LETTERS

Letters are selected from rapid responses posted on bmj.com. After editing, all letters are published online (www.bmj.com/archive/sevendays) and about half are published in print
To submit a rapid response go to any article on bmj.com and click "respond to this article"

PREMATURE DEATHS ACROSS ENGLAND

Austerity measures hit the sickest hardest

Torjesen highlights the stark inequality in life expectancy shown on the Longer Lives website (http://longerlives.phe.org.uk/).[1] The north of England is coloured red and labelled with the "worst" premature mortality, whereas the green fields of the south have the "best" premature mortality.

The north-south divide in life expectancy is nothing new.[2 3] What is new is that local authorities are now responsible for public health. Jeremy Hunt wants the data to be used to identify "local" public health challenges,[1] but our analysis shows the bigger picture.

In the figure, we use publicly accessible data to illustrate the local authority budget cut per head (2010-11 to 2014-15) in relation to premature mortality.[4 5] The figure shows that the largest spending cuts have occurred in the areas with the highest premature mortality, and that the cuts are systematically larger in the north of England.

How are local authorities supposed to reduce inequalities in the face of austerity measures that are likely to do the opposite?

David Taylor-Robinson Medical Research Council population health scientist, Department of Public Health and Policy, University of Liverpool, Liverpool L69 3GB, UK
dctr@liv.ac.uk
Rachael Gosling consultant in public health, Liverpool Community Health NHS Trust, UK
Dominic Harrison director of public health
Mohammed Khan deputy leader and executive member for health and adult social care , Blackburn with Darwen Borough Council, Blackburn, UK
Ben Barr senior clinical lecturer in applied public health, Department of Public Health and Policy, University of Liverpool, Liverpool L69 3GB, UK

Competing interests: None declared.

1 Torjesen I. Maps of premature deaths across England will help tackle variation, say public health chiefs. *BMJ* 2013;346:f3796. (11 June.)
2 Hacking JM, Muller S, Buchan IE. Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. *BMJ* 2011;342:d508.
3 Whitehead M, Doran T. The north-south health divide. *BMJ* 2001:342:d584.
4 Butler P. Council spending cuts: the north loses out to the south. Patrick Butler's Cuts Blog. *Guardian* 2013. www.guardian.co.uk/society/patrick-butler-cuts-blog/2013/jan/11/council-cuts-north-loses-out-to-the-south-newcastle#data.
5 Public Health England. About the data. 2013. http://longerlives.phe.org.uk/about-data.

Cite this as: *BMJ* 2013;347:f4208

Time to focus on health

Instead of focusing purely on negative indicators, Public Health England's "longer lives" project[1] should include positive indicators, especially as the project is trying to promote health.[2] These should reflect individual health knowledge and behaviour, socioeconomic conditions, and the physical environment.[2] Examples include the proportion of children taking enough exercise each week, the proportion of homes with a working smoke alarm, and the proportion of adults having "5 a day." They can also be developed at a higher level—for example, in relation to cycle lanes, swimming pools, and various workplace policies.

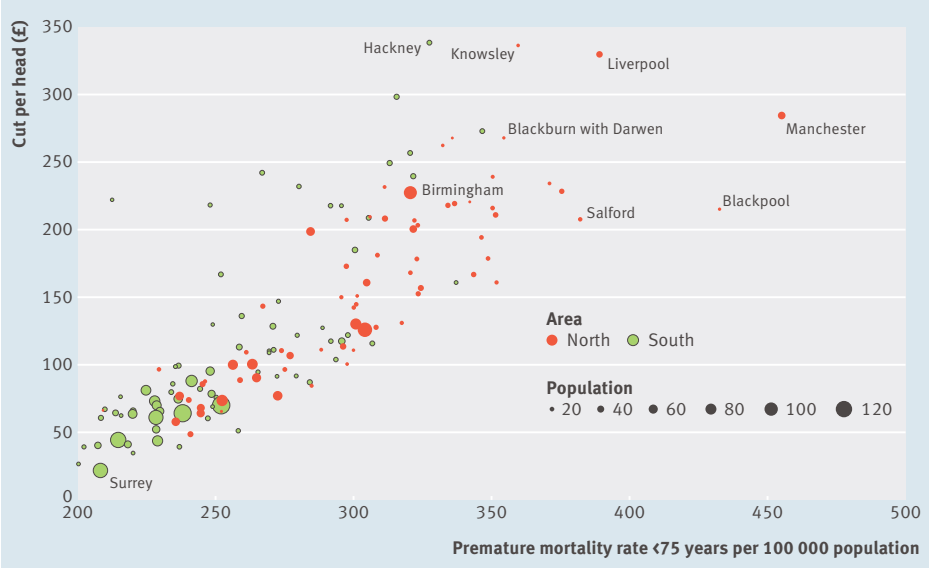
Such health indicators can be used for not only monitoring and evaluation but also motivating the public and professionals to act. Instead of having a society focused purely on deaths, perhaps it is time to change the perspective and have a focus on health.

Michael C Watson associate professor in public health, University of Nottingham, Faculty of Medicine and Health Sciences, Queen's Medical Centre, Nottingham NG7 2HA, UK
michael.watson@nottingham.ac.uk
Emily Clare Watson general practitioner registrar, Barnsley Hospital, Barnsley, UK

Competing interests: None declared.

1 Torjesen I. Maps of premature deaths across England will help tackle variation, say public health chiefs. *BMJ* 2013;346:f3796. (11 June.)
2 Catford JC. Positive health indicators—towards a new information base for health promotion. *Commun Med* 1983;5:125-32.

Cite this as: *BMJ* 2013;347:f4210



Local authority budget cut 2010-11 to 2014-15 versus premature mortality

NICE ON FEVERISH ILLNESS IN CHILDREN

Don't forget hypothermia

Although it is gratifying to see updates to the National Institute for Health and Care Excellence (NICE) clinical guideline on feverish illness in children,[1] we would like to redress the balance for concern about altered thermoregulation in sick children. Fever is a cardinal sign of inflammation, infection, and trauma, but low body temperature is also a manifestation of disordered thermoregulation.

The NICE guideline focuses on febrile illness, giving a clear message about the value of different degrees of fever in the assessment of risk of serious illness. On the spectrum of thermoregulatory disturbance associated with disease and life threatening illness, both high fever and below "normal" temperature are seen in clinical practice. Below normal body temperature is mostly seen in severe sepsis and septic shock and is associated with a higher mortality than fever.[2-4]

A recent (unpublished) audit of body temperature readings in 23 954 children admitted to an emergency department (Sheffield Children's NHS Foundation Trust) found that 21% presented with temperature >37.6°C but 12% had a temperature <36.0°C. Other NICE guidance defines hypothermia as <36.0°C.[5] Therefore, below normal body temperatures are not uncommon, although the lack of standard use low reading thermometers hinders studies on the epidemiology of hypothermia.

The NICE guidance refers to only one side of human thermoregulatory disturbances, so what is its remit? Is it mainly about detecting feverish illness in children or about helping healthcare professionals identify serious childhood illness? If it is the second option, low—as well as raised—body temperature should be included in the assessment of serious illness in children and in future epidemiological studies.

Anna Cronin de Chavez research fellow, health services researcher a.cronin-de-chavez@shu.ac.uk
Charmaine Childs professor of clinical science
Shona Kelly reader in public health
Angela Mary Tod professor of health services research, Centre for Health and Social Care Research (CHSCR), Sheffield Hallam University, Sheffield S10 2BP, UK
Derek Burke medical director, consultant in paediatric emergency medicine, Sheffield Children's NHS Foundation Trust, Sheffield, UK

Competing interests: None declared.

1 Fields E, Chard J, Murphy MS, Richardson M; on behalf of the Guideline Development Group and technical team. Assessment and initial management of feverish illness in children younger than 5 years: summary of updated NICE guidance. *BMJ* 2013;346:f2866. (22 May.)
2 Hofer N, Müller W, Resch B. Neonates presenting with temperature symptoms: role in the diagnosis of early onset sepsis. *Pediatr Int* 2012;54:486-90.
3 Milner D, Wailoo M, Swift P, Fraser M. Prolonged hypothermia following respiratory syncytial viral infection in infancy. *Arch Dis Child* 2003;88:69-70.
4 Remick DG, Hongyan X. Hypothermia and sepsis. *Front Biosci* 2006;11:1006-13.
5 National Institute for Health and Clinical Excellence. Inadvertent perioperative hypothermia. 2008. www.nice.org.uk/nicemedia/live/11962/40396/40396.pdf.

Cite this as: *BMJ* 2013;347:f4220

GLAUCOMA

Central corneal thickness

We add to King and colleagues' review of glaucoma.[1]

Goldmann acknowledged that central corneal thickness affects intraocular pressure (IOP) measurements by applanation tonometry, but the Ocular Hypertension Treatment Study showed that thinner corneas are an independent risk factor for the progression of glaucoma and highlighted the role of corneal pachymetry.[2 3]

Goldmann tonometry is the gold standard for measuring IOP, but in patients with thinner corneas, the real IOP is higher than that measured with applanation tonometry. In such patients, IOP measurements may vary by 2-6 mm Hg or more. If corneal pachymetry is not performed in these people, glaucoma may not be diagnosed or may be undertreated.

In addition, refractive surgery is rapidly gaining popularity. Laser assisted in situ keratomileusis alters the central corneal thickness, leading to underestimation of the IOP pressure; a mean decrease of 1.9-3.8 mm Hg in IOP has been seen after this procedure.[4 5] GPs, ophthalmologists, and optometrists who measure the IOP and screen patients for glaucoma must remember this because incorrect IOP measurements may be misleading and prevent patients with glaucoma from receiving a diagnosis and treatment.

Patients who are having refractive surgery should undergo a preoperative dilated, magnified stereoscopic disc evaluation, with documentation of the findings. If indicated, baseline analysis of the optic nerve head and retinal nerve fibre layer plus autoperimetry should be performed for comparison in the future.

Ilias Georgalas assistant professor
igeorgalas@yahoo.com
Dionisis Pagoulatos ophthalmologist
Chryssanthi Koutsandrea associate professor
Dimitrios Papaconstantinou assistant professor, Department of Ophthalmology, University of Athens, Athens, Greece

Competing interests: None declared.

1 King A, Azuara-Blanco A, Tuulonen A. Glaucoma. *BMJ* 2013;346:f3518. (11 June.)
2 Shih CY, Graff Zivin JS, Trokel SL, Tsai JC. Clinical significance of central corneal thickness in the management of glaucoma. *Arch Ophthalmol* 2004;122:1270-5.
3 Brandt JD, Beiser JA, Gordon MO, Kass MA; Ocular Hypertension Treatment Study (OHTS) Group. Central corneal thickness and measured IOP response to topical ocular hypotensive medication in the Ocular Hypertension Treatment Study. *Am J Ophthalmol* 2004;138:717-22.
4 Luce DA. Determining in vivo biomechanical properties of the cornea with an ocular response analyzer. *J Cataract Refract Surg* 2005;31:156-62.
5 Hsu SY, Chang MS, Lee CJ. Intraocular pressure assessment in both eyes of the same patient after laser in situ keratomileusis. *J Cataract Refract Surg* 2009;35:76-82.

Cite this as: *BMJ* 2013;347:f4215

Authors' reply

Pachymetry needs to be considered when evaluating the risk of developing glaucoma in patients with ocular hypertension. It is recognised that Goldmann tonometry can underestimate intraocular pressure (IOP) in people with thin corneas, including those who have had refractive surgery.

However, although it is well known that corneal thickness influences the measurement of IOP, the extent to which a low corneal thickness is responsible for the increased risk of open angle glaucoma is unclear. There is also no consensus on the clinical relevance of the effect of corneal thickness on IOP measurements.[1] A systematic review reported considerable heterogeneity in studies reporting central corneal thickness as a probable prognostic factor for progression of open angle glaucoma.[2]

We agree that all people undergoing refractive surgery should have a comprehensive evaluation for ophthalmic abnormalities before surgery and that ideally preoperative measurements of IOP should be taken for future comparison and carefully recorded and saved. The need for optic nerve head and retinal nerve fibre examinations should be confirmed by evidence, considering also cost effectiveness.

Anthony King consultant ophthalmic surgeon and honorary associate professor clinical ophthalmology, Nottingham University Hospital and University of Nottingham, Nottingham NG7 2UH, UK
anthony.king@nottingham.ac.uk
Augusto Azuara-Blanco professor of clinical ophthalmology and honorary consultant ophthalmologist, Centre for Vision and Vascular Science, Queen's University Belfast, Belfast, UK
Anja Tuulonen professor of ophthalmology, Tays Eye Centre, Tampere University Hospital, Tampere, Finland

Competing interests: None declared.

1 Burr JM, Botello-Pinzon P, Takwoingi Y, Hernandez R, Vazquez-Montes M, Elders A, et al. Surveillance for ocular hypertension: an evidence synthesis and economic evaluation. *Health Technol Assess* 2012;16:1-271.
2 Ernest PJ, Schouten JS, Beckers HJ, Hendrikse F, Prins MH, Webers CA. An evidence-based review of prognostic factors for glaucomatous visual field progression. *Ophthalmology* 2013;120:512-9.

Cite this as: *BMJ* 2013;347:f4216

CONSULTANTS' CONTRACTS

Time for a putsch of the l'oréal consultants?

Spence makes many important points.[1] Some of us seem to have forgotten the reason that we are in the position we are in—to care for patients.

The consultant contract needs reorganisation so we can have consultant delivered care across all specialties, with trainees aiding the services, not maintaining them.

Yes it will mean major changes, and some colleagues with exuberantly feathered beds may have to be there doing the work, rather than gallivanting up and down the country in planes, trains, and automobiles.

The inequality between consultants in terms of supporting professional activities is another example of our predecessors looking after themselves, patting themselves collectively on the back, and saying that the rest of us have to earn our benefits. These are the same people who benefited from minimally controlled trainee hours and low expectation of consultant presence. The playing field is not only uneven but tilted head down towards those who have suckled for so long on the teat of distinction awards and clinical excellence awards that they have come to believe that they really are worth it. A putsch of the "l'oréal consultants" is long overdue.

Many of the same consultants are involved in management and extremely teat dependent, so they need to be seen to be tough on new consultants to continue to receive their preferential treatment. They are so entwined with management that serious surgery would be required to separate the two.

So yes, let's reorganise, let's tackle these problems, and get into the nitty gritty of consultant contracts.

Jerard Ross neurosurgeon, NHS Lothian, Edinburgh, UK
rossjerard@hotmail.com

Competing interests: None declared.

1 Spence D. Consultants' contracts: could do better. *BMJ* 2013;346:f3701. (12 June.)

Cite this as: *BMJ* 2013;347:f4225