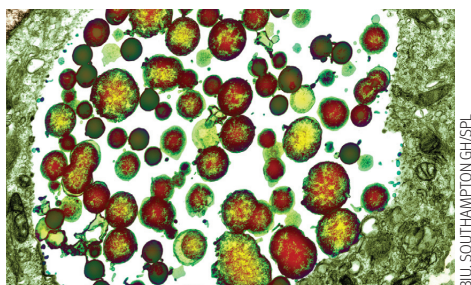


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LETTERS



BIU, SOUTHAMPTON GH/SPL

CHLAMYDIA SCREENING

Time for action on chlamydia

Chlamydia is an important sexually transmitted infection in young people. Rates have been rising steadily over the past decade. Treatment is available and easy to take without many side effects. And young people are rightly worried about chlamydia. The complications, although perhaps not life threatening, can be devastating in later life. Try to explain to a couple in their 30s that they can't have children because of a previous undiagnosed chlamydia infection.

We can look for more and more evidence and do more and more research, all costing a lot of money and delaying any disease control project for many more years. Currently in Lambeth we are screening high numbers of young people, male and female, and our detection rate for chlamydia is above 10%. Practices are paid a small incentive when they manage to screen 10% of young people on their list. Many practices do so, and many do even better. Articles such as that by Low do not help the cause: they only create confusion and feed scepticism.¹

We need optimism. Simple measures would increase the screening target, and, yes, it would be easy to change screening from being opportunistic to proactive. Very simple: make it a quality and outcomes framework. Change the specimen request forms, integrate requests for chlamydia screening with the usual generic pathology forms. This would save a lot of hassle and increase the compliance of clinicians.

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Competing interests: None declared.

1 Low N. Screening programmes for chlamydial infection: when will we ever learn? *BMJ* 2007;334:725-8. (7 April.)

CORONARY ARTERY DISEASE

Case for angioplasty to treat angina

The COURAGE trial results show that patients with stable coronary artery disease who have a good quality of life while receiving medical treatment do not require an angioplasty.¹ Coronary angioplasty in the United Kingdom is generally used to treat stable patients who have angina while receiving medical treatment. This trial therefore has little relevance to UK practice.

Of patients randomised, 43% had little or no angina. In addition, one third of patients in the "optimal medical treatment" arm had an angioplasty by 4.6 years, presumably because of angina while receiving optimal medical treatment. It would be interesting to know how many of these patients started the trial with important (class II or III) angina. The trial may actually show that most patients with class II or III angina will require an angioplasty within five years because optimal medical treatment will not control their symptoms. The primary end point of death or non-fatal myocardial infarction is peculiar and was designed to see angioplasty fail. Interventional cardiologists have never argued that angioplasty affects mortality or reduces the incidence of myocardial infarction. The only patients in whom angioplasty may have a chance of producing this effect, those with left main or severely reduced left ventricular function, were excluded from the trial.

Most coronary angioplasty in the UK is used to treat patients with unstable syndromes, including acute myocardial infarction, rather than patients with stable angina. Interventional cardiologists in the UK will continue to use optimal medical treatment and angioplasty will remain the dominant mode of revascularisation for the foreseeable future.

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Competing interests: None declared.

1 Mayor S. Drugs are as good as PCI in stable coronary artery disease, study shows. *BMJ* 2007;334:713. (7 April.) doi: 10.1136/bmj.39174.633403.DB

Case presented does not wash

COURAGE comes hard on the heels of a recent cost effectiveness analysis that showed that the huge costs of angioplasty compared with medical treatment could not be justified.^{1,2} The study confirms that angioplasty does not improve prognosis in patients with stable angina, and this should clarify a common misunderstanding in the minds of commissioners and patients.³ Thomas (previous letter) notes that 43% of patients in the COURAGE study had little or no angina. It is worrying that such patients should have been exposed to the risk of harm that is inherent in palliative angioplasty, but the proportion of patients randomised to palliative angioplasty in the landmark RITA trial was 45%.⁴

The finding that one third of the COURAGE patients randomised to medical treatment later underwent angioplasty should be balanced by the fact that 20% of the angioplasty group also underwent further angioplasty during follow up. Given the common practice of recommending angioplasty to patients who do not have significant angina, a high proportion of these patients probably had little or no angina.

Thomas argues that most angioplasty procedures in the United Kingdom are used to treat patients with unstable syndromes. Yet the national audit data presented to the 2006 annual meeting (www.bcis.org.uk) showed that 56% of the 70 142 angioplasty procedures in 2005 were for stable angina. COURAGE and the data provided by Griffin et al² combine to suggest that most of these were a costly waste. In the current value for money climate, primary care trusts will be obliged to look much more carefully at the resources they commit to the 40 000 or so palliative angioplasty procedures currently undertaken.⁵

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Competing interests: The National Refractory Angina Centre provides advice and training to commissioners who want to rationalise palliative revascularisation costs.

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TRANSPARENCY IN NICE

Construction and assumptions of models should be explicit

The National Institute for Health and Clinical Excellence (NICE) uses Markov modelling, a form of decision analysis that models the effectiveness and cost effectiveness of drugs or other medical interventions in a cohort of patients over time.^{1,2} Construction of a Markov model relies on judgments of the likely outcomes of drug treatment, including benefits and harms.

I was asked to comment on the updated hypertension guidelines produced by NICE and the British Hypertension Society (BHS) on behalf of the Royal College of General Practitioners as part of the consultation process in spring 2006. Drug treatment for hypertension is a controversial area as guideline recommendations between the United States and the United Kingdom differ in the interpretation of recent randomised trials comparing newer and older antihypertensive agents.³

My comments related to the transparency of the Markov assumptions, including preferential modelling of diabetes as an adverse health state, failure to model differential withdrawals in different antihypertensive agents, and lack of probabilistic sampling in relation to effect size estimates for different classes of antihypertensive agents. None of these suggestions were tackled in the published report, and no comments were made. This is in marked contrast to the methods adopted by the Scottish Intercollegiate Guidelines Network (SIGN), which hosts an open meeting and incorporates consultation and peer review comments in an explicit manner (www.sign.ac.uk).

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Competing interests: None declared.

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CLOSTRIDIUM DIFFICILE

Data on alcohol hand rubs are equivocal

Data on alcohol hand rubs and *Clostridium difficile* are scant and controversial.¹ Bettin et al evaluated the efficacy of liquid soap v chlorhexidine gluconate in 4% alcohol to decontaminate bare or gloved hands inoculated with an epidemic strain of *C difficile*, and found that the two agents did not differ significantly in residual counts of *C difficile* on bare hands, but on gloved hands soap wash was more effective.² Studies on the impact of the introduction of alcohol hand rub policy on *C difficile* incidence are also controversial. Gopal Rao et al found a consistent, though not significant, reduction in methicillin resistant *Staphylococcus aureus* (MRSA) infection and *C difficile* associated diarrhoea.³ King found a reduced MRSA incidence and an increased *C difficile* incidence,⁴ and Boyce et al found essentially no change in the incidence of *C difficile* infection.⁵

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Competing interests: None declared.

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INSTITUTIONAL RACISM

What about stigma, evidence base, and consistency?

If institutional racism is defined as a collective failure that disadvantages people in ethnic minority groups, why is actively treating people for severe illness seen as evidence of such?¹ Were this treatment for hypertension, diabetes, or sickle cell

anaemia, it would be considered a well targeted intervention.

Admission rates and length of stay in mental health do not reflect illness prevalence but the severity and social disruption generated by that illness. Delays in seeking care (and increased Mental Health Act usage) reflect social isolation and stigmatised attitudes.² And were institutional racism the dominant engine of admission, why is it so differentiated in the races it selects?

Did the survey collect ethnicity data on the mental health staff on the wards and in the community teams, where there is a high rate of black and minority ethnic employment? Would that be indicative of institutional racism, or would it be indicative of culturally competent care?

If there is anything to be understood from this editorial, it is that severe mental illness, requiring hospital care, remains deeply stigmatised; that intervention is presented as coercion; and that those working in mental health, whatever their ethnic background, should argue vociferously for proper funding for wards, community teams, and the promotion of mental health for all.

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Competing interests: None declared.

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INTIMATE PARTNER VIOLENCE

Gender neutrality is crucial

The idea that intimate partner violence affects only women remains gospel to some people, which means that male victims suffer a lack of understanding and recognition.¹ Staff involved in this work need to be taught to recognise the injury patterns of intimate partner violence in men as well as women, provide information and support in their workplace, and not fail a considerable proportion of the very group of people they should be helping.

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