LETTERS

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HIV TESTING

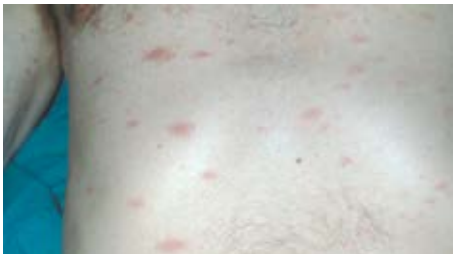
Implementation of HIV testing is patchy in the UK

The clinical review on HIV testing and management is welcome and timely.[1] Since the publication of guidelines on testing in 2008, implementation has been patchy. We recently conducted a systematic review of implementation of these guidelines in the UK; the overall estimate of test coverage was only 27.2% (95% CI 22.4% to 32%) in eligible populations outside of antenatal and sexual health clinics.[2] Rates of test offer were much lower than patient acceptance, indicating that provider behaviours need to change.

We also completed a mixed methods study of people newly diagnosed with HIV in a London trust where around 40% of patients are diagnosed late. Information from 58 recently diagnosed patients, including 25 in-depth interviews, highlighted some of the barriers to early diagnosis that lie with healthcare professionals.

Preliminary analysis found that 66% of patients had consulted a healthcare provider in the year before diagnosis with symptoms that could be attributed to HIV. Some said that testing had not been initiated even though they had described relevant risks. Even when clinicians seemed to suspect HIV, some were reluctant to offer testing, preferring to send the patient to a sexual health clinic. "When I was there she (practice nurse) said she doesn't have the knowledge to diagnose what I had . . . She said there's a clinic over here. I didn't know what type of clinic, mind . . . It wasn't a place where I really wanted to go, to be truthful with you. I've come to the clinic myself because it seems I've got nowhere else to go."

To improve outcomes for people with HIV and reduce onward transmission, we urgently need to normalise testing and implement existing guidelines. Alongside education for healthcare professionals we need awareness campaigns to help people recognise risk and seek testing.



Maculopapular rash of primary HIV infection

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Competing interests: None declared.

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HIV testing in mental health care

Rayment and colleagues recommend that HIV screening be considered for everyone registering in general practice and "all general medical admissions" in areas where prevalence is >2 per 1000.[1] However, they do not comment on mental health settings. This omission is regrettable, particularly in view of current campaigns to tackle health inequalities in this group and move towards "parity of esteem."[2]

International evidence indicates that mental health populations have higher rates of undiagnosed HIV and sexual risk taking behaviour than the general population.[3]

In the absence of guidelines, most psychiatric trainees (who usually perform physical examination and baseline investigations) lack the knowledge and confidence to offer HIV testing. Trainees reported the belief that explicit pre-test counselling is needed and feared it would be inappropriate to offer testing to patients with impaired capacity, despite testing for other potentially stigmatising illnesses (such as syphilis) in patients' best interests.

A recent study showed the acceptability of testing in this patient cohort.[4]

Data from one borough indicate that between July 2013 and July 2014, although 455 screening tests for syphilis were requested (28 positive) for patients in local services, only 14 were ordered for HIV (0 reactive).

Elsewhere in the trust, where a programme is in place to offer screening in our forensic settings, the liaison physician offered HIV testing to nearly all 300 inpatients, with take-up rates of 63%.

Clinicians in psychiatric settings should follow the same guidelines for HIV testing as colleagues in primary and acute settings, including universal screening where recommended, because the benefits of early diagnosis and treatment are reasons that testing may be in patients' best interests. This example also highlights the benefit of a liaison physician in the delivery of integrated care.

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Competing interests: CH has received honorariums for speaking on the subject of HIV and mental health from Janssen and is a personal friend of the authors of the paper.

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GENERAL HEALTH CHECKS

General health checks may work

We disagree with Gøtzsche and colleagues' conclusion that general health checks don't work,[1] which is based on their Cochrane review and the recent Inter99 publication.[2] The Cochrane review included older trials and thus tested outdated screening tests and treatments. A recent meta-analysis of general practice based health checks found small improvements in surrogate outcomes, especially in high risk patients.[3] The Inter99 study was based on lifestyle counselling only and did not include drug treatments.[2] It was a hospital based study with a low participation rate (39-52%).

By contrast, modelling studies indicate that screening for diabetes and cardiovascular risk is cost effective. The Anglo-Danish-Dutch study of intensive treatment of people with screen detected diabetes in primary care found a 17% non-significant reduction in first cardiovascular event for intensive treatment versus routine care. The lack of a significant difference may be due to high treatment quality in the routine

care group. A retrospective analysis found no significant difference in seven year all cause mortality in people thought to be at highest cardiovascular risk at screening (HbA_{1c} ≥48 mmol/mol) versus those with normal glucose tolerance at screening. All cause mortality was twice as high in people thought to be at lowest cardiovascular risk (HbA_{1c} ‹42 mmol/mol at screening). A likely explanation for this paradox is that GPs were falsely reassured by low HbA_{1c} values and did not offer these patients full preventive interventions.[4]

In contrast to Gøtzsche and colleagues, we find that general practice health checks for diabetes and cardiovascular risk may work. Future studies might help us improve health checks by providing information on screening strategies, treatment intensity, and how to maximise attendance rates and adherence. Meanwhile GPs should still offer opportunistic screening for people at high risk of diabetes and cardiovascular disease.[2 5]

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Competing interests: TL has shares in Novo Nordisk.

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NHS Health Check programme: too early to conclude

It would be a shame if the debate about the Inter99 trial was limited to the points raised in the accompanying editorial by Gøtzsche and colleagues.[1 2] Olsen has already pointed out in his rapid response that the stark message of the editorial's title is not supported by its content. The NHS Health Check Expert Scientific and Clinical Advisory Panel has reviewed the Inter99 trial and we highlight below some of our conclusions.[3]

The study is not directly comparable to the NHS Health Check programme. Patients in the NHS programme are older and seem to have worse underlying cardiovascular disease risk than those in the Danish study. Evidence emerging from the NHS programme confirms that substantial levels of undiagnosed treatable illness are being detected. The intervention assessed was also very different. Clinical management of newly detected diabetes, renal disease, or hypertension is part of the NHS Health Check programme, whereas Inter99 was mainly a low intensity lifestyle intervention with the option of referral to primary care.

A population level impact from screening for cardiovascular risk is hard to measure using an intention to treat analysis. Even though participants receiving the intervention achieved positive lifestyle changes, an effect at population level could not be detected after 10 years.

The outcome of the Inter99 trial is indeed reason to reflect on the value and design of population based health check programmes and the research needed to assess them. For example, modelling suggests that redirecting effort towards higher risk people would improve cost effectiveness.[4] Opportunistic screening in primary care alone is not an adequate response and may worsen inequalities. Public health authorities must therefore design integrated strategies to reduce cardiovascular risk that are tailored to the risk profile of their populations and that reflect other aspects of the local context.

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Competing interests: All the authors are employed by Public Health England, the organisation responsible at national level for delivery of the NHS Health Check programme.

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Ethical issues related to health checks

The paper and editorial on health checks highlight crucial ethical issues.[1 2]

It is not just the lack of benefit or the harm to patients—who will never think of themselves as healthy again. It is the waste of resources as governments encourage, and sometimes pay, clinicians to screen healthy patients for cardiovascular risk, producing tonnes of paper with guidelines, recommendations, and rainbow coloured risk charts.

It is also the harm to health systems, many of which struggle with service sustainability and rising costs. With the mounting pressure and strain on primary care services and providers, the opportunity costs of spending time on checks with no evidence of benefits and potential for harm creates an issue of distributive justice. Although largely overlooked in the summaries that underpinned recommendations on risk assessment, primary care studies of cardiovascular risk screening have shown the enormous resource requirements and lack of meaningful benefit to patients.[3-5] These finite resources are then unavailable or available in a less timely way for patients who would benefit from medical care.

It seems futile to tackle the health outcomes of lifestyle issues that are linked to socioeconomic disparity and environmental constraints through individual clinical care. Adverse drug events are now leading causes of death in developed countries. Greater population health gains would probably come from attending to political and social drivers of poor health, as well as creating healthy environments and a regulatory and clinical environment that provides truthful, transparent information from trials and supports doctors and patients in truly assessing the medication risk-benefit balance. The therapeutic imperative in medicine means that we are good at rushing to do things that might "save lives" but not good at not doing, or undoing.

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Authors' reply

As our editorial explained, criticism of a clear negative result cannot turn it positive. Lauritzen and colleagues say that the trials in our Cochrane review tested outdated screening tests and treatments.[1] This is not correct—for example, probably all 14 trials measured blood pressure and six trials tested for diabetes. They also say the trials were old, but if we increase the number of deaths from 11 940 to 15 103 by including the results of the Inter99 trial,[2] the risk ratio for total mortality remains at 0.99, with virtually the same confidence interval (0.95 to 1.02). How can they challenge such results by referring to a meta-analysis of surrogate outcomes and to retrospective non-randomised comparisons? They also argue that the Inter99 trial didn't include pharmacological intervention, but when more diagnoses are made, more drugs are being used.

Newton and colleagues say that the Inter99 trial is not directly comparable with the programme. Of course not, but they ignore that to recommend screening we need randomised trial evidence that it works. The programme operates in direct contradiction to the NHS's own screening criteria (www.screening.nhs.uk/criteria). They say that their patients are older and worse off and that it may take more than 10 years to see an effect. However, all trials included high risk patients, and if there were an effect we would have seen it. Like Lauritzen and colleagues, they talk about modelling studies, which are highly dependent on assumptions, but seem to be the standard "rescue" when results from randomised trials go against popular beliefs.

What we need are not general health checks but structural changes, which should involve a much tighter grip on the food and drug industries. As Mangin points out, adverse drug events are now a leading cause of death in developed countries. It is therefore unconvincing when Newton and colleagues say that "substantial levels of undiagnosed treatable illness are being detected." Treating more people through screening has the potential to increase mortality.

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RESPONSE

Mark Baker replies to Daghni Rajasingam and Kate Harding

Daghni Rajasingam and Kate Harding made several errors in their editorial on the draft guideline on intrapartum care recently released for consultation by the National Institute for Health and Care Excellence (NICE).[1]

The draft update of NICE's intrapartum care guidance, which is still being developed, deals with the care of women who start normal labour without complications. It is not about "obstetric practice" as such. NICE will be developing a separate guideline for pregnant women at high risk of complications during birth who need to deliver in hospital.

The advisory Guideline Development Group (GDG) charged with updating the 2007 NICE guidance on intrapartum care is composed of relevant experts. These include three midwives, two obstetricians, one neonatologist, one obstetric anaesthetist, and a GP. In addition, the group is chaired by a leading obstetrician and it contains two lay members.

NICE uses agreed methods and processes to ensure that recommendations are based on the best available evidence.[2] Relevant evidence is systematically searched, evaluated, and graded.[3] If it does not meet the criteria it is excluded.

After this stage, our advisory groups use the best available evidence to make recommendations for clinical practice. Where there is a lack of consistent and reliable evidence, recommendations may be based on the expert opinion of the GDG.

Pelvic floor injury was excluded from this update because there was no new evidence identified, as highlighted in the opinion piece. If there are ongoing concerns in practice, obstetricians and gynaecologists should have raised these at the time of the scoping consultation (in 2011).[4] The 2007 recommendations therefore remain unchanged because the evidence was not reviewed. The publication of rigorous research is a matter for the professionals who work in the area to address.

S AND R GREENHILL/ALAMY

Neither the original guideline nor the updated draft advocates that a four hour active second stage is normal for any woman.

The review question relating to fetal monitoring did include fetal blood sampling. It is not clear whether the authors examined chapter 10 and its appendices.[5] These sections show in detail the evidence that underpins the individual and grouped components of cardiotocography, and the association with safe maternal and neonatal outcomes.

It would be a weak argument that professionals might prefer a familiar interpretation system (based itself on the previous 2007 GDG's clinical consensus, something they say they do not favour), rather than one grounded in evidence.

The linking of evidence to recommendations is clearly and transparently set out. If clinicians and stakeholders want to improve these draft recommendations, they need to explain where their objections lie, based on evidence. It is an odd criticism that there is too much good quality work for relevant individuals and professional bodies to read and comment on within the long awaited and well advertised consultation timescale that conforms to Cabinet Office guidelines.[6]

Lastly, it was not the group's job to look at how the guidance will be implemented. The updated guidance, once finally published, will be accompanied by other NICE products, including implementation tools and pathways. These will support healthcare professionals in putting the updated recommendations into practice.

The consultation for the NICE intrapartum care guideline update attracted more than 1200 comments. These are being examined and responded to. The final guidance will be issued when these comments have been considered.

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Competing interests: I am director of the NICE Centre for Clinical Practice, overseeing the development of all clinical guidelines.

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