**ROTATOR CUFF DISEASE**

Simultaneous lidocaine may have confounded results

Ekeberg and colleagues in their carefully designed study provide further insight on the optimal approach for treating rotator cuff disease with steroid injections. However, the decision to also inject lidocaine into the shoulder of patients who received systemic treatment by means of corticosteroid injection in the gluteus is not without criticism. It may achieve blinding for the test subject by partly neutralising the potential pain caused by corticosteroid injection of the shoulder in the localised injection group, but it also introduces new confounders. For example, short term relief of symptoms in the systemic group might be a result of a reduction of muscle spasms and tension caused by local lidocaine injection rather than the systemic corticosteroid injection.

**Competing interests:** None declared.


Cite this as: BMJ 2009;338:b641

What is rotator cuff disease anyway?

I am not surprised that the study by Ekeberg and colleagues showed no difference between subacromial ultrasound-guided or systemic steroid injection for rotator cuff disease. What is rotator cuff disease? I submit no such lesion exists. You might as well talk of shoulder pain disease or the long discredited periarthritis. The diagnostic criteria seem to be pain on abduction (active or passive or both?), up to 49% reduced glenohumeral motion in one direction only (active or passive limitation, or both?), with pain on two resisted movements, a positive impingement sign (a painful arc?). What is the basis for deciding that this complicated combination of physical signs correlates with rotator cuff disease? But if it does, what is the logic of trying to treat it by injecting into the subacromial bursa, a different structure? The rotator cuff consists of the tendons of the supraspinatus, infraspinatus, subscapularis, and teres minor muscles blended with the capsule of the shoulder joint. Having decided that the rotator cuff is at fault, the next step is to work out where the lesion lies in the supraspinatus, infraspinatus, or subscapularis tendon. This can be simply achieved by a systematic clinical examination. Treatment can then be given by local steroid infiltration to the affected tissue only, with regularly good results.

Ekeberg and colleagues were probably treating a mixture of conditions, such as lesions of different parts of the rotator cuff and subacromial bursitis. With such a heterogeneous group of patients you cannot expect meaningful results from a clinical trial.

**Competing interests:** None declared.


Cite this as: BMJ 2009;338:b641

The next step?

The next experiment in corticosteroid treatment of rotator cuff disease would be to compare systemic injections with oral steroids and local injection. Given the possible atrophy and weakness that may be caused by local injection, the need is urgent. Imagine if three days (or even one day) of 40 mg prednisolone was as effective as the two injections. The management of this condition would be transformed.

**Competing interests:** None declared.


Cite this as: BMJ 2009;338:b640

**NHS NATIONAL PROGRAMME FOR IT**

Time for a reality check of NPfIT’s problems

Problems with technology, contracts, timescales, organisational change, and user acceptance have continually dogged the NHS national programme for IT (NPfIT), but critics need to get these into perspective before seeking to tear down the enterprise.

Similar difficulties have historically beset most large information technology projects in the corporate and public sectors, and NPfIT is no exception. The reality is that mistakes and wastage are inevitable in a programme of this size and complexity. This is not to say that lessons shouldn’t be learnt and acted on. Nevertheless, when compared with the bailout of the UK’s banks, which some estimate will cost the British tax payer up to £1 trillion, and the Iraq war, estimated as up to £18 billion by 2010, the £12.5 billion cost of delivering a major programme of change to the systems and processes of the world’s largest organisation begins to look like a good deal, even if, as we can expect, the figure goes up.

Despite its many troubles, the NHS IT programme has made considerable gains and is on course to deliver real improvements in the way information and services are managed and delivered. Governments across the globe are trying to do the same. Let’s not fall into the old trap of abandoning or replacing a major NHS programme just at the point where the investment of time, effort, and money is about to pay dividends. We urge clinicians and policy makers to go the distance.

Claudia Pagliari

Associate professor of exercise science and sports medicine, University of Puget Sound, Tacoma, WA 98416, USA claudia.pagliari@ups.edu

**Competing interests:** None declared.

1 Cross M. Problems with computerising patients’ records are “as serious as ever,” say MPs. BMJ 2009;338:b337. (28 January.)


3 Darling warns economy could collapse if bailout fails. Thisismoney.co.uk. 19 Jan 2009. www.thisismoney.co.uk/news/article.html?in_article_id=467909&page_id=2

Cite this as: BMJ 2009;338:b642

"BMJ" | 21 FEBRUARY 2009 | VOLUME 338

LETTERS

These letters are selected from rapid responses posted on bmj.com. Selection is usually made 12 days after print publication of the article to which they respond.

**NHS NATIONAL PROGRAMME FOR IT**

Time for a reality check of NPfIT’s problems

Problems with technology, contracts, timescales, organisational change, and user acceptance have continually dogged the NHS national programme for IT (NPfIT), but critics need to get these into perspective before seeking to tear down the enterprise.

Similar difficulties have historically beset most large information technology projects in the corporate and public sectors, and NPfIT is no exception. The reality is that mistakes and wastage are inevitable in a programme of this size and complexity. This is not to say that lessons shouldn’t be learnt and acted on. Nevertheless, when compared with the bailout of the UK’s banks, which some estimate will cost the British tax payer up to £1 trillion, and the Iraq war, estimated as up to £18 billion by 2010, the £12.5 billion cost of delivering a major programme of change to the systems and processes of the world’s largest organisation begins to look like a good deal, even if, as we can expect, the figure goes up.

Despite its many troubles, the NHS IT programme has made considerable gains and is on course to deliver real improvements in the way information and services are managed and delivered. Governments across the globe are trying to do the same. Let’s not fall into the old trap of abandoning or replacing a major NHS programme just at the point where the investment of time, effort, and money is about to pay dividends. We urge clinicians and policy makers to go the distance.

Claudia Pagliari

Senior lecturer in primary care, Centre for Population Health Sciences, University of Edinburgh, Edinburgh EH9 9DQ claudia.pagliari@ed.ac.uk

Peter Singleton

Principal research fellow, Centre for Health Informatics and Multiprofessional Education, University College London, Archway Campus, London N19 5LW

Don E Detmer

Professor emeritus and professor of medical education, Public Health Sciences, University of Virginia, PO Box 800717, Charlottesville, VA 22908, USA
detmer@virginiahealth.org

**Competing interests:** None declared.

1 Cross M. Problems with computerising patients’ records are “as serious as ever,” say MPs. BMJ 2009;338:b337. (28 January.)


3 Darling warns economy could collapse if bailout fails. Thisismoney.co.uk. 19 Jan 2009. www.thisismoney.co.uk/news/article.html?in_article_id=467909&page_id=2

Cite this as: BMJ 2009;338:b642

"BMJ" | 21 FEBRUARY 2009 | VOLUME 338

LETTERS

These letters are selected from rapid responses posted on bmj.com. Selection is usually made 12 days after print publication of the article to which they respond.
A CONSTITUTION FOR THE NHS

Interpreting the rights in the NHS constitution

Commenting on the new NHS constitution,1 Health Secretary Alan Johnson said “it will no longer be acceptable for a doctor to prescribe painkillers for back pain, for example, without explaining alternatives like physiotherapy where appropriate.” 2 A senior Department of Health source added: “Gone will be the paternalistic days of being told by the doctor that you can’t have physiotherapy for your back pain, or referral to an orthopaedic consultant.”

Although the principle of informed consent is sound, the health secretary’s example is poor. Much back pain is non-specific and self-limiting. Prescribing painkillers (in the form of anti-inflammatory drugs) may be an appropriate first line treatment, and discussing alternatives such as physiotherapy may encourage uptake of comparatively costly interventions. Rather than sending patients with non-specific musculoskeletal pain on a merry-go-round of frequently fruitless referrals, general practitioners are better advised to encourage an early return to work.

Indeed, other government initiatives seek to strengthen general practitioners’ gatekeeper role in sickness absence—for example, by replacing sick notes with electronic wellness notes.

It would be a great shame if the rights enshrined in the new constitution were interpreted in a way that undermined general practitioners’ capacity to treat common ailments pragmatically.

Elaine S Heaver PhD student, Centre for Pain Research, School for Health, University of Bath, Bath BA2 7AY e.s.heaver@bath.ac.uk

David Wainwright senior lecturer in health services research, School for Health, University of Bath, Bath BA2 7AY

Competing interests: None declared.

WHEN CAN DOCTORS STAY AWAY?

Consider employers’ duty of care

Sokol ignores the duty of care owed by employers to their staff.1 In UK law it is to protect, “as far as possible your health, safety, and welfare while you’re at work.”

Although Sokol cites the Toronto outbreak, in which half of those admitted with suspected SARS were health workers, he does not quote the protection recommendations of the Toronto team.2 They include full gloves, gown, hat, and eye protection, plus ventilated helmets for anyone dealing with acutely ill patients. The first are readily available in any hospital, but the second are not, unless all such treatment took place in an orthopaedic laminar flow theatre.

Moreover, no general hospital in the UK that I know of has trained its staff in the detailed anti-contamination measures that would protect them when treating highly infectious patients.

John Davies anaesthetist, Royal Lancaster Infirmary, Lancaster LA1 4RP john.davies@btinternet.com

Competing interests: None declared.

1 Sokol DK. When can doctors stay away? BMJ 2009;338:b165. (16 January.)


Cite this as: BMJ 2009;338:b637

Staying away might be better

If a pandemic hits it is highly unlikely that we will have an adequate, available, and effective antiviral agent that would alter the course of the illness in a significant way.1 Preventing cross infection by closing all schools, surgeries, and public meeting places might save more lives than running an open access emergency clinic staffed by medical heroes.

Hunkering down may be unfashionable and possibly unethical, but what evidence do we have that convincingly shows that frontline medical intervention alters all cause mortality in a serious H1N1 type flu pandemic?

Roderick Champ general practitioner, Ewyas Harold, Herefordshire HR2 0EU quinnchamp@gmail.com

Competing interests: None declared.

1 Sokol DK. When can doctors stay away? BMJ 2009;338:b165. (16 January.)

Cite this as: BMJ 2009;338:b638

ALL ABOUT NICE

NICE does consider patient views

Spiegel and Reaney’s article suggests that the National Institute for Health and Clinical Excellence (NICE) does not take patients’ views into account.1 A cursory review of its website and process and technical manuals shows that the authors are wrong and their conclusions based on factual inaccuracies.2,3

NICE uses a range of means to ensure that the patient perspective informs its processes and committee decision making. The appraisal committee includes three lay members recruited through open advertising. National patient/carer organisations can become consultees to an appraisal and participate at all key stages of the process, including scoping workshops, submitting written evidence, nominating patients (or carers) to attend the appraisal committee meeting, and commenting on the final guidance. This approach is replicated in all of NICE’s guidance development programmes.

The authors also suggest that NICE relies only on generic measures of health status such as the EQ-5D without considering other reported outcomes. However, as described above, NICE uses a range of alternative routes to ascertain what outcomes patients consider important.

The role of NICE raises ethical and methodological questions about how best to allocate resources in a resource limited health service. There should be a national debate about how decisions are made and how patients and the public might get involved. But criticisms should be based on valid observations, not oversimplification or inaccurate portrayal of the process. The new investigation into how to assess the “value” of innovation chaired by Sir Ian Kennedy will contribute to this debate.4

Marcia Kelson associate director, Patient and Public Involvement Programme, National Institute for Health and Clinical Excellence (NICE), London WC1 6NA

Marcia.kelson@nice.org.uk

Carole Longson director, Centre for Health Technology Evaluation, National Institute for Health and Clinical Excellence (NICE), London WC1 6NA

Peter Littlejohns clinical and public health director, National Institute for Health and Clinical Excellence (NICE), London WC1 6NA

Competing interests: None declared.

1 Spiegel and Reaney BMJ 2009;338:b624.

Cite this as: BMJ 2009;338:b630

4 Stiglitz J, Blumrosen L. The three trillion dollar war. Times online 23 Feb 2008. www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article3419840.ece

5 Pagliari C. Implementing the national programme for IT: what can we learn from the Scottish experience? Informatics in Primary Care 2005;13:105-1.

Cite this as: BMJ 2009;338:b643

1 Competing interests: research, School for Health, University of Bath, Bath BA2 7AY

2 David Wainwright

E-mail: e.s.heaver@bath.ac.uk

Competing interests: None declared.

3 Pagliari C. Implementing the national programme for IT: what can we learn from the Scottish experience? Informatics in Primary Care 2005;13:105-1.

Cite this as: BMJ 2009;338:b643

Letters

Volume 338

21 February 2009

428
NICE: alone in Europe but not the world

Assessments and appraisals are almost universal in developed countries, but, as a recent study by the European Observatory on Health Systems and Policies shows, only in England and Wales are they integrated with decision-making, legally binding, national in scale, and put into practice in a system with a single paymaster.1 This quote implies that the National Institute for Health and Clinical Excellence (NICE) is alone in the world in linking funding to health technology assessments, when rather it’s alone in Europe.

The Australian Pharmaceutical Benefits Scheme extends funding only to drugs that are shown to be cost effective. Unlike the NICE model, drug sponsors prepare the health technology assessments, which the Pharmaceutical Benefits Advisory Committee then put to review (via contracted groups in academic institutions).

Malcolm B Gillies medical writer, National Prescribing Service, Surry Hills, NSW 2010, Australia
mgillies@nps.org.au
Competing interests: National Prescribing Service is funded by the Australian Government Department of Health and Ageing.

1 Hawkes N. NICE goes global. BMJ 2009;338:b103. (28 January.)

Cite this as: BMJ 2009;338:b636

Could NICE anxiety guidelines be made more user friendly?

We recently audited the implementation of guidelines from the National Institute for Health and Clinical Excellence (NICE)2 on depression and anxiety disorders.3 4 We were struck by how complicated it was to implement the guidelines for anxiety disorders. For depression, we only had to consult one document,2 but for anxiety disorders, we had to consult three separate documents on anxiety, obsessive-compulsive disorders, and post-traumatic stress disorder.3 5 And they all say slightly different things.

We recognise that NICE has developed three sets of guidelines for these disorders because they are diagnostically distinct. However, this creates difficulties for the NHS, where non-specialists dealing with several different problem areas have to implement the guidelines.

To navigate a way through these guidelines requires a diagnosis. General practitioners mainly refer clients with anxiety disorders and are therefore crucial in implementing the stepped care model. However, diagnosing the different disorders (including severity) requires a lot more time than most of them have.

We call on NICE to think a little more about the implementation of clinical guidelines and about the role of time-poor clinicians assessing and deciding on treatment for already anxious patients. More training materials for the different anxiety disorders would be useful. In addition, a quick reference guide to managing the three anxiety disorders would make it easier for staff to implement these three similar but different sets of guidelines.

Louisa A Rhodes research worker, Institute of Psychiatry, Department of Psychology (PO77), London SE5 8AF louisa.rhodes@iopp.ncl.ac.uk
June S L Brown lecturer, Institute of Psychiatry, Department of Psychology (PO77), London SE5 8AF

Competing interests: None declared.


Cite this as: BMJ 2009;338:b653

NICE guidance on insulin pumps

Guidance on insulin pumps from the National Institute for Health and Clinical Excellence (NICE) recommends that such treatment should be started only by a trained specialist team providing structured education programmes.1 One of our young patients whose type 1 diabetes is managed with an insulin pump bent her insulin catheter while on holiday. Without a spare pump, she attended the accident and emergency department of the local hospital in the hope of being given insulin syringes or pens.

She told the doctors that she had not had any insulin for over four hours and needed some urgently. Her blood glucose concentration was 18 mmol/L.

Coincidently, the hospital has one of the largest populations of patients using insulin pumps in the UK. Despite this the doctors did not know what to do and suggested that they...
should monitor “what happens if we just wait.” Two hours later, still without insulin, her blood glucose had risen to 23 mmol/l. She had also become ketogenic and unwell, and had to be admitted overnight.

We provide patients with diabetes, especially those using insulin pumps, with structured education so that they can be in control of their condition at all times, just as NICE recommends.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

Efficacy of BCG: three quarters full or one quarter empty?

Davies states that BCG is “not a very effective vaccine” because a single immunisation gives “only 75% protection . . . for a maximum of only 15 years.”1

This overly pessimistic interpretation (“it protected only three out of four children”) is often trotted out in discussions of BCG without reference to other established vaccines. For example, in the “Green Book” Vi typhoid vaccine has an efficacy of 55-75% and oral typhoid vaccine “about 50-60%” (both must be boosted every three years); influenza vaccines offer “70 to 80% protection” against well matched influenza virus strains (less in elderly people) for only a year; and a single MMR shot confers 61-91% protection against mumps.2 Classic inactivated vaccines require multi-dose schedules and childhood boosters to achieve 80-90% rates of protection.

Whether BCG should be used in a general or targeted manner in the United Kingdom is open to discussion, but whether an efficacy of 75% that lasts a decade and a half after a single shot is “effective” when compared with other vaccines is not.

Competing interests: None declared.

1 Davies PDO. Why universal BCG in UK was deemed not necessary. BMJ 2009;338:b192. (21 January.)


Cite this as: BMJ 2009;338:b635

UNNECESSARY UNIVERSAL BCG IN UK

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644

UK RATIONING OF NEW MEDICINES

NICE should follow example of Scottish Medicines Consortium

As drug companies are in business to make money, surely it is not in their interest to withhold information that would support the introduction of their product? Therefore if they choose not to submit, the data on cost effectiveness are unfavourable, the safety of the drug is in question, or adequate information on the product is not yet available.

To suggest that patients may be deprived of useful drugs if the National Institute for Health and Clinical Excellence (NICE) does not give a judgment in cases in which drug company information is not forthcoming is to collude with the company and potentially support the introduction of an inappropriate drug.1 NICE should instead follow the example of the Scottish Medicines Consortium.

1 BMJ Group Awards—shortlisted candidates in nine categories. BMJ 2009;338:b129. (29 January.)


Cite this as: BMJ 2009;338:b644