Preventing coronary heart disease

Citation for published version:

Digital Object Identifier (DOI):
10.1136/bmj.332.7544.793

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Publisher's PDF, also known as Version of record

Published In:
BMJ

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Preventing coronary heart disease

High baseline risk strategy and cost effectiveness of guidelines

Editor—Manuel et al found, contrary to Rose’s population health strategy,8 that a high baseline risk strategy was the most effective approach to coronary heart disease prevention with a statin in Canada.1 This approach is consistent with new UK guidelines.2 Using data from the nationally representative Scottish health survey 1998 we estimate that 25% of 40–74 year olds in Scotland would be eligible for primary prevention of cardiovascular disease with a statin when using this approach, with large implications for prescribing budgets. The annual cost in Scotland of treating all those eligible with 40 mg generic simvastatin would be £40m (£58m; $69.8m) and would be substantially higher with branded statins.

In the Scottish health survey 2003, 51% of men and 49% of women aged 55–64 years had high blood pressure and the figure rose to 77% for men and women aged 75 years and older. Treating these patients with a thiazide diuretic would be an effective way of reducing mortality—requires seeing everyone as a case waiting to happen.6 It requires more questions than they answer. For many patients, treatment is decided following discussion of the information provided by ran
domised controlled trials.2

We believe that cost effectiveness of guidelines should be considered before their introduction with comparison to other, potentially more cost effective, approaches to the primary prevention of cardiovascular disease. In addition to lifestyle measures including weight management and smoking cessation, these might include treatment with low dose bendrofluazide if blood pressure is found to be raised. In middle aged and elderly patients this would bring widespread population benefits, reminiscent of Rose’s approach, and is likely to be considerably more affordable and cost effective than using statins.

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Competing interests: None declared.


Patients are people, not cases

Editor—Everyone knows the importance of seeing patients as people, not cases. But the idea seems to have made a less successful transfer in terms of risk reduction.7 Lowering some factor by a small percentage in everyone—regardless of level of risk—requires seeing everyone as a case waiting to happen.8 It requires people with no reason for concern to make unnecessary adjustments to their lives in yet another area. And it requires doctors to provide more warnings about potential problems, even as the time available for the truly sick becomes more limited.

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Competing interests: None declared.

Guidance on blood pressure lowering in people older than 80 is still lacking,9 but this is no reason to deprive this group of appropriate treatment. If, for example, a fit and active 81 year old woman has a minor stroke then it seems appropriate to treat hypertension aggressively. It may be unethical for this patient to be recruited to a placebo arm of a blood pressure lowering trial and be deprived of treatment that may prevent a stroke.

It is thus simply not possible to perform randomised controlled trials in all groups of patients. Moreover, most studies actually ask more questions than they answer. For many cases, treatment is decided following discussion between patient and doctor, with the aid of the information provided by randomised controlled trials.

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Competing interests: None declared.
Estimated glomerular filtration rate needs UK consensus

Editor—Chronic kidney disease imposes a substantial health burden, affecting 5% of the population. The renal national service framework recommends using the estimated glomerular filtration rate as a more sensitive marker for chronic kidney disease than serum creatinine. The quality and outcomes framework 2006–7 requires the estimated rate to achieve six points for a chronic kidney disease register and 21 points for measuring and treating blood pressure in chronic kidney disease.1

In December 2005, 55 out of 58 UK clinical biochemistry departments contacted agreed to be interviewed about current and future reporting, five had no plans to provide additional information, and five provided a related comment. Of 38 (69%) centres not providing additional reporting, five had no plans to provide the service, 24 were planning to start within 12 months. These centres cited information technology problems, concerns over the workload of renal physicians, and confusion concerning the calculation of the rate as reasons for not introducing reporting.

Routine reporting of estimated glomerular filtration rate will become a necessity, but the current provision will be unable to support the quality and outcomes framework for chronic kidney disease. Recommendations are urgently required to standardise the approach to calculate estimated glomerular filtration rate. We believe that the Renal Association’s guidance of using the abbreviated formula for modified diet in renal disease should be adopted.2 In the longer term, the measurement of serum creatinine should be standardised.

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Competing interests: None declared.


Grieving the death of a child

Clinicians should ensure that lethal drugs are handed back

Editor—Davies’s case reports of completed suicide in recently bereaved parents are a timely reminder of one of the few areas in suicide prevention (access to lethality) where clinicians can intervene to save lives.1

Within the anger of acute grief—case 1 describes “holding on” to the decreased person beyond the usual grief experience—the child’s drugs can acquire symbolic value. The same applies to bereaved spouses who may also come to see their late partner’s tablets as hope that betrayed them. Gunnell and Lewis provide a useful conceptual framework in which to consider a person’s risk of suicide:2 a combination of predisposing plus facilitating factors minus protective factors such as social role, parenthood, help seeking behaviours during crisis, and religious belief. In the context of the sudden loss of many protective factors, where most people’s coping skills would be overwhelmed by the loss of a child, clinicians must identify access to lethal overdose.

To ask grieving parents to “hand over the medications” in the immediate aftermath of a death may seem unthinkable, but preparation for this should be part of the anticipatory grieving process.3 One solution would be for carers to sign for controlled drugs when home care is being arranged: “These drugs are for the treatment of X and must be returned to (named key worker) if X leaves this address.” For other lethal drugs—for example, insulin and cardiac drugs—written consent from carers formalises their safe retention in the event of death or other change in circumstances. As Davies points out, relatives with high suicidal intent are likely to deny this, making psychiatric assessment unreliable during the immediate aftermath of a death. There are lessons here for all hospital and community practitioners.

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Competing interests: None declared.

1 Davies DE. Parental suicide after the expected death of a child at home BMJ 2006;332:617-8. (18 March.)

Supporting health professionals who care for grieving patients may benefit all professionals who work in palliative care, and particularly in such circumstances, could be as helpful for them as it may be for their patients. Published work has recognised that patients’ suicide has an impact on psychiatrists.3 4 The qualitative study in which I am currently participating (which includes senior house officers (SHOs) in psychiatry) has identified the traumatic effect of suicide risk assessment on the SHOs when the patient subsequently attempted or committed suicide. The emotional effects of such experiences have a lasting influence on the SHOs’ practice by denting their professional confidence. The feedback from the focus group interviews that I have conducted so far includes comments on the helpful aspects of sharing such experiences and the feelings of guilt and being blamed.

In the accompanying editorial, Raphael addressed the complex issue of supporting parents whose child is dying from a terminal illness and the complexities of grief in such circumstances.5 Despite recognising the invaluable role of such support she seems to be unconvinced by the evidence for providing bereavement support for families and calls for “controlled trials” that would inform the practice. The medical profession should not need controlled trials to justify such care. Anyone who is working with grieving people will benefit from education and training and from more informal ongoing support in their workplace. All this will inform professionals about the complex psychological reaction to loss, facilitate empathy, improve the therapeutic relationship, and ultimately be helpful to the patients. Sharing such experiences in peer reviewed journals, as Davies has done, is for the benefit of all who work in health care.

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Competing interests: None declared.

1 Davies DE. Parental suicide after the expected death of a child at home. BMJ 2006;332:617-8. (18 March.)
Gluteal injections in increasingly obese population

Needle length for intramuscular injections

Enrtron—Nisbet concludes that longer needles should be considered for gluteal injections in an increasingly obese population.1

What is a longer needle? In the fifth edition of the Royal Marsden Hospital Manual of Clinical Nursing Procedures the authors suggest the following needle lengths, based on patient weight, for gluteal intramuscular injections2:

- 3.15–4.00 kg: 25 cm needle
- 4.05–8.000 kg: 5–7.5 cm needle
- > 90 kg: 10–15 cm needle.

They cite Lenz.3

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Competing interests: None declared.

Essential considerations for intramuscular injections

Enrtron—We agree with Nisbet that standard available needles may be inappropriate for gluteal intramuscular injections, especially when the incidence of obesity is increasing.1 However, his paper seems to exaggerate the problem.

Firstly, there are other preferred sites for intramuscular injections—for example, the mid-deltoid, rectus femoris, and vastus latera1ris. Simpler clinical variables such as the weight of the patient, muscle mass of the injection site, and the amount of subcutaneous fat should be assessed for choosing the correct needle length.3

In this study the sole criterion for the assessment of subcutaneous fat at gluteal region was the need to undergo the computed tomography scans of the pelvis without mentioning the indication for which this was performed. Without knowing the underlying indication it is hard to estimate how many of these patients would have required gluteal intramuscular injections.

Secondly, antiemetics and analgesics are the common drugs given intramuscularly.

However, the gluteal region is not the most practical intramuscular injection site in those aged 25–65. These patients do not lie still in bed. They either sit, stand, walk around, or prefer to be injected in other sites.

Thirdly, the gluteal region is the more often used site for intramuscular injections in children, who are held by their parents, and this age group was excluded from the study.

Fourthly, non-ambulant and elderly patients often have atrophy of the gluteal muscles, and they represent the age group of the patients who receive intramuscular injections in the gluteal region most often. This age group was excluded from the study. Surprisingly, age was not correlated with dorsogluteal depth, for reasons not mentioned in this study.

Although the study tries to address an important issue, it does not show the true picture.

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Time to make paracetamol with methionine available

Editor—What happened to the provision of “safe” paracetamol that had been campaigned for—that containing a judicious amount of methionine, which reduced the potential for overdose?1

It was released for public purchase some years ago, being designed to save lives, such as those mentioned in Tanne’s article,2 but it seems to have disappeared from the few pharmacies’ shelves that stocked it seemingly reluctantly. I say reluctantly because I and several others made an effort to check its availability for public purchase and were astounded that most pharmacists when asked for it either kept it “under the counter” or “had to chase it up and would take a couple of days to obtain it”—and in almost every case the purchaser was asked why he or she would wish to purchase it when there was some perfectly safe paracetamol without methionine for sale already.

If “safe” paracetamol is available, and so many people are dying of paracetamol poisoning who could be saved through the widespread sale of “safe” paracetamol, why does the government’s health department fail to ensure its widespread availability?

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Competing interests: None declared.


Competing interests: None declared.
Neonatal lupus erythematosus is not always benign

Before the mobile cataract independent sector treatment centres became operational, putting patients in charge of where they are treated means that all providers have to compete and this competition helps drive a patient-centred service. But offering uncoordinated choice at fixed tariffs may make service planning and the financial viability of NHS providers difficult. Unlimited choice must be expensive. Experience suggests most patients want quick access to good local facilities. Cooperation—for example in clinical networks—rather than competition is thought to drive improved clinical quality. Quality may become a hostage to market forces when the bottom line is profit.

Independent sector treatment centres: experience and spin

Editor—The clinical case described by Dennes and Nelson-Piercy in Minerva (with photographs) described a baby with neonatal cutaneous lupus. This is a benign and self-limiting condition when it is present in isolation, but it should be emphasised that patients with neonatal lupus erythematosus have a substantial risk of congenital heart block, a NFHially fatal complication. Neonatal lupus erythematosus accounts for 80% of all cases of congenital heart block. About half of the reported cases of neonatal lupus erythematosus have skin disease and half have congenital heart block, with 10% having both. Congenital heart block is permanent and requires a pacemaker in many cases. It also results from the passive transfer of maternal autoantibodies, anti-RoSSA and anti-La/SSB as in the cutaneous manifestations. Therefore, all babies with neonatal cutaneous lupus should be investigated for congenital heart block.1

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Competing interests: None declared.

1 Minerva. BMJ 2006;332:676. (16 March.)

Untreated controls are wrong when proved treatment exists

Editor—Madur in his news article reports that Johnson & Johnson had added that “the placebo controlled trial may be ethically acceptable, even if proved therapy is available … Where for compelling and scientifically sound methodological reasons its use is necessary to determine the efficacy or safety of a prophylactic, diagnostic or therapeutic method. However, “the placebo controlled design was required to satisfy the requirements of regulatory authorities” is hardly a scientifically sound reason—it is a commercial one.2

Wear your name badge well

Editor—Essex is right to point out the importance of introducing oneself in all clinical encounters.1 However, the position of the name badge may be acceptable at hip height, depending on where patients are seen, and in which specialty.

Despite my own short stature, most of my patients are around hip height, and so wearing my ID badge there is much easier. In hospital most ward rounds are conducted with the team standing, and so for patients lying or sitting in bed, badges at hip height are probably more easily read. In outpatient clinics most consultations occur while seated, and so a badge at breast height is more appropriate.

Wherever you wear your badge, the most important introduction and identification is with a clear voice.

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Competing interests: None declared.

1 Essex C. Doctor who? BMJ 2006;332:583. (11 March.)

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