Sentiweb remains efficient tool for nationwide surveillance of disease

FLAHAULT, Antoine, et al.

Reference


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Do neuroleptic drugs hasten cognitive decline in dementia?

Carriers of apolipoprotein E ε4 allele seem particularly susceptible to their effects

Editor—We agree with Rupert McShane and colleagues that there is evidence for an association between treatment with neuroleptic drugs and a more rapid cognitive decline in dementia, but we would also point out an additional association with the apolipoprotein E ε4 allele.1 We followed up 135 subjects from the Camberwell dementia case register.2 The patients all fulfilled the criteria for Alzheimer’s disease and Related Disorders Association criteria for Alzheimer’s disease and had an initial score on the mini-mental state examination of ≥5 points (to avoid floor effects) over one year. Throughout this period 23 took neuroleptics and 112 had no evidence of use of neuroleptics. Neither age; sex; initial score on the mini-mental state examination; nor previous evidence of hallucinations, persecutory idea- tion, aggression, or sleep disturbance had any significant relation with the rate of cognitive decline over this period. The subjects who took neuroleptics, however, had a greater rate of cognitive decline than those who did not (mean (SE) 6.2 (1.0) v 2.1 (0.4) points a year, P < 0.0001).

One hundred of these subjects consented to apolipoprotein E genotyping. The presence of the apolipoprotein E ε4 gene alone was not associated with a greater rate of cognitive decline (2.7 (0.6) v 2.1 (0.7) points a year, P = 0.50), which was in keeping with earlier findings.3 A comparison of rates of cognitive decline by neuroleptic use according to the presence or absence of the apolipoprotein E ε4 allele showed that neuroleptic use was not associated with a greater rate of decline in the 41 subjects not carrying the allele (4.2 (2.4) v 1.8 (0.6) points a year, P = 0.2) but was associated with a markedly increased rate of decline in the 59 subjects carrying the allele (7.9 (1.2) v 1.9 (0.5) points a year, P < 0.0001). Thus in this study neuroleptics were associated with a greater rate of cognitive decline in subjects with Alzheimer’s disease, and carriers of the apolipoprotein E ε4 allele seemed particularly susceptible to their effects.

An interaction of the apolipoprotein E ε4 allele with other risk factors in Alzheimer’s disease has been reported elsewhere,4 and these data thus further support the role of the allele in modifying individual susceptibility to environmental and now possibly iatrogenic risk factors.

C Holmes Lecturer in old age psychiatry,
O Fortenza Visiting research assistant,
J Powell Senior lecturer in neuroscience,
S Lovestone Senior lecturer in old age psychiatry and neuroscience,
Institute of Psychiatry, Departments of Old Age Psychiatry and Neuroscience,
London SE5 8AF


Trials must determine which neuroleptics are best in dementia

Editor—Rupert McShane and colleagues conclude that neuroleptic drugs may worsen already poor cognitive function.1 If confirmed in controlled trials, this is indeed an important finding. In their study the neuroleptics used were haloperidol, chlorpromazine, promazine, or thioridazine. The authors mention the possibility that the anticholinergic effects of these neuroleptics may have been responsible for the observed cognitive decline. They seem to have missed the opportunity to explore this possibility by comparing haloperidol (a butyrophenone compound with few anticholinergic effects) with the three other neuroleptics, all of which are phenothiazines with important anticholinergic effects. The importance of the anticholinergic effects of these drugs cannot be dismissed.

The rationale for using anticholinesterase inhibitors to treat dementia is based on the cholinergic hypothesis of dementia.2 The diminution in presynaptic cholinergic neurones and receptors has been correlated with severity of dementia in Alzheimer’s disease. Furthermore, anticholinergic drugs are known to impair learning in both animals and normal human subjects.3 Anti- cholinesterase inhibitors are now broadly accepted as being of small but important benefit in improving cognitive function or slowing cognitive decline in early dementia.

It is reasonable to suggest that compounds with marked central anticholinergic effects may be associated with a worsening of cognitive function and therefore that the type of neuroleptics used may be of major importance. As neuroleptics (and car- bamazepine) are the only compounds that have been shown to be of significant benefit, we use more selective antipsychotics (sulpiride, haloperidol, risperidone) preferentially to treat psychotic symptoms in dementia.

Psychotic symptoms can present major management problems for carers, and in the absence of suitable alternatives the use of neuroleptics is unlikely to be completely replaced—even if there were sufficiently trained staff to implement psychological or behavioural interventions.

Trials are needed to clarify which, if any, of the various classes of neuroleptics and new antipsychotic preparations are best suited for use in dementia.

Robert Tobiansky Consultant old age psychiatrist,
Colindale Hospital, London NW9 3HG
Martin Blanchard Consultant old age psychiatrist,
Royal Free Hospital, London NW3 2QG

Authors have not proved their argument

Editor—Rupert McShane and colleagues report finding worsened cognitive functioning in a group who had been prescribed neuroleptic drugs.1 In concentrating solely on possible changes in cognitive functioning, they are addressing only a part of the question that needs to be asked.

When any drug treatment is prescribed, the benefits have to outweigh problems due to side effects for its use to be worthwhile. Worsening cognitive functioning could be such a side effect. This needs consideration, and the following questions need to be asked. Firstly, what was the indication for the prescription of neuroleptics? What was the drug of choice and the dose regimen? Secondly, did the neuroleptics achieve what was required? Was the level of distress of the patient—due to agitation, hallucinations, or delusions—reduced? Thirdly, did the use of neuroleptics mean that the patient could be maintained at home when in other circumstances he or she might require permanent care in some type of institution?

McShane and colleagues dismiss the possibility that the neuroleptics seemed to cause more rapid decline “because patients who were already on a steeper trajectory of cognitive decline were more likely to be prescribed them” and on the grounds that the point when patients started treatment with neuroleptics coincided with an increase in their rate of cognitive decline. This seems to be a circular argument.

In their key messages the authors state that neuroleptics “may cause more rapid decline in cognitive function” and later that their study “does not prove a causal relation.” This is contradictory. Their study was not designed to show cause and effect, and the best that can be said from the study is that there is an association.

These data seem to be rather old, as the study was conducted “before substituted benzamides such as sulphpride were largely used in Britain for treating elderly people.” This raises doubts about the relevance of the findings, as practice over the past 10 years has changed considerably and, recently, newer atypical neuroleptics (such as risperidone and olanzapine) have been used with increasing frequency. We are concerned that this paper may lead to a reluctance or refusal to prescribe such drugs despite their very real benefits in appropriate cases. We agree that care must be exercised in decisions on whom, what, how much, and how long to prescribe.

P W Bentham
S E Goh
E M Gregg
P Madeley
A R A Patel
A P Taylor
Consultants in old age psychiatry
Mental Health Service for Older Adults, Queen Elizabeth Psychiatric Hospital, Birmingham B15 2QZ

Authors’ reply

Editor—We are pleased that C Holmes and colleagues have replicated our finding that patients with dementia who take neuroleptics decline more rapidly than those who do not. Their finding that the association is confined to those with the apolipoprotein E ε4 is important and deserves wide attention. It may prompt the suggestion that the apolipoprotein E status of patients with dementia should be established before they take neuroleptics. A detailed clinical cost-benefit analysis of neuroleptics in dementia and replication of the finding are both, however, essential before this should be further considered.

We support Robert Tobiansky and Martin Blanchard in their call for controlled trials of different classes of antipsychotics and agree with P W Bentham and colleagues that our findings may not apply to all classes of antipsychotic drugs. Unfortunately, we are unable to examine whether neuroleptics with anticholinergic side effects had a greater effect on cognitive function than those without because insufficient subjects were taking drugs without such side effects. We disagree with Bentham and colleagues’ implication that traditional neuroleptics are so rarely prescribed as to make our results irrelevant to current practice, but we fully support their view that the benefits as well as the risks of neuroleptics need to be taken into account in decisions on whether to prescribe them.

We disagree that our interpretation of the data is circular. The association we reported between more rapid decline and use of neuroleptics has three possible interpretations. Firstly, there may be a causal link. Secondly, it is theoretically possible that neuroleptics were prescribed not, as one might expect, for behavioural problems (which we controlled for in the regression analysis) but because the patients were declining faster. Our finding that the point of onset of more rapid decline coincided with the start of treatment makes this explanation improbable. A third possibility remains that neuroleptics were prescribed for reasons that were associated with more rapid decline but were not included in the regression analysis. We ruled out one such possibility, Lewy body disease, but there may have been others.

We did indeed state that neuroleptics “may cause more rapid decline in cognitive function” and also that our study “does not prove a causal relation.” This is caution, not contradiction.

Rupert McShane
Clinical lecturer
Tony Hope
Reader
Robin Jacoby
Clinical reader
Janet Keene
Research officer
Section of Old Age Psychiatry, Warrmeford Hospital, Oxford OX5 7JX
Christopher Fairburn
Professor
University Department of Old Age Psychiatry, Warrmeford Hospital

Intake of micronutrients in Britain’s poorest fifth has declined

Editor—The Rome Declaration on World Food Security, adopted on 13 November 1996, affirms the “right of everyone to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger.” Hunger and inadequate food intakes are not confined to developing countries; poor people in Britain have also experienced a decline in food security over the past decade. The report Low Income, Food, Nutrition and Health: Strategies for Improvement, recently published by the Department of Health, documents the evidence.

Those on the lowest incomes, whether from means tested benefits such as income support or from low or insecure wages, have markedly low micronutrient intakes. Since 1980, household intake of antioxidants among the poorest fifth of families in the United Kingdom has declined dramatically (β carotene by 47% and vitamin C by 23%). The gap in fruit consumption between the rich and poor sections of the population is widening, reversing a trend from 1899. Patients regularly go hungry to pay domestic bills or ensure children are fed; micronutrient intakes are so low as to jeopardise health in households where income support is reduced to recoup fuel, rent, or water debts (20% of claimants) world food summit highlighted poverty as the major cause of food insecurity: this is true for Britain too. One in 20 teenagers experiences homelessness and is reliant on day centres or “soup runs” for basic needs. One in four households in the United Kingdom lives on less than £115 a week. Low income households lack access to an affordable nutritious diet: they have insufficient money and often live on estates devoid of shops. The rise in supermarkets at the expense of markets and small shops is well documented: Kwik Save, a major discount store serving poor communities, last year announced closure of 10% of its stores to survive in the highly competitive food market.

The Department of Health report called for a coordinated national policy for food and low income, and better support for local initiatives. The latter are easy targets for cuts in all sectors; the food needs of poor people are seldom on the political agenda. The British government accepted the high minded objectives in the Rome declaration: “Governments will implement cost-effective public works programmes for the unemployed, [and] develop social welfare and nutrition safety nets to meet the needs of the food insecure.” There is still a long way to go.

Suizi Leather
Consultant
National Food Alliance, London EC2A 2BH
Elizabeth Dowler
Lecturer
Human Nutrition Unit, London School of Hygiene and Tropical Medicine, London WC1H 0BT

1 Rome declaration on world food security and world food summit plan of action. World Food Summit. Rome 13-17th November 1996
More women drink at hazardous levels in England than Italy

En体现在—Marco Piccinelli and colleagues describe 482 patients who presented to 10 primary care clinics in Italy and completed the alcohol use disorders identification test. In England we are conducting a randomised controlled trial of methods to encourage the uptake and use by general practitioners of a brief alcohol intervention programme incorporating the alcohol use disorders identification test as its screening questionnaire. We have compared characteristics and drinking behaviour of primary care patients in Italy and England.

In our study 128 general practitioners from northern England (one per practice) agreed to implement a brief intervention programme. They were asked to screen the alcohol consumption of all patients over 16 who attended their surgery and to give advice plus a booklet to hazardous drinkers. Data have been analysed for 31 general practitioners (data from 474 questionnaires completed by patients).

Figure 1 shows characteristics of the patients presenting in Italy and England. Although there was no age limit in England, the two samples were relatively comparable. Piccinelli and colleagues diagnosed hazardous drinkers on the basis of quantity-frequency criteria and harmful drinkers on the basis of criteria in the 10th revision of the International Classification of Diseases. We defined hazardous drinkers as those scoring 8-12 on the questionnaire for the alcohol use disorders identification test and harmful drinkers as those scoring 13 or more. In Italy 62 (12.9%) of the sample were hazardous drinkers, of whom 11 (17.7%) were women; and 15 (3.1%) were harmful drinkers, of whom 2 (13.3%) were women. In England sex was identified for 4716 (99.4%) of the patients. Of this sample, 713 (15.1%) were hazardous drinkers, of whom 304 (42.6%) were women; and 191 (4.1%) were harmful drinkers, of whom 70 (36.6%) were women.

The proportion of women in the categories of hazardous and harmful drinking was much higher in England than Italy. The different ways in which hazardous and harmful consumptions were defined between the studies may have affected these findings but are unlikely to have accounted for such large discrepancies. The greater number of English women drinking excessively may reflect different cultural acceptance of drinking by women in Italy and in England. In England the proportion of women drinking hazardous-ously has increased, from 9% in 1984 to 13% in 1994, while men's drinking has remained stable over this time. Our findings suggest that excess drinking by English women is an important issue that should be specifically addressed if we are to meet the targets for alcohol in the Health of the Nation. Given that a high proportion of women present to primary care, this seems to be the ideal setting for such work.

Eileen F S Kaner Research associate Catherine A Haighton Research associate Brian R McAvoy Head of school Department of Primary Health Care, School of Health Sciences, Medical School, Newcastle upon Tyne NE2 4HH Nick Heather Consultant clinical psychologist Elish Ghilvary Consultant psychiatrist Centre for Alcohol and Drug Studies, Newcastle upon Tyne NE1 6UR


Giving children adults’ rights runs risk of making them adults before their time

Editor—Gerison Lansdown and colleagues’ editorial on implementing the UN Convention on the Rights of the Child is remarkable for failing to mention the word “parent” even once. If national and international government policy is ever to address the needs of today’s children it must recognise that one of the primary rights of every child should be adequate parenting. Without this any child is at an immediate and probably permanent disadvantage. Thus, surely, any policy involving children runs risk of making them adults before their time.

Prophylaxis should be considered even for trivial animal bites

Editor—In their report of a case of purpura fulminans caused by infection with Capnocytophaga canimorsus after a dog bite, D J Mellor and colleagues suggested that Pasteurella spp, Staphylococcus aureus, and anaerobic organisms were susceptible to erythromycin and tetracycline. Unfortunately, as few as 20% of Pasteurella multocida in wounds may be sensitive to erythro- mycin, and P multocida meningitis has been reported after failure of treatment with erythromycin.

In cat bites, in which the risk of pasturella and anaerobic infection is dramatically increased, neither tetracycline nor erythromycin provides sufficient cover. Bites from other domestic animals including pigs and horses are not uncommon in our largely rural population, and we have also encountered bites from adders, monkeys, and even a cockatoo. For prophylaxis against infections from large pig bite wounds I advocate adding ciprofloxacin to co-amoxiclav so that any Gram negative organisms such as Flavobacterium species will be covered. Empirical ciprofloxacin would provide cover against species of Vibrio, Aeromonas, and Pseudo- monas and should be considered after bites from exotic pets such as reptiles and marine animals.

As 32% of all cases of C canimorsus septi- caemia to date have occurred in asplenic patients, we routinely tell such patients to seek urgent medical attention and antibiotic prophylaxis for even the most trivial animal bites.

Marina S Morgan Consultant medical microbiologist Pathology Laboratory, Heavitree, Exeter EX2 5AD

are rightly concerned about the question of reasonable chastisement but offer no guidance on any workable alternatives in setting limits to behaviour. By treating children as adults in the definition of their rights we run a risk of making them adults before their time. Perhaps, then, we should not be surprised when they turn up in court facing charges usually associated only with adults, such as murder.

Michael Croft  
General practitioner  
15 York Road, St Albans AL1 4PL


Hypoplastic left heart syndrome

More families now have a choice

Editor—We support the assertion by O'Kelly and Bove in their editorial on hypoplastic left heart syndrome.1 Over the past four years our unit has performed over 100 Norwood procedures for this condition, of which 37 were in 1996. The referral pattern suggests that more families are being given the choice in the United Kingdom. We share O'Kelly and Bove's positive encouragement stance for these patients, backed by a dedicated team rather than offering terminal care, backed by a dedicated team rather than offering terminal care, backed by a dedicated team rather than offering terminal care. Transplantation is not an alternative practical option at present.2

Though most patients present soon after birth, an increasing number are diagnosed antenatally. Diagnosis in fetal life gives the opportunity for choice, counselling as well as planned delivery with service providers alerted. For some patients the course after the first stage can be slow and complicated with immense pressure on the parents and the rest of the family. Family support from the institutions carrying out this procedure is essential, but other parents can also provide valuable advice and help. To achieve this a national parent group has been set up, known as “Left Heart Matters,” in order to support fellow parents with individual requests but also to organise an annual get together; an information booklet for parents has also recently been published by this group. Information on Left Heart Matters and the booklet can be obtained from: Suzie Hutchinson, Cardiac Liaison Sister, Birmingham Children’s Hospital, Ladywood Middleway, Birmingham B16 8ET.

W J Brawn  Consultant cardiac surgeon
J D O’Gorman  Consultant cardiologist
S Hutchinson  Cardiac liaison sister
B Sethia  Consultant cardiac surgeon
E D Silove  Consultant paediatric cardiologist
O Stumper  Consultant paediatric cardiologist
J G C Wright  Consultant paediatric cardiologist

Birmingham Children’s Hospital NHS Trust, Ladywood, Birmingham B16 8ET

1 O'Kelly SW, Bove EL. Hypoplastic left heart syndrome: terminal care is not the only option. BMJ 1997;314:87-8.

Quality of life is also important

Editor—Sean O’Kelly and Edward Bove suggest that we should adopt more active management of babies with hypoplastic left heart syndrome in Britain.1 Bill Brawn’s results in Birmingham over the past four years are commendable but he expresses caution about the long term outcome for these babies.2

Surgeons and the postoperative period are extremely difficult. Survival is important but so is quality of life. Very little has been published on neurodevelopmental outcome. One recent small follow up study from New York, however, reported that of 11 survivors, four had moderate and three severe to profound mental retardation when assessed at 11-67 months of age.3 Delayed motor development was seen in five children and cerebral palsy in two.

 Palliative surgery is increasingly available for hypoplastic left heart syndrome in Britain, though surgery is still less common than in the United States. The alternative active management option of transplantation will remain constrained by a severe shortage of donor hearts.

I urge that children who survive the three stage Norwood palliation of hypoplastic left heart syndrome should have detailed neurodevelopmental follow up to ensure that they receive the necessary input for any developmental problems which become apparent and that units undertaking such surgery should carefully audit and publish quality of life outcome rather than just survival. If the neurodevelopmental outcomes are as poor in Britain as they are in the United States my view would be that parents should be very carefully counselled about treatment options, which should include offering terminal care only.

Robert Thwaites  Consultant paediatrician  
Paediatric Department, St Mary’s Hospital, Portsmouth PO3 6AD

National system for monitoring all drug use in pregnancy already exists

Editor—Discussion of the postmarketing surveillance of a new epileptic drug caused John J Craig and James I Morrow to report their establishment of a register of epileptic patients who become pregnant.1 This is a worthy venture, but doctors may become confused about where they should send communications on drug outcomes in pregnancy.

The National Teratology Information Service is a unit in Newcastle upon Tyne, funded by the Department of Health; it both provides information on drug use in pregnancy and monitors the outcome of pregnancy for a range of drugs, including anticonvulsants. The centre is also part of a European network of teratology information services, which enables the pooling of data from across the European Community and hence has the potential to produce a more comprehensive comparison of risk.2 In addition, obstetricians in Scotland have their own initiative in collaboration with us.

In these circumstances, therefore, we wish to remind readers of the national system, which applies to all drug use and chemical use in pregnancy of which we are
Hormone replacement therapy

Damage is done by pressure groups that distort the evidence

Editor—Elizabeth H Price and colleagues present a biased analysis in their letter stating that women need to be warned about the dangers of hormone replacement therapy. They confine the epidemiology of oral contraceptive use and that of hormone replacement therapy, which is less advanced. Oral contraceptive use and that of hormone replacement therapy are available, one should be cautious about suggesting the use of hormone replacement therapy for women without symptoms of osteoporosis.5

At the very least, the women should be informed about the background of both the risks and benefits.

S Lange Research fellow Department of Medical Informatics, Biometry, and Epidemiology, Ruhr-University Bochum, 44780 Bochum, Germany

Table 1 Results of studies regarding hormone replacement therapy (HRT) and the prevention of hip fractures (ever users v non-users)

<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Odds ratio/relative risk (95% CI)</th>
<th>Reference</th>
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<tr>
<td>Hullinson et al, 1979</td>
<td>CC</td>
<td>0.22 (0.06 to 0.81)*</td>
<td>Lancer 1979;9:705-9</td>
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<tr>
<td>Weiss et al, 1980</td>
<td>CC</td>
<td>0.48 (0.36 to 0.63)*</td>
<td>N Engl J Med 1980;303:1195-8</td>
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<tr>
<td>Johnson and Speight, 1981</td>
<td>CC</td>
<td>0.72 (0.48 to 1.09)</td>
<td>Am J Public Health 1981;71:138-44</td>
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<tr>
<td>Paganini-Hill et al, 1981</td>
<td>CC</td>
<td>0.72 (0.42 to 1.22)*</td>
<td>Ann Intern Med 1981;95:25-28</td>
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<td>Kreiger et al, 1982</td>
<td>CC</td>
<td>0.48 (0.27 to 0.86)</td>
<td>Am J Epidemiol 1982;116:141-8</td>
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<tr>
<td>Kanis et al, 1992</td>
<td>CC</td>
<td>0.55 (0.36 to 0.85)</td>
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<tr>
<td>Griffo et al, 1994</td>
<td>CC</td>
<td>0.49 (0.19 to 1.25)*</td>
<td>N Engl J Med 1994;330:1555-9</td>
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<tr>
<td>Kist et al, 1997</td>
<td>RC</td>
<td>0.44 (0.22 to 0.86)</td>
<td>N Engl J Med 1997;337:1169-84</td>
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<tr>
<td>Looker et al, 1993</td>
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<td>Osteopetro Int 1993;1-77-4</td>
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<td>Maxim et al, 1995</td>
<td>RC</td>
<td>0.85 (0.35 to 1.70)</td>
<td>Osteopetro Int 1995;5:23-9</td>
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<tr>
<td>Naessens et al, 1990</td>
<td>PC</td>
<td>0.78 (0.68 to 0.93)</td>
<td>Ann Intern Med 1990;113:95-103</td>
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<tr>
<td>Paganini-Hill et al, 1991</td>
<td>PC</td>
<td>1.02 (0.81 to 1.27)</td>
<td>Epidemiol 1991;2:16-25</td>
</tr>
</tbody>
</table>

Notes

1 Price EH, Little HK, Grant ECG, Steel CM. Women need to be warned about dangers of hormone replacement therapy. BMJ 1979;315:376-7. (1 February.)
3 Haskow K. Use of hormone replacement therapy. BMJ 1996;313:806.

Letters

notified. We hope that Craig and Morrow will collaborate with existing national databases, including that held by the Committee on Safety of Medicines, which is used extensively for drug regulatory purposes.

D N Bateman Reader in therapeutics
P McElhatton Teratologist, national teratology information service
National Drug and Therapeutics Centre, NHS Executive, Wolfson Unit, Newcastle upon Tyne NE2 4HH

1 Craig JJ, Morrow JI. New antiepileptic drugs. BMJ 1997;314:603. (22 February.)

Be cautious about using HRT for women without symptoms of osteoporosis deficiency

Editor—Elizabeth H Price and colleagues express doubts about the beneficial effects of hormone replacement therapy in preventing cardiovascular diseases and osteoporosis. This is quite remarkable because there is sometimes on the one hand a tendency to understate the possible risks of hormone replacement therapy (particularly the risk of breast cancer), while on the other hand the assumed protective effects are overemphasised, especially by those who take the menopause as an adverse event.2,3

The doubts can be supported by a review of those studies that are regarded as efficacy proofs of hormone replacement therapy concerning the prevention of hip fractures, which are the most important manifestation of osteoporosis. The review included studies published until 1995 (table 1); from multiple publications of the same study only the latest was included.4

There is an inverse relation between the protective effect seen in the analysed observational studies and the methodical state of the respective types of study. The odds ratios found in case-control studies (n = 7) varied from 0.22 to 0.72 for ever users compared with non-users of hormone replacement therapy, indicating a substantial preventive effect; while there was a range of 0.65 to 0.85 in retrospective (n = 3) and a range of 0.79 to 1.02 in prospective (n = 3) cohort studies, respectively, indicating only a slight or no effect. The type of study (case-control, retrospective, or prospective cohort) explains about 63% of the variability in the relative risk estimators; the difference between the three types of studies is significant (analysis of variance, P<0.01, F = 8.59, 2 d.f.).

On the basis of these findings, until the results of the first randomised study primarily investigating the protective ability and detrimental effects of hormone replacement therapy are available, one should be cautious about suggesting the use of hormone replacement therapy for women without symptoms of osteoporosis.5

At the very least, the women should be informed about the background of both the risks and benefits.

S Lange Research fellow Department of Medical Informatics, Biometry, and Epidemiology, Ruhr-University Bochum, 44780 Bochum, Germany

1 Price EH, Little HK, Grant ECG, Steel CM. Women need to be warned about dangers of hormone replacement therapy. BMJ 1979;314:376-7. (1 February.)
Studies exploring health in relation to intrauterine life should look at birth order

Editor—Stephanie J C Taylor and colleagues report a cross-sectional study of size at birth and blood pressure.1 We would underline the fact that birth order is not taken into account in most studies exploring health in relation to size at birth. Yet birth order is the best known single factor influencing birth weight and placental ratio. For example, according to a British calculation, the average difference in birth weight between first-born and second-born children is 138 g.2

One of us (JT) has assessed the levels of anxiety of male and female students aged 20 by using the “STAT test.” A significant positive correlation between levels of anxiety and birth weight was originally presented as the main conclusion of the study.3 Afterwards we controlled for birth order. It now seems that one of the main factors influencing anxiety levels at age 20 is birth order.

Most epidemiological studies exploring health in relation to intrauterine life have largely ignored birth order; studies that focus on birth order are conducted in the framework of social sciences and tend to ignore fetal life. Interdisciplinary bridges need to be built.

Michel Odent Director Primal Health Research Centre, London NW3 2NP Janko Tsufino Research fellow Keio University, Department of Education, Japan


Effect of sending clients a personalised summary letter is being studied

Editor—B W Lloyd reports a randomised controlled trial of dictating the clinic letter in front of the patient. In his commentary Mike Pringle raises the issue of what happens if the parents disagree with the consultant’s remarks? Is there an opportunity to question the consultant? What happens if there is something in the letter that the parents don’t understand? What is the child’s view of the dictated letter?

Mike Pringle’s commentary is wrong to focus on the narrow issues of case mix and the phrasing of the questionnaire. Rather we should be examining the practice such as Lloyd’s has not become the norm. Further research is indeed needed, but it should be qualitative and should examine the process of information giving from the parent’s perspective, with the aim of making it truly interactive. This is a good example of a situation in which the priority is to put the existing research into practice rather than initiate yet further studies on the same question.

Tony Waterston Consultant paediatrician Arthur’s Hill Clinic, Newcastle upon Tyne NE4 6BT

1 Lloyd BW. A randomised controlled trial of dictating the clinic letter in front of the patient. BMJ 1997;314:347-8. [With commentary by M Pringle.] (1 February)

Letting patients see copy of consultant’s letter is being studied in trial

Editor—B W Lloyd shows that patients approve of a consultant’s dictating clinic letters in front of them, but Mike Pringle asks for more evidence to support the idea.1 Our study, funded by Devon Family Health Services Authority, may give this evidence.

During 1994, consecutive referrals from two general practitioners were randomised to (a) dictation in their presence or immediately after they left the room and (b) whether they were sent a copy of their referral letter. Terminations of pregnancy were excluded. All patients were sent a questionnaire. We monitored attendances at hospital. Altogether 171 patients entered the study. The randomisation was to a Latin square design, thus of the 137 (80%) patients who responded to the questionnaire, 65 had had dictation in their presence and 72 had not; and 70 had received a copy of the letter and 67 had not. Forty patients received both dictation and a copy of the letter. Fifty three patients rated dictation in their presence very helpful, nine moderately helpful, and two not very helpful; one patient made no answer. Fifty three patients rated receipt of a copy letter very helpful, 12 moderately helpful, and five not very helpful. Eighty one respondents stated that the referral process had increased their understanding of their condition. This was unrelated to dictation in their presence or receipt of a copy letter.

Table 1 Accuracy of referral letter, depending on whether dictation was done in patient’s presence, for patients who received copy of their referral letter. Figures are numbers (percentages)

<table>
<thead>
<tr>
<th>Accuracy</th>
<th>Dictation in patient’s presence</th>
<th>No dictation in patient’s presence</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely accurate</td>
<td>51 (78)</td>
<td>13 (43)</td>
<td>44 (63)</td>
</tr>
<tr>
<td>Mostly accurate</td>
<td>6 (15)</td>
<td>12 (40)</td>
<td>18 (26)</td>
</tr>
<tr>
<td>Partially accurate</td>
<td>3 (6)</td>
<td>5 (17)</td>
<td>8 (11)</td>
</tr>
</tbody>
</table>

\[x^2=8.61, P=0.013.\]

and 72 had not; and 70 had received a copy of the letter and 67 had not. Forty patients received both dictation and a copy of the letter. Fifty three patients rated dictation in their presence very helpful, nine moderately helpful, and two not very helpful; one patient made no answer. Fifty three patients rated receipt of a copy letter very helpful, 12 moderately helpful, and five not very helpful. Eighty one respondents stated that the referral process had increased their understanding of their condition. This was unrelated to dictation in their presence or receipt of a copy letter.

Table 1 shows the effect of dictating the letter in their presence on its accuracy, as judged by the patient. All 89 patients who received a copy letter attended their outpatient appointment, but five of the 82 without a copy letter did not.

Previous studies of sending a copy of hospital letters to the patient have shown 91-96% satisfaction among patients.3 Lloyd’s study and ours are as convincing for dictation. Immediate dictation or receipt of a copy letter relieves anxiety that the referral might be delayed. Equally plausible is that the new process includes the patient. One comment—“I feel I have been fully consulted and treated as an intelligent adult”—exemplifies this.

Assessments of the accuracy of referral letters, finding levels of 63-95%, have concentrated on measurable items, such as the presence of a drug history.4 Thus our figure of 78% (31/40) complete accuracy after dictation in front of the patient cannot be directly compared but is much better than 43% (15/30) without immediate dictation.

The 100% attendance rate of those who received a copy letter and the 6% non-attendance rate of the controls, compared with a local mean non-attendance rate of 6.2%, is currently being studied in a randomised controlled trial.

William Hamilton General practitioner 12 Barnfield Hill, Exeter EX1 1PB Alison Round Senior registrar in public health medicine Dean Clarke House, Exeter EX1 1RB Phil Taylor General practitioner Axminster, Devon EX13 1AQ


1 Lloyd BW. A randomised controlled trial of dictating the clinic letter in front of the patient. BMJ 1997;314:347-8. [With commentary by M Pringle.] (1 February)

Further research should be qualitative

Editor—In Editor’s Choice the editor asks readers to take up the challenge of the methodology in B W Lloyd’s paper.1 I wonder whether we are asking the right question. Surely there is no doubt that patients (in this case parents) want and are entitled to full information about the consultation, and we as doctors should examine the process of how to provide this. It has already been established that the patients appreciate receiving a copy of the letter to the general practitioner after an outpatient visit.2 Yet it is still the exception for parents to receive such a letter, at any rate in my district. There are many questions about Lloyd’s practice that a questionnaire would not answer: what happens if the parents disagree with the consultant’s remarks? Is there an opportunity to question the consultant? What happens if there is something in the letter that the parents don’t understand? What is the child’s view of the dictated letter?

Mike Pringle’s commentary is wrong to focus on the narrow issues of case mix and the phrasing of the questionnaire. Rather we should be examining the practice such as Lloyd’s has not become the norm. Further research is indeed needed, but it should be qualitative and should examine the process of information giving from the parent’s perspective, with the aim of making it truly interactive. This is a good example of a situation in which the priority is to put the existing research into practice rather than initiate yet further studies on the same question.

Tony Waterston Consultant paediatrician Arthur’s Hill Clinic, Newcastle upon Tyne NE4 6BT

1 Lloyd BW. A randomised controlled trial of dictating the clinic letter in front of the patient. BMJ 1997;314:347-8. [With commentary by M Pringle.] (1 February)
had an electrocardiograph and defibrillator for many years.

Prehospital thrombolysis has been used for four patients: anistreplase has been given once at home, twice in the surgery, and once in the community hospital. During the same period over 90 patients with a myocardial infarct were admitted to the district general hospital. In the light of Vale and colleagues' paper I asked the doctors why our use of anistreplase was so low. All the doctors were aware of the availability of anistreplase and that early thrombolysis is beneficial. Five doctors thought that the benefit was large (>10%), two thought it moderate, one thought it small (<5%), and one did not know. Three doctors had used anistreplase; interestingly, these were not the three who had used thrombolysis in hospital during training.

When I asked the doctors “What prevents you from using thrombolysis?” four said that extra work was involved. Reasons given for this were establishing a diagnosis of sufficient certainty and performing electrocardiography. Two of the three doctors who had used anistreplase did not report extra work. No doctor reported that financial considerations were a barrier. Four doctors thought that availability of the drug was a problem. The need for refrigeration and the long delays in replacing stock were commented on. When asked “How confident are you at using anistreplase?” half of the doctors said that they were confident to use it with support from ambulance staff or a nurse. Most wanted a trained person with them; three doctors wanted medical support before using anistreplase.

Solutions to the low uptake of prehospital thrombolysis lie in increasing doctors’ confidence and giving reassurance about the safety of prehospital thrombolysis. Since 1992 the development of larger rotors for emergency medical care has changed the way that many doctors work. Cars with sophisticated equipment are becoming more common. To overcome problems with refrigeration and availability, perhaps streptokinase should be reconsidered as a prehospital thrombolytic agent.

Increasing doctors’ confidence would solve low uptake of prehospital thrombolysis

Editor—Luke Vale and colleagues calculate that the additional cost of thrombolysis in the community compared with hospital use is modest and suggest further research on the impact of a policy of community thrombolysis.1

I work in a rural practice 35 km from the nearest district general hospital; anistreplase was introduced into the practice four years ago. The 10 doctors serve a resident population of 14 000 people; in addition there are many holidaymakers and a local community hospital. Almost all patients with chest pain are seen by a doctor before their transfer to the district general hospital. The practice has

| Table 1 Patients’ response to personalised summary letter sent to them |
|-----------------|-------|
| No of patients  |       |
| Very pleased    | 11    |
| Quite pleased   | 9     |
| Mixed feelings  | 5     |
| Indifferent     | 2     |
| Not very pleased| 0     |
| Not at all pleased| 1    |

conducts a semistructured interview with the patient within a few weeks of the initial consultation, assessing satisfaction with various aspects of the consultation and compliance with treatment. Most of the patients in the group who received a letter showed a positive response to receiving it (table 1). They often commented that it seemed personal, made them feel listened to and understood, and acted as a reference. Twenty-six of the 28 patients reported that they found the letter easy to understand, and the same number considered the letter to be very or quite accurate. In the control group, 18 of the 28 patients said that they would have liked to receive a similar letter. Most importantly, there was also a trend for patients in the experimental group to be more satisfied with their initial consultation than the control subjects (Wilcoxon’s test: P = 0.07).

Our preliminary findings suggest that it is feasible to share clinical information with patients in such a sensitive specialty as psychiatry and that this may positively affect patients’ views of the consultation. We are now looking at the effect of the intervention on compliance with treatment and outcome, which we will report when the project is completed.

Harriet Humfress
Research psychologist
North West London Mental Health Trust,
London NW8 0EH

Ulrike Schmidt
Consultant psychiatrist
Maudsley Hospital, London SE5 8AZ

1 Lloyd BW. A randomised controlled trial of dictating the clinic letter in front of the patient. BMJ 1997;314:570-2. (With a commentary by M Pragnell (1 February).)


Rate of hysterectomy is lower among female doctors and lawyers’ wives

Editor—In his editorial on the bill resulting from hysterectomy R J Lilford cites a study by Bunker and Brown, carried out 27 years ago.2 The results of this study support his statement that the prevalence of hysterectomy among doctors’ wives showed no difference from that in the control group matched for social class.3 The results were seriously flawed by the role of American economic barriers to medical care for the whole population due to a lack of a universal health insurance.

We conducted a similar study in a fee for service healthcare market (Switzerland) in which financial barriers to medical care for the whole population were largely removed 80 years ago.4 Unlike Bunker and Brown, we used strictly the same methodology to collect and analyse data for each social class. Our results, contrary to Bunker and Brown’s findings, show that the standardised rate of hysterectomy among women in the general population (n = 808; prevalence 15.7%) was significantly higher than that among female doctors (n = 433; 9.96%) and lawyers’ wives (n = 188; 8.45%) (P < 0.01) and the same as that among other professionals with a university degree (n = 159; 13.88%).

Thus our results suggest that, in a fee for service market, as economic barriers to health care are removed so a social class gradient in consumption will appear. We also found that lawyers seem to be regarded by their doctors as special patients, probably because lawyer-patients are potentially more able to cause legal trouble if an adverse event or outcome related to the surgical procedure should happen.

A more recent study that we carried out on the lifetime prevalence of some surgical procedures in Switzerland shows that, for hysterectomy and other procedures, the most coveted surgical patients are the less well educated and best insured (in Switzerland, patients with private hospital insurance).5 The prevalence of hysterectomy among generally insured patients was 12.2% (n = 2221) and that among privately insured patients was 18.1% (n = 1052) (P < 0.001). In this last group the lifetime prevalence of hysterectomy among less educated patients was 29.9% (n = 396) and that among highly educated patients was 12.9% (n = 468) (P < 0.001).

These results seem to suggest that the assumption that gynaecologists “exploit women for personal gain or take some sort of covert delight in the procedure”6 is no longer to be rejected. Another of our studies showed that female gynaecologists performed about half as many hysterectomies (median yearly number 18) as male gynaecologists (median yearly number 34).5 Perhaps fortunately for male patients, in that time no female urologists practised on the Swiss health market scene.

Gianfranco Domenighetti
Head
Antoine Casabianca
Economist
Cantonal Health Office, 6000 Bellinzona, Switzerland

1 Lilford RJ. Hysterectomy: will it pay the bills in 2007? BMJ 1997;314:169-1. (18 January.)


Health workers need information from countries with better health indicators than Britain and the US

Editor—Meeting the information needs of public health workers in developing countries is an urgent problem.1 Information has become familiar with information exchange people working in public health should become aware of this need. We argue that information flowing into developing countries should come not only from Britain and the US but also from countries with successful public health programmes. In Medline during the past 20 years, however, more than half of the information on public health was from Britain and the United States. We have described several possible ways of doing this, but in Japan and 0.01% from Iceland, the countries with the highest life expectancy. It was from Japan and 0.01% from Iceland, the countries with the highest life expectancy. It might be better to model at least part of the public health programmes in Africa on the successes of Japan. There are several possible ways of dealing with the language barrier to global health data. There are other key issues. Firstly, people working in public health should become familiar with information exchange through the internet. For this purpose we have conducted several training courses worldwide such as the World Health Organisation/global health network joint programme internet training course in Japan (http://www.pitt.edu/~akira/). Secondly, worldwide web mirror sites should be set up so that people can have faster access to the information. The global health disaster network was set up in this manner (http://hypnos.m.ehime-u.ac.jp/GHIDNet/ in Japan, and http://www.pitt.edu/~ghdnet/GHIDNet/ in the United States). Thirdly, we have to discuss how we can develop an infrastructure for the information with low band width connectivity, because only information with low band width reaches most of the developing countries that have access to the Internet. There is little question that we have learnt much through the enormous amount of public health information from Britain and the United States. We can also, however, learn much from the areas with the best health indicators, which disproportionately provide less information than these two countries.

Akira Sekikawa
Jallow
Ronald E Laporte
Professor
Department of Epidemiology,
University of Pittsburgh, Diabetes Research Center, 3500 Fifth Avenue, Pittsburgh, PA 15213, USA

Toshihiko Satoh
Assistant professor
Department of Hygiene and Public Health, Tokyo Women’s Medical College, Tokyo 162, Japan

Genro Ochi
PhD
Department of Emergency Medicine,
Ehime University School of Medicine, Ehime 791-02, Japan

1 Smith R. Meeting the information needs of health workers in developing countries. BMJ 1997;314:1-40. (11 January.)
3 Sekikawa A, Libman I, Iochida L, LaPorte R, Boosstrom E. People will be able to surf across languages for health data on the Internet. BMJ 1996;313:1296-7. (16 November.)

Sentiweb remains efficient tool for nationwide surveillance of disease

Editor—Our paper on Sentiweb, the French electronic sentinel system for surveillance of communicable diseases on the world wide web, was accompanied by three commentaries.1 In one of them Norman Noah was surprised by the low rate of reports, considering that (only?) 330 000 cases were notified in 12 years, leading to one case per doctor per week. Noah’s calculations were not, however, appropriate. Some diseases shown on the internet (for example, chickenpox and diarrhoea) have been under surveillance for only six years. Estimates of nationwide incidences take into account the variable participation in the network and the network’s representativeness. Eventually, other sources of information can cross validate the system, such as the estimated number of cases of chickenpox each year (600 000); this number is of the same order of magnitude as a birth cohort in France. Hence, around 90% of cases are known to be diagnosed by general practitioners and 95% of the population has been infected.

The system was conceived as a complement to the notifying system.2 This was the consequence of close collaboration between INSERM and the French Department of Health. Rare events (for example, rabies) are obviously unlikely to be accurately detected through a sentinel system. However, measles was not noticeable after 1986, when the notification system collected less than 300 cases in a single year; the sentinel system estimated the actual incidence to be around 300 000 cases. Nowadays, with an estimate of more than 50 000 cases a year detected by general practitioners in France, the sentinel system remains an efficient tool for nationwide surveillance of the disease, although not for the detection of local outbreaks.

Do clinical cases of acute diarrhoea or influenza-like illness detected in primary care correspond to true cases?3 Preliminary results of a case-control study with that we conducted, in addition to the surveillance, indicate that cases of acute diarrhoea in winners are not due to consumption of shellfish or tap water.4 Moreover, general practitioners’ attitudes to diagnosis, prescribing, and sick leave in the care of influenza-like illness were found to be similar whether the virus was influenza or respiratory syncytial virus (F Carrat et al, third international congress on options for the control of influenza, Cairns, Australia, 4-9 May 1996).

The last point debated by Noah concerned the huge number of maps and graphs available to net users. He sounds to us like a disappointed customer facing the catalogue of an airline company: “Several thousand destinations are provided; therefore I don’t know where to go, and I would prefer a catalogue of domestic flights for my next holiday.”

Antoine Flahault
Head of Sentinel system
Eric Boussad
Computer scientist
J-F Vibert
Maître de conférences des universités–praticien hospitalier
Alain-Jacques Valleron
Director of epidemiology and information sciences, INSERM unit INSERM U444, Reseau Sentinelles, 75371 Paris cedex 12

The world health report 1996.2 World Health Organisation.

Achievements in new deal for junior doctors’ hours should be independently audited

Editor—Medicopolitical Digest comments on the new deal for junior doctors’ hours, with its target date of 31 December 1996.1 While the NHS Executive admits that there is still a hard core of problems to resolve, I believe that in many cases the methods of gathering data lead to poor quality data and unanswerable questions. It is also too common for an ambitious junior doctor, anxious about the allocation of a training number, to be drawn into collusion with his or her employing authority about hours of work. The commonest evidence for this has been the rush of accountants intent on reducing the amount of pay, whether or not the clinical team has achieved a reduction in hours of work. The result of these forces is that neither the trainee nor the institution has any interest in admitting the true working hours.

The most important advance would be realistic independent audit, which should not require young doctors to risk their career ambitions by seeming to be out of step with their seniors. Until this issue is resolved, many of the data gathered may be spurious.

A W Clark
Consultant surgeon
The Howe Nuffield, Hove BN3 4BG

1 Beechan L. Taking forward the new deal on junior doctors hours. BMJ 1997;314:148. (8 February.)