (138 parents, 68%). For 15% of refusals (31) the extra injection was the reason, while only 2% (five parents) refused all vaccines, at least some of these on presumed homoeopathic grounds. Taking 88% as the uptake figure when these refusals occurred, 2% of all infants did not receive the new vaccine because it involved an extra injection, and a maximum of 0.3% because of a parental preference for homoeopathy. Simpson and colleagues have found that 0.3% of children eligible for routine immunization did not receive it, the most common reason being a parental preference for homoeopathy.[2]

The likely introduction in the near future of a quadruple vaccine against diphtheria, tetanus, pertussis and *Haemophilus influenzae* type b, where all antigens are combined in one vaccine, will thus have the potential for a small increase in vaccine uptake. Perhaps more importantly, it will allow for the introduction of further vaccines into routine use, such as Meningococcus C conjugate vaccine, because although parents generally accepted two concurrent injections given monthly on three occasions, there is likely to be greater refusal of three concurrent injections.

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2. Simpson N, Lenton S, Randall R. Parental refusal to have children immunised: extent and reasons. *BMJ* 1995; **310:** 227.

Over-the-counter medicines

Sir,
We were interested to read the discussion paper by Bradley and Bond (October *Journal*, p.553). The increase in the number of drugs available over the counter has important ramifications for patients' use of medication and the work of both general practitioners and community pharmacists. The paper raised a number of important issues particularly relating to the work of the general practitioner. The effect of this change on the role of the community pharmacist also needs to be highlighted. As more drugs become available over the counter, the community pharmacist is being increasingly called on to act as gatekeeper to minimize the risks associated with the use of potent drugs. Some of the findings we obtained from a recent survey of community pharmacists' attitudes towards the over-the-counter availability of H_2-antagonists suggest that pharmacists are experiencing difficulties in carrying out this role.

In November 1994 a postal questionnaire survey was undertaken of a random sample of 500 pharmacists from eight family health services authorities across England. Of the 500 pharmacists, 272 (54.4%) responded. The questionnaire included a series of questions relating to the pharmacist's attitudes towards dispensing of medicines by community pharmacists without a doctor's prescription, with particular reference to H_2-antagonists which became available over the counter in April 1994.

Only 67.6% of respondents agreed to cimetidine being available over the counter to adults aged under 45 years with dyspepsia not responsive to antacids. Pharmacists were asked to report any concerns they had regarding the over-the-counter availability of H_2-antagonists. Inappropriate advertising was mentioned by 26% of 234 respondents, problems in giving advice by 14%, masking of a serious condition or a serious condition not being diagnosed by 12%, and drug interactions or side effects by 12%.

Of the 272 community pharmacists, 79.7% reported being asked for advice on H_2-antagonists at least once a week in the six months before the survey. Pharmacists were asked to describe any difficulties that they had encountered in giving this advice. A total of 164 pharmacists responded to this question. Fifty two respondents (31.7%) reported that customers resented questions or were reluctant to answer. Fifty respondents (30.5%) reported that patients see television advertisements and expect to be sold the product freely without questionning. Only 9.6% of the 272 pharmacists reported having discussed the appropriate management of customers seeking over-the-counter H_2-antagonists with their local general practitioner.

This survey indicated that many community pharmacists find the television advertising compaigns for H_2-antagonists inappropriate because they do not prepare customers for questioning by the pharmacist. As a result pharmacists experience difficulties in providing advice and have concerns about patients' use of these potent drugs. The communication between general practitioners and community pharmacists that could facilitate the appropriate provision of H_2-antagonists over the counter is not yet taking place.

A new extended role for the community pharmacist, resulting from the increased availability of over-the-counter medicines, requires a greater awareness by manufac-

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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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