Preventing coronary heart disease

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Letters

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,1 that a high baseline risk strategy was the most effective approach to coronary heart disease prevention with a statin in Canada.2 This approach is consistent with new UK guidelines.3 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 potential candidate for cholesterol lowering 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 large trial.8 However, 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 patients, 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.

3 Wright JM, Lee CH, Chambers GK. Systematic review of antihypertensive therapies: Does the evidence assist in choosing a first-line drug? CMAJ 1999;161:25-32

Blood pressure lowering in elderly patients with stroke

Editor—Mant et al say that the results of PROGRESS are not applicable to the stroke population in the community.7 One reason cited is that patients in the community were 12 years older than those recruited to PROGRESS. The authors explain the dangers of aggressive blood pressure lowering for people older than 80 and recommend further urgent studies.

Guidance on blood pressure lowering in people older than 80 is still lacking,8 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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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.

Lowering some factor by a small percentage in everyone—regardless of level of risk—requires seeing everyone as a disease waiting to happen.1 2 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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Letters
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 proposed reporting of estimated glomerular filtration rate and methods for estimated glomerular filtration rate and creatinine. Seventeen (31%) were providing some information rate for ethnicity, nine provided no correction, the estimated glomerular filtration rate needs UK consensus.

The estimated glomerular filtration rate was calculated by abbreviated (four variable) modified diet in renal disease (MDRD) equation (15 centres),2 the MDRD equation (one centre),3 and the Cockcroft and Gault equation (one centre).4 Serum creatinine was measured by the kinetic Jaffe method in all these laboratories by using different analytical platforms. One centre routinely corrected the estimated glomerular filtration rate for ethnicity, nine provided no correction, two provided the correction if ethnicity was stated, and five provided a related comment.

Of 38 (68%) centres not providing 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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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.

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 a 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:1 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 grief process.2 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 return 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.

Supporting health professionals who care for grieving patients may benefit all

Editor—Davies outlined two cases of palliative care in the community for children where mothers committed suicide after the death of their children by using the remaining opioid drugs.3 Supporting healthcare 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.4,5 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.1 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: BMJ 2006;332:647-8. (18 March.)


3 Raphael B. Grieving the death of a child. BMJ 2006;332:620-1. (18 March.)
Gluteal injections in increasingly obese population

Needle length for intramuscular injections

Enntror—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 injections:2

- 31.5-40.00 kg: 25 cm needle
- 40.5-90.00 kg: 5-7.5 cm needle
- > 90 kg: 10-15 cm needle.

They cite Lenz.3

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Competing interests: None declared.

1 Nisbet AC. Intramuscular gluteal injections in the increasingly obese population: retrospective study. BMJ 2006;332:675-8. (18 March)

Essential considerations for intramuscular injections

Enntror—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 lateralis.3 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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Competing interests: None declared.

1 Nisbet AC. Intramuscular gluteal injections in the increasingly obese population: retrospective study. BMJ 2006;332:675-8. (18 March)

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.

1 Tanne J. Paracetamol causes most liver failure in UK and US. BMJ 2006;332:628-a. (18 March)

Googling your treatment for analgesia in labour

Editor—Giustini described how Google has become the most powerful influence in searching the internet.1 In a recent observational study on the labour ward at University College Hospital, London, we found that 53% of pregnant women used the internet as a source of information about labour pain relief. This is a change from the results of a previous study conducted five years ago in Liverpool, in which the internet had been used by less than 3% of pregnant women.2

We wondered what expectant mothers would find on “Googling your treatment.”3 When searching for health information, patients are known to look only at the first few links after their search, and very few of them later remember from which websites they retrieved information or by whom the sites were created.4

We feared that the one third of pregnant women using the internet were accessing information that was inaccurate and potentially misleading their labour analgesia choices. We performed a search at the main Google UK site (not Google Scholar), using “labour pain relief” as our criterion. The search provided “about 3 300 000 results,” of which we examined the top 10.

Six were written by or had direct contribution from a doctor, two were articles in peer reviewed journals, one was by a midwife, and one was a commercial website selling TENS machines. All of the non-commercial websites were informative and of high quality, providing balanced information. We considered the information to be anaesthetist friendly, and we were reassured by our investigation.

In our internet savvy society, we suggest that healthcare providers google their particular topic to discover what kind of information their patients are finding. A cautionary note: as search engines continuously update the pages to which they link and their ranking, we advise regularly repeating the search to keep up with the dynamic flux of the internet.

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Competing interests: None declared.

3 Eyenfeld G, Kohler C. How do consumers search for and appraise health information on the world wide web? Qualitative study using focus groups, usability tests, and in-depth interviews. BMJ 2002;324:575-7. (9 March)
Neonatal lupus erythematosus is not always benign

Editor—The clinical case described by Dennes and Nelson-Piercy in Minerva (with photography) describes a baby with neonatal cutaneous lupus.1 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 non-fatal complication. Neonatal lupus erythematosus accounts for 80% of all cases of congenital heart block.2 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.3

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Independent sector treatment centres: experience and spin

Editor—Independent sector treatment centres were recently praised by the Department of Health.1 Ophthalmologists have highlighted the problems experienced and predicted for cataract centres.2,3 The government argument that independent centres provide value for money in elective surgery is unconvincing because it considers “spot purchasing” costs of “waiting list initiatives” rather than the costs of planned NHS care.4 Procurement may drain the NHS of funds that might otherwise be invested in comprehensive care in NHS hospitals.

Clinical quality in some ophthalmology schemes has also been a concern.5 Furthermore, cataract waiting times had come down before the mobile cataract independent sector treatment centres became operational.6 “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.

To date, no training in ophthalmology has been provided in independent sector treatment centres. No innovation has emerged from those for cataracts—rather, overseas teams have had to improve their standards to reach NHS ophthalmology standards.7,8 The much trumpeted innovation of mobility is of uncertain benefit to patients who often have to travel further to reach these mobile units than to receive conventional care locally. High volume NHS cataract surgery operating lists can, and often do, achieve the same numbers of patients treated per session as in the mobile units. However, NHS units also provide holistic and comprehensive ophthalmology care to all comers, and clinical training.9 Reform and “self improvement” of NHS services is also urged.10 However, most of the process redesign now claimed existed in initiatives such as the “Action on Cataract” schemes.11 These self improvements are testimony to both the innovative skills of NHS ophthalmologists and the close collaboration between hospital and primary care. These professional leadership qualities may be lost in the fragmentation of the current procurement of the independent sector centres.

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Untreated controls are wrong when proved treatment exists

Editor—Madur in his news article reports that Johnson & Johnson had added that “the placebo controlled design was required to satisfy the requirements of regulatory authorities to allow their evaluation of the risk/benefit of the drug” in compliance with good clinical practice and the Declaration of Helsinki.1 Article 29 of the Declaration of Helsinki states that the benefits, risks, burdens, and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic, or therapeutic method exists.

The World Medical Association later added a footnote, saying that “a 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.”2 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.

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Wear your name badge well

Editor—Essex is right to point out the importance of introducing oneself in all clinical encounters. 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 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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Letters

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