Domiciliary thrombolysis by general practitioners

Citation for published version:

Link:
Link to publication record in Edinburgh Research Explorer

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

Published In:
BMJ

General rights
Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.
Domiciliary thrombolysis by general practitioners

EDITOR,—The results of the Grampian region early anastomotic trial needed to be taken within the context of the burden of myocardial infarction that is carried by a community. The general practitioners who participated clearly, and effectively, performed a good deal of selection. Recruitment of over 30% of patients during the months that means that most patients with myocardial infarction were not entered into the trial. A local estimate for Plymouth Health Authority is of 8 to 10 myocardial infarctions per general practitioner each year for a population of 200,000. Assuming a 30% death rate if medical help is not called, these general practitioners’ patients would have suffered 1537 myocardial infarctions, but only 311 were entered into the trial.

Another way of looking at this is to consider the total number of deaths ascribed to myocardial infarction among patients of the doctors in the study. Extrapolation from local data for Plymouth gives 6 deaths in the period of the study. A considerable proportion of these will have been sudden deaths; this still leaves many more deaths than those noted during the study.

Any strategy for implementing a new advance needs to take into account the whole range of presentations of conditions; for thrombolysis this means not only patients with classical myocardial infarction diagnosed by general practitioners but also, for example, people with atypical chest pain and those who do not perceive their symptoms as serious.

ALISON ROUSD Plymouth Health Authority, Plymouth PL6 5XN


John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA

EDITOR,—I am surprised that in the Grampian region early anastomotic trial no patients were diagnosed as having unstable angina, which is the most common differential diagnosis and the most difficult to make in the early stages of a myocardial infarction. It is likely that the patients in the diagnostic groups “possible myocardial infarction” and “ischaemic heart disease” in fact had unstable angina. If only definite and probable myocardial infarctions are counted the diagnostic accuracy of the general practitioners was 57% (and of the hospital doctors 66%). This may also account for the lower mortality and fewer Q wave infarctions in the domiciliary group.

As there is no evidence that thrombotic treatment is of benefit in unstable angina, it is quite likely that nearly half the patients in the study received thrombolytic treatment inappropriately and were needlessly exposed to the risks of haemorrhage. Colleagues and I found similar figures in a study of somerset, where 49% of patients with an accurately diagnosed myocardial infarction on clinical grounds (without electrocardiography in most cases) in 45% of cases (S Rule et al, unpublished work). Again this was largely because many patients with unstable angina were thought to be in the early stages of myocardial infarction.

Diagnosing myocardial infarction at the onset can be difficult, but at a minimum a good history should be obtained from an electrocardiogram properly interpreted. In the Grampian study the general practitioner was required to record an electrocardiogram but not to interpret it, which seems pointless. It is the electrocardiogram, however, that causes problems for many general practitioners as individually they will see few cases of myocardial infarction each year. The higher diagnostic accuracy in hospital may relate to this.

John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA


Domestic thrombolysis by general practitioners

EDITOR,—The results of the Grampian region early anastomotic trial needed to be taken within the context of the burden of myocardial infarction that is carried by a community. The general practitioners who participated clearly, and effectively, performed a good deal of selection. Recruitment of over 30% of patients during the months that means that most patients with myocardial infarction were not entered into the trial. A local estimate for Plymouth Health Authority is of 8 to 10 myocardial infarctions per general practitioner each year for a population of 200,000. Assuming a 30% death rate if medical help is not called, these general practitioners’ patients would have suffered 1537 myocardial infarctions, but only 311 were entered into the trial.

Another way of looking at this is to consider the total number of deaths ascribed to myocardial infarction among patients of the doctors in the study. Extrapolation from local data for Plymouth gives 6 deaths in the period of the study. A considerable proportion of these will have been sudden deaths; this still leaves many more deaths than those noted during the study.

Any strategy for implementing a new advance needs to take into account the whole range of presentations of conditions; for thrombolysis this means not only patients with classical myocardial infarction diagnosed by general practitioners but also, for example, people with atypical chest pain and those who do not perceive their symptoms as serious.

ALISON ROUSD Plymouth Health Authority, Plymouth PL6 5XN


John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA

EDITOR,—I am surprised that in the Grampian region early anastomotic trial no patients were diagnosed as having unstable angina, which is the most common differential diagnosis and the most difficult to make in the early stages of a myocardial infarction. It is likely that the patients in the diagnostic groups “possible myocardial infarction” and “ischaemic heart disease” in fact had unstable angina. If only definite and probable myocardial infarctions are counted the diagnostic accuracy of the general practitioners was 57% (and of the hospital doctors 66%). This may also account for the lower mortality and fewer Q wave infarctions in the domiciliary group.

As there is no evidence that thrombotic treatment is of benefit in unstable angina, it is quite likely that nearly half the patients in the study received thrombolytic treatment inappropriately and were needlessly exposed to the risks of haemorrhage. Colleagues and I found similar figures in a study of somerset, where 49% of patients with an accurately diagnosed myocardial infarction on clinical grounds (without electrocardiography in most cases) in 45% of cases (S Rule et al, unpublished work). Again this was largely because many patients with unstable angina were thought to be in the early stages of myocardial infarction.

Diagnosing myocardial infarction at the onset can be difficult, but at a minimum a good history should be obtained from an electrocardiogram properly interpreted. In the Grampian study the general practitioner was required to record an electrocardiogram but not to interpret it, which seems pointless. It is the electrocardiogram, however, that causes problems for many general practitioners as individually they will see few cases of myocardial infarction each year. The higher diagnostic accuracy in hospital may relate to this.

John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA

Domestic thrombolysis by general practitioners

EDITOR,—The results of the Grampian region early anastomotic trial needed to be taken within the context of the burden of myocardial infarction that is carried by a community. The general practitioners who participated clearly, and effectively, performed a good deal of selection. Recruitment of over 30% of patients during the months that means that most patients with myocardial infarction were not entered into the trial. A local estimate for Plymouth Health Authority is of 8 to 10 myocardial infarctions per general practitioner each year for a population of 200,000. Assuming a 30% death rate if medical help is not called, these general practitioners’ patients would have suffered 1537 myocardial infarctions, but only 311 were entered into the trial.

Another way of looking at this is to consider the total number of deaths ascribed to myocardial infarction among patients of the doctors in the study. Extrapolation from local data for Plymouth gives 6 deaths in the period of the study. A considerable proportion of these will have been sudden deaths; this still leaves many more deaths than those noted during the study.

Any strategy for implementing a new advance needs to take into account the whole range of presentations of conditions; for thrombolysis this means not only patients with classical myocardial infarction diagnosed by general practitioners but also, for example, people with atypical chest pain and those who do not perceive their symptoms as serious.

ALISON ROUSD Plymouth Health Authority, Plymouth PL6 5XN


John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA

EDITOR,—I am surprised that in the Grampian region early anastomotic trial no patients were diagnosed as having unstable angina, which is the most common differential diagnosis and the most difficult to make in the early stages of a myocardial infarction. It is likely that the patients in the diagnostic groups “possible myocardial infarction” and “ischaemic heart disease” in fact had unstable angina. If only definite and probable myocardial infarctions are counted the diagnostic accuracy of the general practitioners was 57% (and of the hospital doctors 66%). This may also account for the lower mortality and fewer Q wave infarctions in the domiciliary group.

As there is no evidence that thrombotic treatment is of benefit in unstable angina, it is quite likely that nearly half the patients in the study received thrombolytic treatment inappropriately and were needlessly exposed to the risks of haemorrhage. Colleagues and I found similar figures in a study of somerset, where 49% of patients with an accurately diagnosed myocardial infarction on clinical grounds (without electrocardiography in most cases) in 45% of cases (S Rule et al, unpublished work). Again this was largely because many patients with unstable angina were thought to be in the early stages of myocardial infarction.

Diagnosing myocardial infarction at the onset can be difficult, but at a minimum a good history should be obtained from an electrocardiogram properly interpreted. In the Grampian study the general practitioner was required to record an electrocardiogram but not to interpret it, which seems pointless. It is the electrocardiogram, however, that causes problems for many general practitioners as individually they will see few cases of myocardial infarction each year. The higher diagnostic accuracy in hospital may relate to this.

John E Sanders
Taunton and Somerset Hospital, Taunton TA1 5DA
study in the absence of electrocardiographic criteria is not necessarily generally applicable. Unless thrombolysis is restricted to those presenting early and with classic symptoms of infarction, the proportion of alternative diagnoses (2-3%) is unlikely to be substantiated. For example, phase 1 of the myocardial infarction triage and intervention project found only one in six confirmed infarctions among those evaluated before admission to hospital.

The statement that “even in an urban area there would be a temporal advantage in the general practitioner giving thrombolytic therapy in the home” is untested and cannot be extrapolated from the present study. A 999 call and shortening of the delays in hospital would have reduced the difference between home and hospital treatment substantially. We have shown that in an urban area the time of administration of thrombolytic treatment after the onset of symptoms was reduced to a median of 150 minutes by the introduction of a “fast track” system.

Until these issues are resolved it may be premature to advise widespread implementation of pre-hospital thrombolysis without electrocardiographic confirmation.

A.C.H. FELL
K.A. FOX
Cardiovascular Research Unit,
Edinburgh University,
Edinburgh EH3 9XP


Entron.—Much publicity has been, and will be, given to the finding of the Grampian region early anistreplase trial that patients who received thrombolytic treatment (anistreplase) at home had 49% fewer deaths than those who received it in hospital.1 Unfortunately, the trial was really too small to estimate reliably any reduction in mortality, and so significance could be achieved only if (because of either chance or bias) an impossibly large treatment difference was observed. In our earlier Bayesian analysis,2 a useful interpretation by setting a surprising finding in the context of more cautious prior belief.

First one expresses prior belief about the proportionate improvement in mortality due to thrombolysis at home. Given the known benefits of early thrombolysis3 and the average two hours saved in time to treatment, it could be argued that a 15-20% reduction in mortality is highly plausible, while the extremes of no benefit and a 40% reduction are both unlikely. The figure (a) shows such a distribution of prior belief. This prior is compatible with the results of the European myocardial infarction project, in which the same drug was given to over 5000 patients.

In the Grampian region early anistreplase trial 23 of the 148 patients who received home thrombolysis died within three months compared with 13 of the 163 who received hospital thrombolysis. This is displayed in the figure (b). The observed 49% reduction is the mode of this distribution, and the 2% tail area beyond no effect indicates p=0.02 one sided. The widely spread distribution illustrates the inevitable uncertainty with only 36 deaths in total.

Using Bayes’s theorem, we have combined the prior belief and likelihood to produce a posterior belief distribution (figure c). This quantifies how much opinion on the efficacy of home thrombolysis should be affected by the limited amount of highly positive data in the Grampian region early anistreplase trial. The peak of the posterior distribution is a 25% reduction in mortality, with a 95% confidence interval from no effect to a 43% reduction. Thus belief is shifted in a positive direction, but not by much, and, specifically, a halving of mortality remains implausible.

(b) Likelihood based on 23/148 + 13/163 deaths

Bayesian analysis of data from Grampian region early anistreplase trial

Perhaps the Grampian region early anistreplase trial was just lucky. For instance, based on the figure (a) a difference of 23 versus 13 deaths or more should occur with probability 0.1. We are also concerned, however, about the emphasis on three month mortality (not a predefined end point), the lack of independent monitoring of data, the randomisation method, and the early stopping of the trial.

Overall, such an important therapeutic issue requires larger scale trials which can quantify the treatment effect precisely. Here we seem faced with publication bias. A small positive trial (the Grampian region early anistreplase trial) gets emphasised while another larger trial emphasised precisely. Here a Bayesian method, (a) a a

(c) Prior distribution

% Change in risk in using home treatment

On site medical services at major incidents

EDITOR.—Matthew W Cooke3 and D G Nancekievill emphasise the need for better organisation and training for hospital staff in providing on site medical services when a major incident occurs. A hospital coping with a deluge of casualties from a major incident might be overstretched in providing one or more appropriate teams as well as a doctor or senior enough to be the medical incident officer (the Department of Health has abandoned the term site medical officer). Cooke highlights the paucity of training in this role. Wide ranging discussions have taken place in London with representatives of the London accident and emergency consultants’ group, the London Ambulance Service, the British Association for Immediate Care, and health emergency planning officers from each Thames regional health authority with the aim of creating a cadre of 40-50 trained and accredited medical incident officers. This scheme relieves the main receiving hospital of the onerous duty of providing all the resources required at the site. The scheme has been approved by all participants, but, in view of its variation from guidance from the Department of Health, individual units will retain the option of making their own arrangements.

Two established training courses for doctors are available nationally. A one day course is run by the British Association for Immediate Care each year in Cambridge, and a three day course on the medical management of major incidents is run jointly by the Royal Postgraduate Medical School and the British Association for Immediate Care at Hammersmith Hospital. This course is multi-disciplinary and includes lectures, seminars, and practical training for NHS staff called on to work in prehospital incident officers or with mobile medical and nursing teams. In the two years that the course has been run, 102 people have been trained. The participants undertake an assessment at the end of the course, a major function of which is to allow the course organisers to assess the effectiveness of the training offered in key principles.

Though advanced trauma life support courses offer excellent training in clinical aspects, specific training is required for all prehospital care, including elements of safety and working with the emergency services.

ROBERT A COCKS
Royal Postgraduate Medical School,
Hammersmith Hospital,
London W12 0HS

1 Cooke MW. Arrangements for on scene medical care at major incidents. BMJ 1992;305:748. (26 September.)
2 Nancekievill DG. On site medical services at major incidents. BMJ 1992;305:736-7. (26 September.)

EDITOR.—We agree with D G Nancekievill that both medical incident officers and site medical teams for major incidents need to be trained and to be familiar with the procedures of the other emergency services. We agree also that there is a problem. The British Association for Immediate Care has been training doctors in this work for many years.

The association produced its first guide to managing major incidents in 1985,4 and the skills of doctors trained by the association were recognised in the report on the railway accident at Clapham.5 The association’s inter-service and disaster liaison committee has been working with the ambulance, police, and fire services and the armed forces, coastguard, mountain rescue services, and, latterly, the Home Office adviser on civil emergencies on all aspects of managing major incidents. The association has provided guidelines on the medical aspects of managing major incidents.