asymptomatic thyroid failure showed that they had initially raised serum total cholesterol concentrations, which fell with treatment with thyroxine¹⁸; the serum cholesterol concentration was also higher when the thyroxine dose was such that the thyroid stimulating hormone concentration was within the normal range than when it was suppressed to below normal.¹⁸ These findings suggest that reducing thyroxine dosage in patients being treated for hypothyroidism may exchange an increased risk of osteoporosis and bone fracture for an increased risk of hypercholesterolaemia and coronary artery disease—hypotheses that require examining in more patients of both sexes and different ages.

What advice can be given in our present state of knowledge? We believe that it is wise to avoid prescribing higher than conventional doses of thyroxine for hypothyroidism unless suppression of thyroid stimulating hormone is important, as

in patients with a history of carcinoma of the thyroid; steps should be taken to ensure long term compliance with thyroxine and to avoid undertreatment, and that entails occasional biochemical monitoring with adjustment of the dose of thyroxine when necessary. The question that cannot yet be answered, we believe, is whether maintenance of thyroid stimulating concentrations within the normal range should be the prime objective for clinicians who prescribe thyroxine—as is increasingly the practice in North America.

J A FRANKLYN
Senior Lecturer in Medicine
M C SHEPPARD
Professor of Medicine

University of Birmingham,
Queen Elizabeth Hospital,
Birmingham B15 2TH

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Screening elderly patients

A task well suited to health visitors?

As long as 25 years ago a study on elderly patients in general practice alerted us to the many who were suffering from disorders that were not reported to or identified by their doctors.¹ Despite vast developments in practice organisation and in the care of the elderly since then, serious disorders still often go unrecognised. Some recent practice surveys found that only two fifths of patients over 75 with acute depression were receiving treatment and that less than three quarters of patients with moderate or severe dementia had had their problem identified by a general practitioner.^{2,3} Other studies have found that only two fifths of people over 80 with painful feet were receiving chiropodical treatment; that only a third of people with dental problems in sheltered housing perceived a need for treatment; and that many deaf people in residential care had wax in their ears, had not had audiological assessment, or had hearing aids that were not working.^{4,6}

Despite such evidence of unresolved need in the elderly screening programmes have achieved only modest benefits.^{7,9} These have included a reduction in the amount of time spent in hospital, a lower mortality, and tenuous evidence of improved morale and self esteem. Screening has not been shown to alter the frequency of socioeconomic, function, or medical disorders or the severity of physical disability, anxiety, or depression. Furthermore, programmes are expensive, initially requiring the equivalent of 18 hours a week of health visitor work for a practice with 4000 patients of all ages.¹⁰ Despite this and despite the fact that screened

patients are more likely to be referred to social or health agencies a screening programme in Scandinavia cut by half the cost of care for people over 75. Studies in other countries with different systems of social and health care would be required to validate this figure.

These uncertainties help explain why in the mid 1980s a postal questionnaire found that only 37% of general practitioners, 59% of geriatricians, and 33% of professors of general practice thought that screening was necessary for the adequate care of old people.¹¹ Furthermore, a cheaper and equally effective way of collecting information on old people is to record it as part of a patient initiated consultation.¹² This technique has provided contact with more than 90% of patients over 75 in some practices.¹³ It is then a simple task to arrange for the screening of the remaining 10%.

The new general practice contract requires a member of the practice to visit patients over 75 each year, and health visitors might be well suited to this task.⁸ Many studies have shown that they can identify the health and social needs of the elderly effectively and report these to general practitioners. If health visitors are to take on this aspect of the care of the elderly, however, many more will be needed.

Opinions vary as to what information should be collected as part of a screening programme, but some of the more important items are social contacts, mobility, nutrition, house safety, awareness of welfare services, availability of carers, continence, housing, awareness of benefits, hearing, personal

hygiene, foot care, vision, and dentition.¹⁴ In the elderly—as in other age groups—there is little place for screening for asymptomatic disease.¹⁵ An exception might be the identification and careful treatment of patients up to the age of 80.¹⁶

If screening programmes are to have any impact it is important that identification of problems is followed by action. General practitioners, for example, will have to have facilities for evaluating or referring patients who are identified as having visual or hearing defects and give attention to using effective instruments for differentiating dementia from depression in patients with psychiatric abnormalities.¹⁷ Moreover, screening will probably further highlight deficiencies in the local provision of geriatric, psychiatric, social work, and ancillary services. Though doubts remain about the value of recent legislation, it should at least focus attention on the needs of the elderly and stimulate debate on how best to improve their quality of care.

W J MACLENNAN

Professor of Geriatric Medicine,
City Hospital,
Edinburgh EH10 5SB

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High street eye tests

Payments are deterring the elderly and blindness will increase

The government abolished routine free eye testing from 1 April 1989, hoping to save an estimated £70 million a year or 0.35% of the annual budget for the NHS (Department of Health, personal communication). A recent survey has shown a 30% fall in the number of people going to high street optometrists for eye examinations.^{1,2} As a result an estimated 135 000 fewer patients will have been referred to general practitioners and ultimately to hospital eye services. This estimate is based on an average referral rate from optometrists to general practitioners of 4.5% (British College of Optometrists, personal communication) and uses the annual number of eye tests for 1987-8—that is, 13.48 million.¹ The reduction in the number of eye tests reported by the survey may in part be owing to the large number of people going for a test before the deadline. It is unlikely, however, that this accounts for the entire 30% decline as there was only a 7% increase in the total number of eye tests during 1988-9 over the previous year.¹ Even though there is no accurate estimate of the age of the people not being tested, the clinical impression is that elderly people have been deterred most. This is particularly worrying as the two most common causes of blindness—age related macular degeneration and glaucoma—are most prevalent in the elderly.

Age related macular degeneration accounts for 30-40% of all new registrations for blindness.^{3,4} Around one third of all of the over 75s are affected with some form of the condition.⁵ The recent introduction of laser treatment for subretinal neovascular membrane—the more devastating form of the disease—has reduced the risk of severe loss of vision,⁶ and the better the visual acuity at the time the subretinal neovascular membrane is discovered the more likely the treatment is to be successful.⁷ A recent survey at Leicester Royal Infirmary showed that half of the patients with treatable subretinal neovascular membranes were referred to the eye clinic after routine eye testing by optometrists (M Acar, personal communication).

Open angle glaucoma is the second most common cause of registrable blindness in Britain and accounts for 10-15% of all

new registrations.^{3,4} Age and family history are the two most important risk factors,⁸ and around 7% of the over 75s are affected.⁵ Again, the earlier the diagnosis is made the more effective is the treatment in slowing down or stopping the irreversible loss of visual field.⁹ Surveys have shown that opticians refer nearly three quarters of new cases of open angle glaucoma seen in the hospital eye service.¹⁰

The fundamental objection to payment for routine eye testing is that it is a breach of the principle of free access to primary health care. Under the NHS the British public has a right to screening for conditions that cause blindness—just as they do for screening for other conditions with a high morbidity or mortality such as cervical cancer, breast cancer, raised serum cholesterol concentration, and hypertension. It would be unthinkable to ask patients to pay for their blood pressure to be measured or for cervical smear testing. The recent reforms of the NHS claim to place greater emphasis on preventive medicine. It is therefore inconsistent as well as morally wrong to charge for eye tests.

In Canada in August 1987 the eye examination was removed from the Alberta health insurance scheme for people between the ages of 19 and 64. The demand for eye examinations then dropped by between 30% and 40%. On 1 July 1988, the government of Alberta restored the eye examination to their health insurance scheme—because of public pressure and the worry that blinding disorders were going undetected (British College of Optometrists, personal communication). The British government should follow suit; it should abolish the misguided policy of private fees for eye testing as soon as possible. If the Department of Health waits three to five years to see if the predicted increase in registrable blindness occurs then it will be entirely to blame for the resulting suffering and human misery.

A RALPH ROSENTHAL

Professor of Ophthalmology,
University of Leicester School of Medicine,
Leicester Royal Infirmary,
Leicester LE2 7LX