LETTERS

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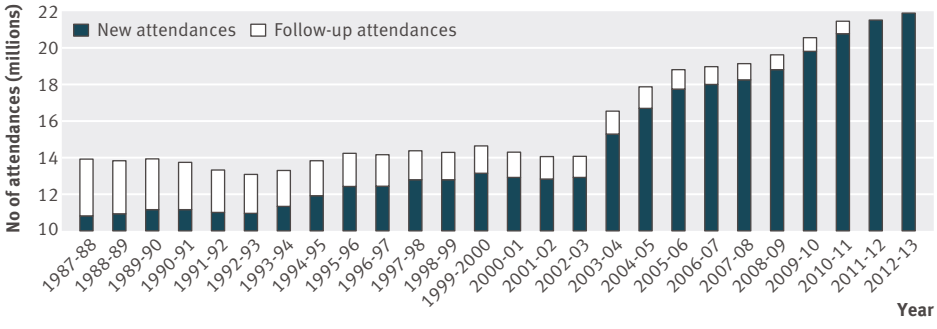

Numbers of attendances at emergency departments in England, 1987-2013

OUT OF HOURS CARE

Bring back local GPs for urgent and out of hours care

Any willingness among GPs to reclaim urgent and out of hours care would be greeted with joy in English emergency departments, which are currently struggling with the twin demands of rising attendances and an acknowledged crisis in the medical workforce.[1 2] Despite numerous and varied initiatives, emergency department attendances continue to rise, with the biggest jump coinciding with the point at which GPs could relinquish out-of-hours responsibility entirely (April 2004; figure).

The important development in Hackney,[2] where patients seeking a GP will once again be seen by "doctors they know," provides a natural experiment that must be carefully studied to assess its impact across the emergency care system. It may prove to be the most cost effective intervention we have in the ongoing struggle to control spiralling hospital demand.

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Competing interests: None declared.

1 Kmietowicz Z. Hackney GPs plan to take control of out of hours care from April. *BMJ* 2013;346:f309. (16 January.)
2 White C. Taskforce seeks to tackle "crisis" in emergency medicine recruitment. *BMJ Careers* 2012. http://careers.bmj.com/careers/advice/view-article.html?id=20008702.

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Rise in A&E attendances not caused by GP contract changes

In the previous letter, Benger links the rise in emergency department attendances to the 2003 General Practitioner Contract.[1] However, GPs were not able to opt out of out of hours care until 1 April 2004 and could not do so without an accredited scheme being in place until 31 December 2004 (most practices continued to provide out of hours care for most of this time). If this had been responsible it would be expected to have produced a rise in attendances in 2004-05, with a further rise in 2005-06, whereas the largest rise was between 2002-03 and 2003-04 (before this part of the contract was implemented). The figures do not support the hypothesis that the change to the contract was the cause of the rise in attendances.

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Competing interests: None declared.

1 Kmietowicz Z. Hackney GPs plan to take control of out of hours care from April. *BMJ* 2013;346:f309. (16 January.)

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Turn non-urgent cases away from A&E

Benger says that GPs taking back out of hours care "may prove to be the most cost effective intervention we have in the ongoing struggle to control spiralling hospital demand."[1]

I cannot see how this could be cost effective when GPs cost more per hour than everyone except the highest paid emergency department employees.

The best option would be for senior doctors in emergency departments to send away, without treatment, more people who have misused the system by presenting with non-urgent problems that should be seen in primary care during working hours, and that this change be widely publicised.

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Competing interests: I am a GP who is never going to do out of hours care again, no matter what the pay. I have also recently worked as a GP in an emergency department seeing primary care problems.

1 Kmietowicz Z. Hackney GPs plan to take control of out of hours care from April. *BMJ* 2013;346:f309. (16 January.)

Cite this as: *BMJ* 2013;346:f991

ABDOMINAL PAIN IN PREGNANCY

Don't forget pre-eclampsia

Jones and colleagues did not mention a key differential diagnosis in their endgame on abdominal pain in pregnancy.[1] Pre-eclampsia must be considered in any woman presenting in the third trimester of pregnancy with abdominal pain, particularly right upper quadrant pain.

Hepatic pain from liver involvement in pre-eclampsia is often severe and not infrequently misdiagnosed. The initial assessment of the woman must include measuring blood pressure and checking for proteinuria.

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Competing interests: None declared.

1 Jones D, Wilson J, Warnock NG, Alexander DJ. Abdominal pain in pregnancy. *BMJ* 2012;345:e6818. (17 October.)

Cite this as: *BMJ* 2013;346:f1056

BIOPSYING THE PROSTATE

Antibiotic resistance and transrectal prostate biopsies

We wish to add to the comprehensive review of prostate screening.[1] Before considering the management of any potential cancer, a persistently raised prostate specific antigen test result usually demands a tissue sample, most often obtained transrectally. However, such sampling is not only of questionable sensitivity in early stage disease, but may also be becoming hazardous.[1-3]

Recently, a medical colleague underwent a transrectal biopsy with prophylactic antibiotic cover. Twenty four hours later he developed life threatening sepsis caused by fluoroquinolone and aminoglycoside resistant *Escherichia coli*. Interestingly, he had worked for more than 30 years in secondary care and had never taken antibiotics.

Evidence is fast emerging of the benefit of prebiopsy rectal cultures. By targeting prophylactic antibiotics according to gut flora resistance, we can decrease these harmful consequences.[4] But is this a warning of things

to come? Will targeted antibiotics only select yet more resistant strains?

Furthermore, what effect does working in a medical setting have on our gut flora? Are we at higher risk than the general population and what extra precautions should be considered before carrying out "routine" biopsies?

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Competing interests: None declared.
Patient consent obtained.

1 Wilt TJ, Ahmed HU. Prostate cancer screening and the management of clinically localized disease. *BMJ* 2013;346:f325. (29 January.)
2 Onik G, Miessau M, Bostwick DG. Three-dimensional prostate mapping biopsy has a potentially significant impact on prostate cancer management. *J Clin Oncol* 2009;27:4321-6.
3 Carignan A, Roussy JF, Lapointe V, Valiquette L, Sabbagh R, Pépin J. Increasing risk of infectious complications after transrectal ultrasound-guided prostate biopsies: time to reassess antimicrobial prophylaxis. *Eur Urol* 2012;62:453-9.
4 Duplessis CA, Bavaro M, Simons MP, Marguet C, Santomauro M, Auge B, et al. Rectal cultures before transrectal ultrasound-guided prostate biopsy reduce post-prostatic biopsy infection rates. *Urology* 2012;79:556-61.

Cite this as: *BMJ* 2013;346:f1171

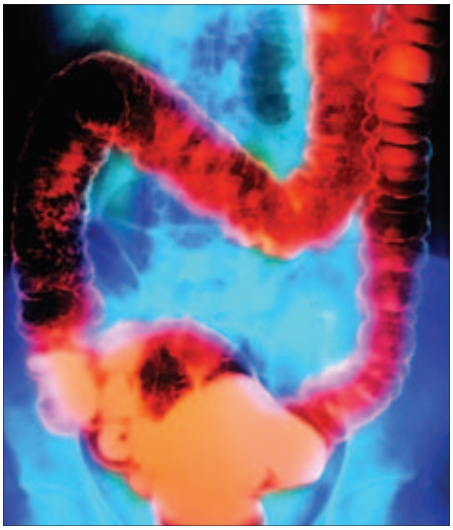
ULCERATIVE COLITIS

Failings in chronic disease management in the NHS

Ford and colleagues' summary of the current management of ulcerative colitis highlights the major failings of chronic disease management in the current purchaser-provider split NHS; this will only get worse with the upcoming changes.[1]

They rightly highlight the importance of preventing opportunistic infections with immunisations. I have been trying to do this for many years, even before European guidelines strongly endorsed this practice.[2]

In ulcerative colitis, the window of opportunity for providing vaccinations effectively and safely before patients start taking steroids or immunomodulators is often small. Yet patients do not seem to be able to get this done. Most local general practitioners will not vaccinate because these vaccinations are not listed in the *Green Book*,[3] or local drug and therapeutic groups have not endorsed their usage.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Vaccinations could easily be given in secondary care, and would generate income for trusts. However, this is not allowed by trusts because purchasers have not commissioned this service.

There is the dilemma—if a comprehensive service for a chronic disease like ulcerative colitis is commissioned, surely it should include all facets, such as prophylactic immunisations? Or, if this is specifically excluded from the secondary care pathway, then surely by default it is a primary care activity?

It seems we are moving further away from a genuinely seamless service for chronic diseases.

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Competing interests: None declared.

1 Ford AC, Moayyedi P, Hanauer SB. Ulcerative colitis. *BMJ* 2013;346:f432. (5 February.)
2 Rahier JF, Ben-Horin S, Chowers Y, Conlon C, De Munter P, D'Haens G, et al. European evidence-based consensus on the prevention, diagnosis and management of opportunistic infections in inflammatory bowel disease. *J Crohns Colitis* 2009;3:47-91.
3 Department of Health. The Green Book. http://immunisation.dh.gov.uk/category/the-green-book/.

Cite this as: *BMJ* 2013;346:f1189

PUBLICATION OF ALL TRIAL RESULTS

Research ethics committees have the power

It seems to me that research ethics committees (RECs) have much more power than medical journals to enforce a higher publication rate by drug companies.[1] RECs guard the gateway to patient trials that drug companies badly want, so they have a strong bargaining position.

Yet RECs seem unwilling to step up to their responsibilities, viewing themselves too much as a David facing a Goliath.

There are reasonable and practical "excuses" for RECs to shy away from action: no one can ensure publication and cut-off dates may legitimately need extensions. When pressed, drug companies will produce plausible weasel words promising something like "best endeavours" to publish.

I would like a "boiler plate" statement that RECs require pharma to sign up to. Something like: "[The drug company funding the research] undertakes to publish the full results of this trial within one year of the trial's end, either in a public journal or, failing that, on its company website." If the company has no local website, the full results will be forwarded to the approving REC.

If the company does not meet its commitment, then the REC should be duty bound to alert the Health Research Authority (HRA), which should then send out a notice that drug company X is in breach of its agreement. New studies would be blocked and existing ones reviewed and possibly suspended.

The HRA is committed to act. It should:

- Specify what the initial commitment has to say. Make it as watertight as possible. Make it part of the REC standard operating procedures
- Make compliance a matter explicitly for the drug company
- Make explicit the sanctions that the HRA will enforce and make them onerous.

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Competing interests: None declared.

1 Krumholz HM, Jackevicius CA, Ross JS. Tamiflu: 14 flu seasons and still questions. *BMJ* 2013;346:f547. (25 January.)

Cite this as: *BMJ* 2013;346:f1201

DOCTORS AND DRUG INDUSTRY DOCUMENT

Conflicts of interest still being sought

Although the *Lancet* has withdrawn its support for the Ethical Standards in Health and Life Sciences Group (EHLSG) document,[1] 17 other bodies including the BMA, Royal College of Physicians (RCP), and Department of Health signed up to it. Will these bodies also consider withdrawing support? As a member of both the BMA and RCP I feel uncomfortable about such an association.

Like others I was horrified when I encountered the document and contacted Sir Richard Thompson, who co-chairs EHSLG, to ascertain the names of the clinicians on the committee and those involved in drawing up the document, together with their conflict of interest declarations. Although he has kindly agreed to supply this information, nearly three months on I am still waiting. I imagine this delay is largely caused by this information having to be sought out. When I served on local medicines management committees such declarations were a standard requirement, so I am astonished that they were not mandatory for those involved in the EHSLG document.

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Competing interests: None declared.

1 Hawkes N. Lancet withdraws its support of document on collaboration between doctors and drug industry. *BMJ* 2013;346:f770. (5 February.)

Cite this as: *BMJ* 2013;346:f1188