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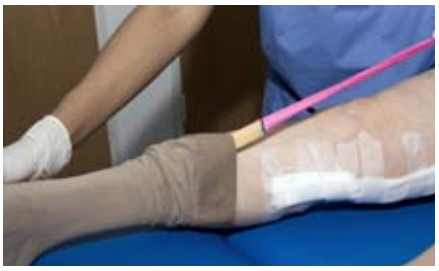
NICE ON THROMBOEMBOLISM

Challenging the evidence for compression stockings



DR P MARAZZI/SPL

Welfare highlights important points surrounding the recommended use of anticoagulants to prevent venous thromboembolism (VTE).[1]
We highlight problems surrounding National Institute for Health and Care Excellence (NICE) recommendations that all hospital inpatients, excluding those with stroke, are considered for mechanical prophylaxis. This is most commonly translated as graduated compression stockings.[2] These recommendations were based on a Cochrane review[3] and a trial in patients with stroke.[4]

Cochrane included 18 small trials (18-152 patients) of medical and surgical patients. Two large trials were excluded, one in 2518 patients with stroke,[4] and one in 874 orthopaedic patients.[5] Reasons for exclusion were too specific a population and too pragmatic a study, respectively—neither trial supported the use of compression stockings. In six of the 18 trials, the stocking was applied to one leg only, with the other leg as control. All 18 included trials detected VTE radiologically, but it is unclear whether patients had symptoms. Also, Cochrane identified only 10 of the 14 trials (of 18) that had received support from stocking manufacturers. Furthermore, the authors parted from Cochrane guidelines when producing their funnel plot and on this basis concluded that no publication bias was present. We repeated the exercise using the guidelines and our findings were different (figure online).

NICE included one of the studies rejected by Cochrane,[4] which formed the basis of advising against stockings in patients with stroke. NICE does not comment whether this conclusion might apply to the medical patients included in the other studies, or whether the inclusion of that study in the statistical analysis would have modified its conclusion.

NICE and Cochrane acknowledge their analyses are not statistically powerful enough to detect differences in mortality.

We believe that NICE's recommendations on compression stockings should be reviewed and should not prevent more research to establish their validity. The cost associated with these measures is considerable and the benefits uncertain.

Laurence Whittaker foundation year 1 doctor, County Durham and Darlington NHS Foundation Trust, Darlington DL3 6HX, UK laurence.whittaker@cantab.net
Trevor Baglin divisional director of pathology and consultant haematologist, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK
Alain Vuylsteke consultant in anaesthesia and intensive care, Department of Anaesthesia and Intensive Care, Papworth Hospital NHS Foundation Trust, Cambridge, UK

Competing interests: None declared.

Full response with figure at www.bmj.com/content/343/bmj.d6452/rr/647011.

1 Welfare M. NICE's recommendations for thromboembolism are not evidence based. *BMJ* 2011;343:d6452. (7 December.)
2 National Institute for Health and Care Excellence. Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital. CG92. 2010. http://guidance.nice.org.uk/CG92.
3 Sachdeva A, Dalton M, Amaragiri SV, Lees T. Elastic compression stockings for prevention of deep vein thrombosis. *Cochrane Database Syst Rev* 2010;7:CD001484.
4 Dennis M, Sandercock PA, Reid J, Graham C, Murray G, Venables G, et al. Effectiveness of thigh-length graduated compression stockings to reduce the risk of deep vein thrombosis after stroke (CLOTS trial 1): a multicentre, randomised controlled trial. *Lancet* 2009;373:1958-65.
5 Cohen AT, Skinner JA, Warwick D, Brenkel I. The use of graduated compression stockings in association with fondaparinux in surgery of the hip. A multicentre, multinational, randomised, open-label, parallel-group comparative study. *J Bone Joint Surg Br* 2007;89:887-92.

Cite this as: *BMJ* 2013;346:f3653

BAD MEDICINE: DIABETES MANAGEMENT

EMA must take account of degludec's cardiovascular harm

The way we manage diabetes is bad medicine and, with the increasing use of analogue insulin, type 2 diabetes is pharma's lottery win.[1] Degludec insulin (Tresiba), Novo Nordisk's novel analogue, may be viewed in this context. Our concerns about its marketing led us to submit a letter to the European Medicines Agency (EMA) (available at: www.bmj.com/content/346/bmj.f2695/rr/648949).

The EMA approved degludec in September 2012, but the US Food and Drug Administration asked the manufacturer to conduct further cardiovascular safety studies (February 2013) on the basis of a meta-analysis of studies to date. The analogue increased the risk of major adverse cardiovascular events (hazard ratio 1.67, 95% CI 1.01 to 2.75).[2] These data were available to EMA, but because its prespecified analysis used a different definition of events, the hazard ratio was 1.097 (0.681 to 1.768).[3] For all five definitions of major adverse cardiovascular events, the point estimate corresponds to an increase in risk from 9.7% to 61.4%. Like the FDA, we argue that any questionable benefit over existing long acting insulin analogues through claimed lower risk of hypoglycaemia does not outweigh the additional cardiovascular risk.

Type 2 diabetes more than doubles the risk of cardiovascular disease, with little or no benefit from glucose lowering,[4] and cardiovascular disease continues to be patients' major cause of death. Changes in glycated haemoglobin are a poor surrogate for cardiovascular risk reduction, with a 1% reduction associated with only 10-15% improvement.[4] Because the risks of cardiovascular complications in these patients far exceed those of patient relevant microvascular complications, glucose lowering treatments must show beneficial, or at worst neutral, cardiovascular effects.

We call on EMA to amend its summary of products characteristics for degludec to state that the FDA found sufficient evidence of cardiovascular harm not to register degludec insulin.

Thomas A Schmidt associate clinical research professor, Holbaek University Hospital, 4300 Holbaek, Denmark tasm@regionsjaelland.dk
Clifford J Rosen professor of medicine, Maine Medical Center Research Institute, Scarborough, ME, USA
John S Yudkin emeritus professor of medicine, University College London, London, UK

Competing interests: TAS holds Novo Nordisk stock.

1 Spence D. Bad medicine: the way we manage diabetes. *BMJ* 2013;346:f2695. (29 April.)
2 Food and Drug Administration Endocrine and Metabolic Drugs Advisory Committee Meeting 8 November 2012. www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/EndocrinologicandMetabolicDrugsAdvisoryCommittee/UCM330923.pdf.
3 European Medicines Agency. CHMP assessment report: Tresiba. 2012. www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002498/WC500139010.pdf.
4 Control Group, Turnbull FM, Abraira C, Anderson RJ, Byington RP, Chalmers JP, Duckworth WC, et al. Intensive glucose control and macrovascular outcomes in type 2 diabetes. *Diabetologia* 2009;52:2288-98.

Cite this as: *BMJ* 2013;346:f3731

PREVENTING ADMISSION OF OLDER PEOPLE

An integrated approach works

D'Souza and Guptha rightly suggest that reducing beds for older people is not well evidenced policy.[1] Their own use of evidence is somewhat selective—for example, quoting Purdy's King's Fund 2010 report in support of their case but ignoring her clear statement in favour of hospital at home schemes.[2]

Many attempts to case manage in the community have been "parachuted" in as "stand-alone" interventions, rather than evolving through integrated working between primary care, community social care, and secondary care staff.

In East Devon, our population structure is equivalent to predictions for England in 2035. Striking and consistent differences exist in standardised admission rates between areas that use a proactive approach (intervene within two hours when patients are at high risk of admission) and predictive modelling as a focus for multidisciplinary discussions and action to reduce risk compared with areas without such an approach.

When, as Purdy recommends, "avoidable" admissions such as those in the standardised ACSC (ambulatory care sensitive conditions) are the focus, sustained differences in admission rates are even more striking.

Teams working in this way can also "pull" patients out of hospital as soon as their diagnostic and treatment planning phase is complete. Working in these ways does not necessarily require extra resources, except for the cost of the predictive modelling tool.

I hope those who read this editorial will understand that it is an argument against bed reductions not against developing systems that allow frail older people to be in hospital only when and for as long as needed.

Babies and bathwater come to mind.

Phil Taylor general practitioner, Axminster Medical Practice, Axminster EX13 7RA, UK
philtaylor@nhs.net

Competing interests: PT is eastern Devon locality commissioning lead for healthcare for older people.

1 D'Souza S, Guptha S. Preventing admission of older people to hospital. *BMJ* 2013;346:f3186. (20 May.)
2 Purdy S. Avoiding hospital admissions. What does the research evidence say? King's Fund, 2010. www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf.

Cite this as: *BMJ* 2013;346:f3723

Geriatricians can be lynchpin of integrated care

D'Souza and Guptha argue that frail older people who are unwell need hospital admission for assessment and immediate treatment.[1] We agree, but we also believe that active community services achieve more than is suggested.

The King's Fund review quoted by the authors finds that "hospital at home" services can help to manage the crises that precipitate admissions.[2] Such alternatives may be preferable for patients with multimorbidity who have well established care packages and do not want the upheaval of hospital admission. Other activities, such as liaison in care homes and active working with ambulance services around problems like falls management, can reduce admissions. The sharing of information can ensure that risk is shared more appropriately and not avoided by sending the patient to hospital.

However, the success of community services cannot be judged solely on prevention of hospital admission. An integrated multidisciplinary team working across health and social care can reduce occupied bed days by pulling older people along a care pathway and back into the community before, during, and after a crisis. This can be achieved by providing genuine alternatives to admission, sharing information about care plans to shorten hospital stay when admission is needed, and effecting rapid discharge as soon as a patient is ready.

Geriatricians can be the lynchpin of integration, bridging the gap between hospitals and community teams. Across the UK geriatricians are helping to develop integrated services, and models in Leeds, Southampton, Leicester, Sheffield, and Warwick are producing results.[3]

Pitting acute and community services against one another is counterproductive; we should focus on ensuring that older people have access to specialist health and supportive care when and where they need it.

Paul Knight BGS president president@bgs.org.uk
Gill Turner BGS vice president clinical quality, British Geriatrics Society (BGS), London EC1M 4DN, UK

Competing interests: None declared.

1 D'Souza S, Guptha S. Preventing admission of older people to hospital. *BMJ* 2013;346:f3186. (20 May.)
2 Purdy S. Avoiding hospital admissions. What does the research evidence say? King's Fund, 2010. www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf.
3 Philp I. The principles behind integrated care for older people. *Health Serv J* 30 Nov 2012.

Cite this as: *BMJ* 2013;346:f3725

DSM-5: A FATAL DIAGNOSIS?

Academic psychiatry, research ethics, and the drug industry

In his article on DSM-5 (the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*), Gornall mentions Charles Nemeroff, a professor at Emory University.[1] Nemeroff concealed huge payments made covertly to him by GlaxoSmithKline, makers of the antidepressant paroxetine, while lead investigator on a National Institutes of Health (NIH) study of that very drug.[2] Nemeroff was obliged to resign from Emory but was then appointed chair of psychiatry at the University of Miami. The US Senate Committee on Finance wrote to NIH to ask why it had granted Nemeroff $400 000 (£261 560; €306 160) a year for five years when he remained under federal investigation.[3]

None of this seems to worry the Institute of Psychiatry, King's College London, Europe's largest psychiatric research centre. The institute has invited Nemeroff to give the inaugural annual lecture of its new Centre for Affective Disorders on 17 June 2013, describing him as "one of the world's leading experts in the neurobiology of depression."

This case tells us about how the biomedicine driven research world works. Nemeroff was appointed to another chair of psychiatry when the case against him was not closed, he received substantial new grants, and the Institute of Psychiatry in London continues to laud him as "one of the world's leading experts." All of this shows how psychiatric academe sails blithely on as if such revelations raise no broader questions about its supposed scientific independence, research ethics, and how conflicts of interest contaminate the research data informing scientific publications.

Finally, no clinically meaningful "neurobiology of depression" has been discovered. This is not surprising when "depression" is merely a syndromal category, subsuming a heterogeneous range of patients whose understanding of their distress points more often to social space than to mental space.[4]

Derek A Summerfield honorary senior lecturer, Institute of Psychiatry, London SE5 8BB, UK }
derek.summerfield@slam.nhs.uk

Competing interests: None declared.

1 Gornall J. DSM-5: a fatal diagnosis? *BMJ* 2013;346:f3256. (22 May.)
2 Harris G. Top psychiatrist didn't report drug makers' pay. *New York Times* 2008. www.nytimes.com/2008/10/04/health/policy/04drug.html?pagewanted=all&_r=1&.
3 Dorschner J. Senator complains to NIH about UM doctor. *Miami Herald* 2012. www.miamiherald.com/2012/05/30/2823784/senator-complains-to-nih-about.html.
4 Summerfield D. Depression: epidemic or pseudo-epidemic? *J R Soc Med* 2006;99:1-2.

Cite this as: *BMJ* 2013;346:f3655