Elderly patients are dying after surgery because of poor care, confidential review says

Susan Mayor LONDON

Only a third of elderly patients who died in UK hospitals within 30 days of undergoing surgery were considered to have received good care, warns an expert review of more than 800 cases by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), published this week.

The NCEPOD survey looked at the hospital care given to patients over the age of 80 who had had surgery and died within 30 days—most of whom had undergone emergency surgery. NCEPOD identified 1756 cases and sent out questionnaires concerning these. The hospitals returned 820 sets of case notes and 1120 surgical, 957 anaesthetic, and 283 organisational questionnaires.

The reviewers considered that only 38% of the cases they reviewed (295 of 786 complete sets of case notes) had received what they considered to be good care. More than two thirds of patients (653 of 965) had not been reviewed by specialists in the care of elderly people.

“Most patients were admitted as emergencies by very junior doctors without timely input of senior care-of-the-elderly clinicians,” said Ian Martin, NCEPOD’s clinical coordinator in surgery and the report’s lead author. “There is still a long way to go to ensure good practice and appropriate care—this is despite our advice in 1999 and recommendations in the 2001 national service framework calling for specialists to be involved at every stage of elderly care.”

NCEPOD advisers identified lack of acute pain services as a major factor in the poor management of some patients. The survey found that one in four hospitals responding to the inquiry (71 of 283) had no well resourced acute pain services.

The inquiry also found that poor nutrition and associated illness were common. Delays were also frequent, with clinically significant delays between admission and surgery.

An Age Old Problem: A Review of the Care Received by Elderly Patients Undergoing Surgery is available at www.ncepod.org.uk.

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Stafford inquiry will probe why external supervision systems failed

Clare Dyer BMJ

A public inquiry that opened this week will learn NHS-wide lessons from the scandal of Stafford Hospital, the lawyer chairing the inquiry pledged.

Investigations into the hospital, run by Mid Staffordshire NHS Foundation Trust, found that patients received “appalling” care and that more than 400 excess deaths occurred between 2005 and 2008.

“Opening the inquiry, its chairman, Robert Francis QC, said it was important to “keep at the forefront of our minds the terrible effect of the system’s failings on those it was meant to serve.” Mr Francis said he had listened to “many stories of appalling care” during the inquiry he conducted last year into failings at the hospital, which was heard in private.

“As I did so, the questions that went constantly through my mind were: why did none of the many organisations charged with the supervision and regulation of our hospitals detect that something so serious was going on, and why was nothing done about it?”

Among those expected to face public questioning are former health secretary for England Alan Johnson and Andy Burnham, in office during the previous Labour government. They commissioned investigations into the scandal but refused relatives’ demands for a public inquiry.

Last June, after the Conservative and Liberal Democrat coalition government took office, the new health secretary, Andrew Lansley, ordered the latest inquiry, which has power to compel witnesses to attend and give evidence. He told parliament, “I am confident that we will, for the first time in this tragic saga, be able to discuss conclusions rather than questions.”

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**Cardiologist Wilmshurst faces further claims of libel over radio comments**

Clare Dyer BMJ

Peter Wilmshurst, the British cardiologist who is being sued for libel by the US medical device manufacturer NMT Medical, faces a further libel claim by the company over remarks he made about defamation law during a BBC radio broadcast in 2009.

The original libel action against him, started in 2007 and still ongoing, was over comments he made to a US based medical website about the conduct of a clinical trial of the company’s STARFlex device. Dr Wilmshurst, a consultant cardiologist at the Royal Shrewsbury Hospital, was a lead investigator in the trial of the septal repair device for migraine.

Now NMT has sent him a letter before claim, threatening action over an interview he gave to the BBC Radio 4 Today programme in November 2009, which was part of an item on the chilling effects of English libel laws on scientific and medical discussion.

The new accusation comes as Dr Wilmshurst prepares to ask the High Court at the end of this month to order NMT to provide “security for costs” of £3.5m (€4.1m; $5.7m) as a condition of allowing its claim against him to go ahead.

In the English courts, where the loser is usually ordered to pay the winner’s costs, a party may seek such an order if, for example, the other party is a company incorporated abroad or someone with limited assets, making any costs order that might be made at the end of the case hard to enforce.

Dr Wilmshurst said the Today programme item had been pre-recorded “so the BBC lawyers could listen to it and make sure there was no libel.”

The Libel Reform Campaign, run by Sense about Science, Index on Censorship and English PEN, is calling for fundamental changes to the libel laws to protect scientific debate. Jonathan

**Doctors discuss why medical practice deviates from evidence**

Nigel Hawkes LONDON

When Sharon Straus, co-chair of Knowledge Translation Canada, made a presentation to a group of businessmen, they were bewildered. She explained that well established medical evidence, backed by double blind trials and systematic reviews, was often ignored by doctors.

“You say there’s evidence and these doctors aren’t using it?” asked one of those present. “Why don’t you just fire them?”

Professor Straus was speaking on the second day of Evidence 2010, an international conference at BMA House devoted to understanding why medical practice so often deviates from medical evidence and what might be done to narrow the gap.

Victor Montori from the Mayo Clinic in Rochester, Minnesota, set the scene by quoting a figure of $290bn (£181.4bn; €208bn), the money estimated by the New England Healthcare Institute to go to waste in the US healthcare system every year as a result of patients not taking medicines as prescribed.

“Only half of clinicians prescribe the right drugs, and half the patients who are prescribed them stop taking them,” he said. “So an intervention with the capacity to cut deaths by 25% only achieves 6%. Patients . . . suffer the side effects but don’t get the benefits.”

Dr Montori, a specialist in diabetes, said patients come to his clinic and say they are taking the drugs he prescribed. “I know they’re not, and they know I know they’re not, and I know they know I know they’re not,” he said.

“But nobody admits it. We’re both saving face and creating a gap in the relation between doctor and patient.”

Coercion through threats of dire outcomes for the non-compliant is doubly unethical, he said. “It doesn’t work, and highly anxious patients withdraw from care when threatened. They say, ‘I’m not going to see my doctor because I’ll be yelled at.’”

His strategy combines better explanations with the capacity to cut deaths by 25% only achieves 6%. Patients . . . suffer the side effects but don’t get the benefits.”

Dr Montori said the Today programme item had been pre-recorded “so the BBC lawyers could listen to it and make sure there was no libel.”

The Libel Reform Campaign, run by Sense about Science, Index on Censorship and English PEN, is calling for fundamental changes to the libel laws to protect scientific debate. Jonathan
Heawood, director of English PEN, said, “It seems odd to be suing someone now for comments they made almost a year ago. At this rate, the only option for Peter Wilmshurst seems to be total silence on the subject, which would go against his public spirit and his integrity as a scientist.”

NMT’s solicitor, Robert Barry, said, “It’s another instance of defamation which we’re adding to the case. It’s another example of Peter Wilmshurst defaming our client and doing it on prime time radio to millions of listeners.”

The government has pledged to reform the libel laws and is looking at what any new bill should cover. The attorney general, Dominic Grieve, told a meeting at the Conservative party conference last month that the coalition “will not shirk” reforming the law.

He said the private member’s bill on defamation drawn up by the Liberal Democrat peer Anthony Lester QC largely reflected ministers’ thinking. Lord Lester’s bill would require corporate bodies to show that the publication had caused or was likely to cause them substantial financial loss before they could sue and contains a provision intended to curb libel tourism.

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not leave the patient spending hours each day organising his pills and arranging tests and appointments. For a diabetic patient with multiple comorbidities, doing this can turn into “a part time job,” Dr Montori said.

Paul Glasziou, a GP and former director of the Centre for Evidence-Based Medicine at Oxford, said that GPs could not hope to be experts in every condition they were likely to meet. Although half a GP’s consultations would be about just 30 common conditions, the other half would cover at least 800 other diseases.

“Some we’ve got to learn about when the patient walks through the door,” he admitted.

The evidence for treating all of them existed but was not always readily accessible.

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Key players for new GP led commissioning are quitting NHS jobs

Adrian O’Dowd LONDON

Expert managers in primary care trusts who could provide invaluable help to the new GP led commissioning consortiums are already accepting redundancy, MPs have been told.

Doctors’ leaders giving evidence to the parliamentary health select committee on 2 November warned that the government should ensure there was a managed transition to the new NHS arrangements in which GP consortiums will control most of the NHS budget.

The worry was that expert managers were already leaving and might have to be re-employed by GP consortiums at a much higher cost from private sector companies.

MPs on the committee quizzed doctor representatives as part of their inquiry into how the government intends to implement changes to commissioning in the NHS through policies in the health white paper.

Richard Vautrey, deputy chairman of the BMA’s GP committee, giving evidence, said the BMA had serious concerns that senior primary care trust managers were leaving their jobs and taking redundancy.

“One of the things that has often been misunderstood about this process is the idea that GPs are going to be running everything, doing everything, and managing everything,” he said. “There will be a very small number of GPs directly involved in management and leadership, but the bulk of the work will be done by expert lay managers and we hope the very people who are involved in the NHS now will be retained.

“What we don’t want to do is for the best managers to leave and go to large multinational firms only then to have to hire them back at an inflated rate of pay. We’ve already got examples where whole departments of people have accepted redundancy terms. We need to have a managed transition.”

MPs asked how the witnesses viewed the double challenge being faced by the NHS of making an expected £15bn (£17.3bn; $24bn) to £20bn worth of efficiency savings by 2014 while setting up a new GP led commissioning system.

The witnesses said that by engaging the clinical community more actively in the commissioning process the Department of Health was enhancing its chances of delivering the efficiency gain that it needed.

Dr Vautrey said that, by getting more involved, health professionals “will hopefully achieve some of those savings and enable us to reinvest resources in better care pathways.”

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Celebrating life

Nigel Hawkes LONDON

Letters written by organ recipients to the families of the donors have been collected and published as a celebration of organ donation.

Moving, emotional, and sometimes awkward, the letters express thanks for the years of life gained through a stranger’s donation. “This has not been an easy letter to write,” admits Helen Eccles (pictured left), who had a liver transplanted two days after her daughter Ella (right) was born.

She writes again 10 years later, when Ella was 14, saying that one of the legacies of being a transplant patient is that she appreciates the small things in life as well as the more sublime. “The ability to delight in the mundane and to live in the ‘Now’ becomes more and more central,” she says.

Thank You for Life was inspired by Andrew Burroughs and Linda Selves of the Royal Free Hospital, London, and is published by the Royal College of Physicians and the Department of Health.


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Food chains still promote unhealthy choices to children despite pledges to change, study finds

Bob Roehr DENVER
A study of the 12 largest fast food chains in the United States has criticised the energy, sugar, fat, and sodium content in the foods they market to children. Its authors hope that a combination of public outrage and the threat of new laws and enforcement of existing laws on truth in advertising may bring about the changes they seek.

The report, by the Rudd Center for Food Policy and Obesity at Yale University, was presented on 9 November at the 138th annual meeting of the American Public Health Association in Denver.

It found that every day a third of US children and teenagers eat fast food; it is the source of 16-17% of the energy intake of adolescents. Furthermore, those companies “have been front and centre in making pledges to market less unhealthy food to children,” said Kelly Brownell, the centre’s director.

The US fast food industry spent more than $4.2bn (£2.6bn; €3bn) on marketing in 2009, said Jennifer Harris, one of the authors. The exposure to advertising begins when children are as young as 2 years old.

“Some of it is targeted to children specifically, but just as important is their secondhand exposure to ads for adults,” which in fact are most of the advertisements they see, said Dr Harris. These advertisements promote larger portions and sugary drinks.

“The two fast food companies that have pledged to reduce unhealthy marketing to youth—McDonald’s and Burger King—have actually increased the number of ads that they show to children on television,” Dr Harris said. “Their child targeted marketing is rarely about the food; it is about building brand loyalty. In general the message to kids is the fun experience [of going to those places].”

She did acknowledge that the companies have done better in terms of providing healthier food alternatives where once none existed. The centre analysed 3039 possible children’s meal combinations and found that only 12 met the criteria for older children.

The study’s “mystery shopper” field researchers visited fast food locations to examine in-store marketing and the default combinations of food for children.

Marlene Schwartz, another researcher on the project, said, “In the majority of cases they were automatically given an unhealthy side dish and soft drink, with no healthy alternative offered by the sales person.”

The Subway sandwich shop chain was the only one where the default drink for the children’s meal package was milk or fruit juice rather than a soda drink.

Changing the default side dish, drink, and size of the portions is the first thing the companies could do to improve the healthiness of their products for children, said Dr Harris.

The centre also wants to change the definition of television programmes that require restrictions on advertising. Rather than the current standard of whether the programme is created solely for children, it wants a broader standard, such as the total number of children that watch a programme. That would extend the reach of child advertising guidelines to such popular shows as American Idol and Glee.

The Fast Food FACTS (Food Advertising to Children and Teens Score) report and supporting materials for consumers are available at www.fastfoodmarketing.org.

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Drug companies to declare all payments to doctors from 2012

Jo Carlowe LONDON

Doctors have welcomed changes to the UK drug industry’s code of practice, which requires companies to make an annual declaration of how much money they have paid to doctors for use of their services.

The ruling is part of several amendments to the Association of the British Pharmaceutical Industry (ABPI) code of practice.

The changes will see each drug company declare the amount and the number of times payments were made to doctors, including speaker fees, advisory boards and consultancy, and sponsorship for attendance at meetings.

The first declaration will be made in 2013 for payments made in 2012. The code, however, does not require individual doctors to be named.

Another change to the code, which comes into effect on 1 January 2011, will ban the pharmaceutical industry from providing branded promotional items, such as headed stationery, mugs, and pens, to healthcare professionals. Only inexpensive items to be passed on and used by patients as part of a formal patient support programme will be permitted.

Health professionals may still get pens and notebooks at conferences, but these will not bear the name of any medicine, only the name of the company providing them.

And the rules over joint working between the NHS and the pharmaceutical industry are also redefined—with an emphasis on ensuring that any joint working does not “constitute an inducement to health professionals. . . to prescribe, supply, recommend, buy or sell any medicine.”

The changes are aimed to increase transparency of working practices between the drug industry and healthcare professionals and were prompted in part by a report published in 2009 by the Royal College of Physicians called Physicians and the Pharmaceutical Industry.

Among its recommendations, the report called for a curb on gifts to doctors, stating: “In the spirit of a more balanced and mutually respectful partnership, all gifts to doctors, including food and travel, become untenable and should end.”

The changes to the code have been well received by clinicians.

Steve Field, chairman of the Royal College of General Practitioners, said, “I welcome the increased transparency. Pharmaceutical companies should not influence doctors’ prescribing decisions made in the surgery, which should be based on evidence and should be impartial.”

And he lauded the end of “freebies” to doctors. “For many years I have thought that the trinkets that the pharmaceutical industry gives to doctors are patronising and the receipt of these by doctors demeaning,” said Professor Field.

Nonetheless, he acknowledged that a close working relationship between the drug industry and the NHS was important.

“These new rules should help increase the trust that patients, the public, and doctors have in what, after all, is an important part of the nation’s business and industrial base,” he said.

Simon Jose, president of the ABPI, said: “We operate in a world where customers’ and society’s expectations of our industry have increased, and it is only right that we adapt to this. We want to shift the debate to focus on how we can improve health outcomes for patients through science and innovation.”

Two German doctors are convicted of taking drug company bribes

Annette Tuffs HEIDELBERG

Two doctors in Germany have been convicted of bribery for accepting money from a drug firm for prescribing its drugs.

The two non-hospital doctors were found guilty at the district court in Ulm of accepting €19 000 (£16 400; $26 400) in return for prescribing generic drugs made by the company Ratiopharm. The two doctors have appealed against the suspended sentence of one year in prison and a fine of €20 000.

However, the court decision has been hailed as a breakthrough in the fight against bribery, because up to now it seemed that it was possible to charge only hospital doctors with accepting money or gifts for prescribing drugs.

The legal loophole arose from the fact that the choice of drugs made by hospital doctors was seen to financially affect their institution, whereas the choice made by doctors who had their own practices (in Germany this includes GPs and specialists) was considered to affect only the doctors themselves. Furthermore, until now doctors with their own practices were not thought to be answerable to the state health insurance companies and therefore, it was determined, couldn’t be charged with bribery.

The court in Ulm has taken the view that doctors are answerable to the health insurance companies after all. The two doctors had prescribed drugs from Ratiopharm and were paid according to the amount they prescribed. Ratiopharm makes only generic drugs, but its products are more expensive than those of rival generic producers. Therefore health insurance companies had had to pay more.

The court’s decision may be the first in a series of similar cases in the wake of an investigation by Stern magazine into a major alleged bribery scandal. After the magazine’s disclosures police raided the flats of 400 drug company sales representatives all over Germany and searched more than 2000 doctors’ practices. Police found that it was common practice for doctors to have accepted money or gifts such as coffee machines or table lamps.

However, many district attorneys dropped their initial investigations because of the perceived legal loophole.

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Acute respiratory infections are world’s third cause of death

Susan Mayor LONDON

Acute respiratory infections such as pneumonia, flu, and respiratory syncytial virus are responsible for 4.25 million deaths worldwide each year, new figures show.

The data from the World Lung Foundation’s first Acute Respiratory Infections Atlas show that acute respiratory infections are the third largest cause of deaths in the world (after heart disease and stroke) and the leading killer in low and middle income countries. But despite the high death toll and morbidity, respiratory infection gets only a fraction of the support from governments, donor agencies, and charities that other illnesses receive, says the foundation.

However, the four million figure is likely to be an underestimate, said the charity, because of poor surveillance data in many countries.

Peter Baldini, the foundation’s chief executive officer, said that despite the high death toll the global health community does not recognise respiratory infections as a distinct disease group.

“The goal of the Acute Respiratory Infections Atlas is to demonstrate in vivid detail the scale of this problem and to kickstart a serious conversation about addressing it,” he said.

Mr Baldini said that directing relatively modest resources to improving the prevention and treatment of acute respiratory infections could save millions of lives.

The atlas says that more needs to be done to educate the public about the signs of serious respiratory disease and how to control infection; to improve nutrition of people on low incomes; and to reduce air pollution and smoking.

It warns that children with HIV are 40 to 50 times as likely to develop pneumonia as other children, are less likely to respond to treatment, and are three to six times as likely to die from pneumonia as a child without HIV.

The atlas is available at http://ARIAtlas.org.

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Official resigns amid prostate screening controversy

Jeanne Lenzer NEW YORK

An officer with a federal US health agency is resigning his position amid a controversy about who should be screened for prostate cancer.

Kenny Lin, a family physician and medical officer with the Agency for Healthcare Research and Quality, which provides scientific support to the US Preventive Services Task Force, wrote in his blog that “politics trumped science” after a two day meeting that was due to begin on 1 November was abruptly cancelled (http://commonsensemd.blogspot.com/2010/11/meeting-wasnt-and-surprise.html).

The task force was about to vote on recommendations about prostate cancer screening and was likely to have come down against its routine use in men of all ages. If it had done so it could have sparked a controversy similar to the one last year when the agency said that women aged 40-49 should not have routine mammography for cancer and instead suggested that women discuss it with their doctors (BMJ 2009; 339:b5012).

Karen Migdail, a spokeswoman for the agency, told the BMJ that the reason the meeting was cancelled was purely a “scheduling conflict” and that the meeting has been rescheduled for March 2011.

An article in the Wall Street Journal (http://blogs.wsj.com/health/2010/10/26/prevention-task-force-cancels-nov-meeting-would-have-included-prostate-screening-vote) said that taskforce members cast a preliminary vote in November last year to give routine prostate cancer screening a “D” rating for men of all ages, which means the taskforce “recommends against the service, [as] there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits” (www.uspreventiveservicestaskforce.org/uspsf07/ratingsv2.htm). But the taskforce opted instead to vote again.

The current taskforce rating on prostate cancer screening is “I,” meaning that the taskforce found insufficient evidence to recommend either for or against screening, except for men aged 75 years or older, for whom it issued a “D” rating.

The agency, formerly known as the Agency for Health Care Policy and Research, has previously come under attack. In the early 1990s it angered the North American Spine Society after it published several studies indicating that spinal fusion surgery was often ineffective and sometimes harmful.

The society, which is heavily funded by device manufacturers, attacked the agency and lobbied Congress, which in turn voted in 1995 to eliminate the agency’s budget. The American Medical Association fought back on behalf of the agency, and 75% of the original budget was restored, but the agency stopped issuing practice guidelines.

Jerome Hoffman, professor of emergency medicine at the University of Southern California, Los Angeles, told the BMJ that it would be extremely disturbing if outside pressure meant that the task force failed to change its recommendation to D.

Cite this as: BMJ 2010;341:c6346

US Republicans take aim at health reform after electoral gains in mid-term elections

Janice Hopkins Tanne

NEW YORK

Republican victories in the US mid-term elections on 2 November are likely to result in attempts to repeal or gut the health reform act passed by the US Congress in March.

In the elections Barack Obama’s Democratic party lost control of the House of Representatives but kept control of the Senate. The victors—including members of the Tea Party group, who are nominally Republican but more right wing than the party mainstream—will take office in January, a few weeks after more reforms required by the act take effect.

Repeal of health reform is unlikely, as President Obama can veto such a bill. However, the Senate minority leader Mitch McConnell (Republican, Kentucky) was widely quoted as saying that Republicans would try to cripple the act by removing funding for its provisions.

Although the health reform gives Americans new health insurance protections, and some popular changes have been in effect since September, many Americans don’t support the law. Major insurance protections and
changes will take effect in 2014—after the next presidential election in 2012.

Other changes occur sooner. For example, in 2011 the act calls for employers to report the amount they paid for a worker’s health insurance on a standard tax form. It also requires health insurance plans to spend 80% or 85% of the premiums they receive on providing healthcare. Under the Medicare insurance scheme for elderly people a website reporting on the quality of doctors will be set up. And the Center for Medicare and Medicaid will have a new innovation centre testing reforms and to reward healthcare providers for quality of care, somewhat similar to the National Institute for Health and Clinical Excellence in the United Kingdom.

These programmes require funding, and President Obama may face a difficult situation if Republicans attach an amendment to the bill preventing funding of such health reforms. Republicans can also obstruct health reform by calling on administration executives such as Kathleen Sebelius, the federal secretary of health and human services, and Donald Berwick, head of the Centers for Medicare and Medicaid Services, to testify at frequent and time consuming hearings.

The health insurance industry did not support the Republican and Tea Party protests. The health reform means that the industry gains about 31 million new customers, because the legislation requires everyone to have health insurance by 2014 and provides subsidies for middle and low income families and some small businesses.

John Zarocostas GENEVA
Although the global burden of tuberculosis is slowly falling, more intense efforts are needed to save an estimated five million lives between 2011 and 2015, a World Health Organization report says.

Efforts to plan, finance, and implement the Stop TB strategy need to be scaled up, says the report. For the strategy to be effective, diagnosis and treatment of tuberculosis need to be expanded, more care providers need to be engaged in control of the disease, and surveillance of its incidence, prevalence, and mortality needs to be strengthened.

The latest WHO data show that between 1995 and 2009 a total of 49 million people had tuberculosis, about 41 million of whom were successfully treated through the Stop TB strategy.

In 2009 there were an estimated 9.4 million cases of tuberculosis, equivalent to 137 cases per 100 000 population, down from a peak of 142 cases per 100 000 in 2004.

But the report says that a lot more needs to be done to increase the rate of detection of cases. Last year an average 63% of the estimated number of new cases of tuberculosis were diagnosed and notified to national surveillance systems, up from 56% in 2005. Although detection averaged a high of 80% in the European region, it was just 50% in the African region.

Mario Raviglione, director of the Stop TB department at WHO, told the BMJ, “We still have a gap of one third” between the number of estimated cases and the number notified.

WHO officials say that one of the best ways to increase detection is for national tuberculosis control programmes “to establish collaboration with the full range of healthcare providers.” New data for 2010 from 15 countries show that mixed public-private sector approaches can help boost case detection rates.

Most of the cases in 2009 were in Asia (55%) and Africa (30%), with fewer cases in WHO’s Eastern Mediterranean region (7%), the European region (4%), and the Americas (3%). The countries with the largest numbers of cases last year were India (two million), China (1.3 million), South Africa (690 000), Nigeria (460 000), and Indonesia (430 000).

The report says that the rate of successful treatment of new cases in the 2008 cohort (2.6 million patients) was 86% overall worldwide and 87% in the 22 countries with a high burden of the disease. The Global Tuberculosis Control 2010 report is available at www.who.int/tb.

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