

LETTERS

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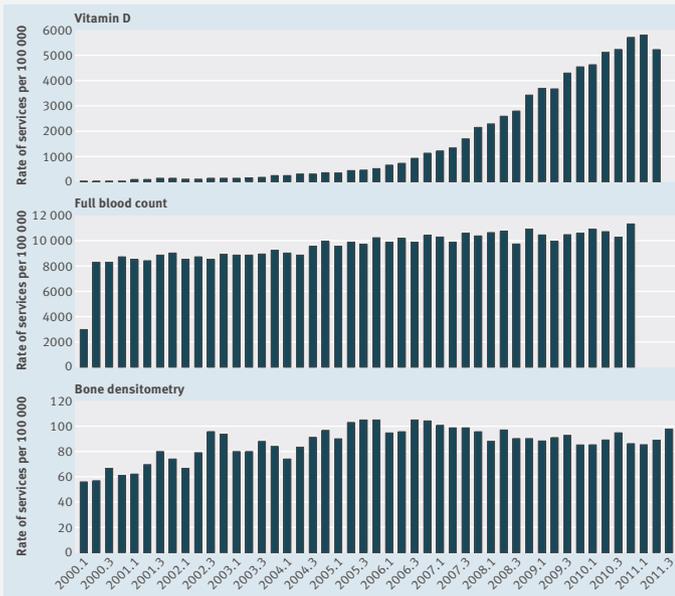
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PREVENTING OVERDIAGNOSIS

The rise and rise of vitamin D testing

Moynihan and colleagues' report highlights the increasing trend for overdiagnosis, particularly of endocrine disorders.¹

Similar concerns exist for overdiagnosis and overtreatment of vitamin D deficiency.²⁻³ Currently, the appropriate timing and frequency of testing for the diagnosis of vitamin D deficiency is unclear. The cost of testing



Requests per 100 000 for vitamin D, full blood count, and bone densitometry between 2000 and 2011

in Australia increased from \$A1m (£0.66m; €0.83m; \$1m) in 2000 to \$95.6m in 2010, on average 59% each year.² Similarly, in Ontario, Canada, testing increased 25-fold from 2004 to 2010. Projections suggest that \$C150m (£95m; €120m; \$147m) will be spent on vitamin D testing in 2012, up from \$38m in 2009.⁴ Similarly, the UK has seen a sixfold increase in such tests between 2007 and 2010.⁵

Our data show that the past 11 years have seen an unsustainable growth in vitamin D testing in Australia (figure). These findings have widespread consequences in terms of quality of care, unnecessary cost, and potential overdiagnosis. Further studies are needed to determine whether this increased testing translates into improved vitamin D status in the population and subsequent health outcomes. Worryingly, however, this large increase in vitamin D testing did not translate into increased testing for osteoporosis, as shown by the flat trend in bone density measurements (figure).

Guidelines are urgently needed to limit overtesting, overdiagnosis, and as a consequence overtreatment for vitamin D deficiency.

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POST-MARKETING STUDIES

Contributions to medical knowledge can be important

My experience in collaborating with various drug companies in the design, execution, analysis, and publication of post-marketing surveillance (PMS) studies differs greatly from that described in your recent article.¹ The general consensus was that PMS studies serve a scientific purpose. Studies typically had predefined scientific questions and were powered to answer them. Some studies had been recommended by the regulatory authorities, such as ones investigating tolerability in high risk subpopulations,² underlying pathophysiology of disease,³ and disease assessment tools.⁴

Properly designed PMS studies are not scientifically inferior to randomised controlled trials—they just serve a different purpose. Being closer to real life, they often reflect a broader

spectrum of patients, and because per patient costs are lower, can often recruit larger numbers of patients than would be possible in trials. Their main disadvantage is the lack of a control group, but that can be partly overcome.⁵ This results in lower internal validity but greater external validity than with trials. Although they cannot be used to make claims about the absolute efficacy of a given treatment, the often large numbers of patients can allow the analysis of subpopulations or the application of multiple regression models to analyse potentially related variables with adequate statistical power.

I do not claim that in the past PMS studies have not been used as marketing tools disguised by poor science. Investigators, drug companies, and journal editors are all responsible for ensuring that only PMS studies with relevant scientific questions and methods are performed and published. Such PMS studies can make important contributions to medical knowledge.

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COOL HEADED CLINICIANS

Imperturbability is not incompatible with empathy

Sokol misrepresents what empathy means and creates the idea that imperturbability is incompatible with genuine clinical empathy.¹

Empathy is a complex multidimensional concept that has moral, cognitive, emotive, and behavioural components. It involves the ability to understand the patient's situation from his or her perspective and communicate that understanding in a helpful (therapeutic) way.² It is a powerful clinical skill that can be taught with specific communication skills training. It is not the ability to cry with someone but to convey to that person that you are attuned to his or her emotions. It does not require the doctor to have those feelings too. Sokol is describing sympathy and not empathy.

Doctors who are trained to be empathic have a positive effect on the patient experience because they convey genuine regard rather than the often stereotyped image of the cold distant professional.

In a highly charged situation imperturbability is indeed an effective quality, but is more likely to be gifted to an empathic person who can see things from another person's point of view.

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LYME BORRELIOSIS

Doctors need accredited information

The recent focus on Lyme borreliosis helps raise awareness at a time of year when incidence is highest and there is increased need for vigilance.¹ However, there appears to be a missed opportunity in terms of the quality and bias of information provided.

The true incidence of Lyme disease in the UK is unknown but is certainly higher than thought. On the basis of a clinical diagnosis of erythema migrans rash, an audit at a highly aware GP practice in Scotland found an incidence of 370 per 100 000 population compared with the laboratory confirmed 17 per 100 000 in the surrounding area (personal



communication). Although this was a small sample, it is possible that 95% of cases do not enter official statistics.

Duncan and colleagues quote the British Infection Association (BIA) position paper and recommend it as useful reading²: "Erythema migrans occurs in 90% of symptomatic Lyme borreliosis 2-40 days after exposure." This misleading statement is based on unreferenced surveys in continental Europe, where doctors and the public are more aware of the importance of the rash. Notably, two studies of UK patients treated for Lyme disease found that 77% and 65% reported an erythema migrans rash.^{3,4}

This is not the only important point where the BIA statement misleads. A full comment on the BIA paper, written at the request of the BIA president so it could be put before the BIA council for consideration, can be read on the Lyme Disease Action website.⁵

It is a pity that the resources recommended to doctors are unaccredited (BIA paper, Health Protection Agency website) or geared towards the US (Wolters Kluwer Health). Doctors could more usefully be directed to the Lyme Disease Action website, which is accredited to the Department of Health's Information Standard.

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Competing interests: None declared.

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May manifest as ocular inflammation

Lyme disease has several important ophthalmic manifestations that are important to highlight.¹

Self limiting follicular conjunctivitis is probably the most common early ocular manifestation and occurs within the first few weeks of infection in around 10% of patients. Periorbital oedema has also been reported in the early stage.^{2,3} Other ocular manifestations include anterior, intermediate, and posterior uveitis; keratitis; and episcleritis.³

Among all cases of uveitis, Lyme disease was the underlying cause in 4.3% of patients, and all patients with Lyme uveitis had posterior ocular manifestations, such as vitritis, retinal vasculitis, or neuroretinitis.⁴

Photophobia and severe periodic ocular pain can be characteristic symptoms of Lyme borreliosis.³ Doctors should be aware that patients presenting with eye pain, redness, photophobia, or reduced visual acuity could have ocular manifestations of Lyme disease.

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- Competing interests: None declared.
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MAY CONTAIN NUTS

Common treatment for epistaxis contains peanut oil

The recent 10-minute consultation on epistaxis offered some sound advice.¹

The suggestion of prescribing 0.1% chlorhexidine/0.5% neomycin cream is a well accepted practice within the ear, nose, and throat community. A study in children with recurrent epistaxis found antiseptic cream to be a suitable treatment,² whereas a Cochrane review concluded that the optimal management is unknown.³

Doctors should ask all patients if they have a peanut allergy before prescribing this cream because it contains peanut oil (arachis oil). A UK survey found that only 62.6% of ear, nose, and throat consultants and 87.3% of registrars ask their patients this question.⁴ Mupirocin 2% may be considered as an alternative.

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Competing interests: None declared.

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FIVE YEARS AFTER BABY PETER

GPs' role in safeguarding children

The debate between Spence and Masters about whether the modern GP is a key player in safeguarding children from abuse and neglect risks polarising this discussion and wasting the opportunity to make better use of the systems we have.¹

Child maltreatment is common and often chronic, but many affected children only occasionally, or never, reach the threshold for investigation or intervention by child protection services.² The health professional's role must therefore go beyond identification and referral to social care to include a breadth of responses. This includes recording concerns in the electronic health record, discussing the matter with colleagues, monitoring, information gathering, and, for GPs, regular practice meetings to discuss management of vulnerable families.³ GPs, unlike teachers or other health professionals, see multiple family members and can identify risk factors in the parents, such as substance misuse or mental health problems. A Danish study found that more than half of the cases of a child in need discussed by participating GPs had come to their attention through consultations with the parents and subsequent reflection.⁴

Even if modern GPs do not know families in the way they used to, consistent data recording would support the continuity of care and build up a cumulative picture of concern. On the basis of a collaborative project with the Royal College of General Practitioners, we propose a simple and feasible way to improve recording of safeguarding concerns in electronic GP records,⁵ with a pragmatic and easy to use recommended coding list available at: www.clininf.eu/childmaltreatment-codes.html.

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PRIMARY-SECONDARY CARE DIVIDE

Answer is not more specialist physicians in community

I agree with Hughes that everyone involved with caring for elderly people should be aware that "the urgent admission to hospital of a vulnerable old person in crisis must be questioned at all times."¹ However, putting more specialist physicians into the community may not solve the problem. This proposal might improve elderly people's independence and quality of life, but it won't stop them being admitted late in the evening when they feel unwell and a neighbour or concerned person isn't sure what to do. I suggest:

- The government puts more money (real money, not fudged budgets) into out of hours primary care, community physiotherapy, and occupational therapy.
- Having done this (and not before), the government reimposes the obligation for general practice to provide 24/7 care for patients.
- Commissioners encourage specialists to provide rapid access assessment clinics for elderly people, including domiciliary visits if needed.
- The registration of all care homes should require that admission assessments of residents include an explicit agreement about what to do in the event of acute illness. Admission rates of patients from care homes should be monitored and those with rates well above average visited by the appropriate regulator.



ROB WHITE

- Emergency ambulance crews are given explicit guidance about the admission of elderly people from care homes. In particular, crews should ask staff, residents, and relatives: "how do you think the person will benefit from being admitted to hospital as an emergency?"

Accusations of ageism may inhibit such conversations, but local health organisations and the NHS need to be upfront about why this discussion is necessary.

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1 Hughes J. The primary-secondary care divide fails older patients. *BMJ* 2012;344:e4009. (14 June.)

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Integrated care reduces deaths of elderly people in hospital

We agree that more integrated medical care is needed in the community.¹ Many patients in residential and nursing homes lack access to appropriate medical care. This can lead to unnecessary hospital admissions and patients' lives ending needlessly in hospital. Various models for delivering medical care in nursing homes have been proposed.²

Three years ago we were asked to provide a locally enhanced service for patients in three nursing homes. Before this, nursing home visits were arranged on an ad hoc basis. A local 2008-9 audit had shown that only 68% of expected deaths occurred at the patient's home, care home, or hospice. We now carry out a weekly visit and review of all nursing home patients. End of life planning is discussed and agreed for all such residents.

Documentation is made in the nursing home notes and on our computer records. The local out of hours GP service and ambulance service have access to these reports and decisions.

A 2011-12 audit found that 97% of expected deaths now occur in the patient's home, care home, or hospice, with most occurring in our nursing homes.

Hughes makes a valid point about out of hours services in the light of the renegotiated GP contract.¹ However, forward planning, good documentation, and good communication with out of hours services mean that frail, elderly, and often demented patients need not be inappropriately admitted to hospital. Of course they occasionally will be, but good liaison between primary and secondary care means that patients are often discharged back to nursing homes for appropriate palliative care. Michael A H Cohen general practitioner michaelcohen1@nhs.net
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Competing interests: None declared.

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PRODUCTIVITY CHALLENGES

Politicians cannot provide the leadership needed

It is ironic that Appleby's hard hitting paper came in the week that the priority setting debate among politicians hit an all time low.¹ The Labour Party's offering was the superficial NHS Check Report and the Conservatives' response was that no care should be rationed on grounds of cost.

The reasons for such derisory contributions can only be guessed at, but they may include:

- Wilful or neglectful ignorance of the facts. For example, need already exceeds demand so rationing is extensive and pervasive. Worse, the extent of rationing needed varies geographically because some primary care trusts receive up to 20% more funding than they should while others get less. Current NHS funding does not create a level playing field.
- Self delusion as the result of adopting the mantra that no patient should be denied effective treatment.
- Deception, because politicians want votes, and promising the public it can have everything it wants seems to get them.

Politicians' "shock" and cries of "unacceptable" at the suggestion that access to care is restricted will be viewed as disingenuous by budget holders in the NHS, just like the idea that £20bn (€25bn; \$31bn) to £40bn can be found through increased productivity.

Politicians clearly cannot be relied on to provide the leadership needed to meet the Nicholson, let alone the Douglas, challenge.¹ If our politicians are not well informed and do not show courage and honesty, how will the NHS fairly distribute resources with a reducing budget in relative terms?

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Competing interests: None declared.

- 1 Appleby J. A productivity challenge too far? *BMJ* 2012;344:e2416. (19 June.)

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Social determinants of health are comorbidities

The distinction between health and social care is spurious.¹ Patients are stuck in hospital because social care is insufficient. Patients are attending my GP surgery to discuss cuts to

incapacity and other benefits. When people are distressed, they stop taking care of themselves. Self management of chronic diseases is half way up most poor people's hierarchy of needs; undermine their welfare and their healthcare suffers. I cannot discuss glycaemic control with patients who have just had their benefits unjustly taken away. The recent Marmot report about health inequalities in London, the BMA report on welfare reform, and the Glasgow Deep End reports make this abundantly clear. Furthermore, the NHS will be doing social work because those without welfare have nowhere else to go, and this will prevent medical productivity from improving.

To avoid this catastrophe we need to end the spurious distinction between health and social care and properly understand social determinants of health as comorbidities. We do not stand a chance without political commitment, and urgent economic analysis is needed to help make the case for this.

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- 1 Appleby J. A productivity challenge too far? *BMJ* 2012;344:e2416. (19 June.)

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OPEN SCIENCE

Time for an open access secure online data collection tool



We welcome the call for greater openness in science¹ and propose the development of a high quality tool for the online collection of data to facilitate collaboration and data sharing.

We recently conducted a multicentre observational study, collecting data from around 1000 patients. Data in such studies are typically acquired by completing case record forms on paper, which are then sent to a central collection site for database entry. Such practice, although standard, may be prohibitively resource intensive and fails to take advantage of recent advances in technology.

The technology for collaborative data collection is already available. We considered several web based data collection tools in our study, Google Docs being particularly promising. Free online, it allows multiple users

to remotely populate electronic case record forms simultaneously, including through mobile devices, obviating the need for a separate data entry step and making data available as soon as the patient is included in a study. It has already been used in a clinical trial.²

Collaborative data collection over the internet shares many of the technical challenges and risks of data sharing, including the difficulty of ensuring the security of data in transit or storage. Potential breaches in patient confidentiality and inappropriate data manipulation are possible, but none of these risks should be insurmountable, as Groves and Godlee argue.¹ The power of Web 2.0 technologies such as Google Docs should be harnessed to create an open access online data collection tool that is sufficiently secure for clinical studies. Such a tool would not only facilitate collaborative data collection but also increase the ease of data sharing.

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Competing interests: None declared.

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LESSONS AS A DOCTOR-PARENT

Never treat your own family

I recently had to learn a similar lesson.¹ My 10 year old son got slower and slower when walking. If we walked 20 yards, he would be 15 yards behind us. He never complained of pain, and I put it down to laziness.

It was when I came home one day to find him going up the stairs on his bottom that I finally realised that something wasn't right. But still, I bypassed my GP partners, who would have been more objective, and took him to a physiotherapist who said he needed orthotics. Luckily, the only way into orthotics locally was via a paediatric orthopaedic surgeon, who took the time to examine him for the first time.

After a biopsy of his growth plate he was diagnosed with chronic relapsing multifocal osteomyelitis.

This episode taught me never to treat my own children, or indeed any relative. It is a valuable lesson we can all learn.

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Patient consent obtained.

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