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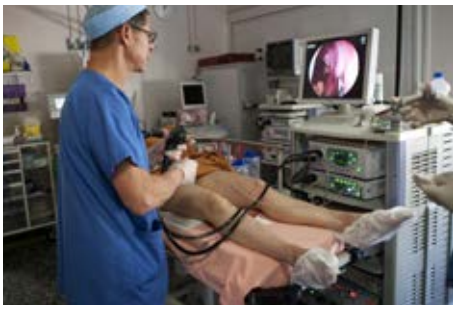
SELF REFERRAL FOR CANCER TESTS

Will self referral cancer tests improve mortality outcomes?



I heard the news about self referral for cancer tests on the radio, and my heart sank. Having read your detailed account,[1] I am not reassured.

A key problem is confusing the three related, but very different, concepts: survival, disease specific mortality, and overall mortality. Conflate these with changing the paradigm from investigating relevant symptoms after initial assessment by a clinician (the acknowledged world leading—UK model of "primary care targeted gatekeeping"[2]) to open access self referral (the more expensive US model), and surely we are heading for an expensive mess?

Giuliani's 2007 New York mayoral election campaign epitomised this. He claimed that prostate cancer survival was 87% in the US and 44% under the NHS. The overall mortality from prostate cancer in the UK and US are almost identical—the survival difference represents much earlier diagnosis in the US because of widespread measurement of prostate specific antigen.[3]

Negative test results for unlikely serious diagnoses don't reassure people,[4] and data suggest that open access does not improve hard outcomes.[5]

It's not that people don't want to die from a particular cancer, but they don't want to die prematurely. This lies behind much of the controversy relating to prostate and breast cancer screening—disease specific mortality may be reduced, but if overall mortality is unaffected little has been gained.[3]

Finally, unless any damage from testing (open access or screening) has been quantified, how can we properly advise our patients?[6]

I suggest more is not invariably better, and unlikely to be cheaper. Equally, to misquote Mencken, "For every complex problem there is an answer that is clear, simple, and wrong." Beware the law of unintended consequences.

Is this a good use of increasingly hard pressed NHS resources? The evaluations (including harm) will need to be rigorous if national policy and NHS expenditure are to depend on them.

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1 Wise J. Self referral for cancer tests is to be piloted in England. *BMJ* 2015;350:h185. (13 January.)

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DIAGNOSTIC DELAY IN CANCER

The number of primary care visits before cancer diagnosis

Use of the number of relevant consultations in primary care before a cancer diagnosis is problematic.[1]

Consultations can be counted only retrospectively, which could lead to an incorrect assumption about the index consultation. After diagnosis of lung cancer, an initial consultation in a male smoker for a winter cough might be counted, even though referral at that point would not have been appropriate. If he came back after antibiotics (if indicated) failed to resolve the problem, would he be regarded as having had two consultations?

It is also not clear that the authors differentiated between consultations arranged by the patient and follow-up arranged by the GP. In the above example, if I arranged a chest radiograph the next day and a follow-up appointment two days later, I would have seen the patient three times but referred him promptly, if necessary. By contrast, as few as two consultations for uncommon presentations that suggest cancer as the most likely diagnosis could represent delay.

The diagnosis of cancer is a joint responsibility between primary and secondary care, and timely investigation in primary care is, in my rural part of the country, good practice. Any discussion of referral to hospital needs to consider the harms of unnecessary referral for patients and the financial cost. Surely society should decide the level of risk at which investigations for cancer should be funded, and patients should decide with their GP whether to accept, for example, the small risk of endoscopy to exclude a small cancer risk. In my view, the increased public emphasis the NHS is placing on early diagnosis of cancer, desirable as it may be, is ignoring the need for debate.

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1 Lyratzopoulos G, Wardle J, Rubin G. Rethinking diagnostic delay in cancer: how difficult is the diagnosis? *BMJ* 2014;349:g7400. (10 December.)

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Authors' reply

We argued that multiple pre-referral consultations have a range of underlying causes, beyond the clinical reasoning skills of individual doctors.[1 2] We therefore agree with Taylor that for some patients multiple pre-referral consultations will be generated by guideline concordant expectant management or investigations.[3]

Repeat consultations are nonetheless associated with longer times to referral, and efforts are needed to minimise their occurrence.[2] For patients with low risk symptoms (not mandating immediate referral) in whom primary care led investigations are deemed necessary, the diagnostic process can be accelerated by shortening scheduling and reporting delays.[3] The difficulty in coming to a diagnosis varies greatly by cancer.[2] We agree that the diagnosis of lung cancer is particularly challenging,[1] as detailed clinical audit and patient symptom studies show.[4-6] Multifaceted approaches to reducing multiple pre-referral consultations include the development of novel tests, clinical audit activity (possibly triggered by multiple consultations in patients later diagnosed as having cancer), and the design of swift and integrated diagnostic care services that remove barriers between primary and specialist care.

In addition, system-wide approaches are needed to shorten prolonged intervals to presentation caused by psychosocial patient factors and to reduce avoidable delays that may occur after referral and within secondary care.[2] There is unlikely to be a "quick fix" for the problem of multiple pre-referral consultations. Better appreciation of the complexity of the underlying causes is needed to make progress.

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DOMINIQUE FAGET/GETTY IMAGES

EBOLA VIRUS DISEASE

Concerns about cohorting of patients with suspected Ebola

Balancing the rights of the individual against the collective interest in preventing the spread of Ebola virus disease is challenging.[1 2] One concern relates to the cohorting of patients with suspected Ebola.

Because the presentation of Ebola is relatively non-specific, any cohort will include people with and without the disease. Non-infected and infected people may share space for days. Some may become informal carers. They have no training or personal protective equipment. Any healthcare worker who enters the cohort area even briefly has training and protective equipment.

The risk to non-infected people is higher if facilities are poor, those likely to be highly infectious are not effectively segregated, the case definition is not rigorously applied, and asymptomatic contacts are admitted. The potential injustice is exaggerated if there is an element of social pressure to request admission and if the freedom to leave is denied.

Is such a system justified to limit the spread of Ebola? Subordination of the rights of one to the good of many is not an easy ethical position to hold.[2] Is it justified because those who are not infected are at similar risk at home? That is unlikely if they come from a household where no one is infected. Perhaps the most worrying thing is the lack of discussion. A global conference discussed problems related to potential Ebola treatments but didn't discuss this problem.[3]

Furthermore, if non-infected people acquire infection in a cohort area this could fuel the outbreak. Has the global response to Ebola subordinated the rights of the poor and sick to the fears of the affluent well?

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1 Devnani M, Guo Y. Ethical issues in isolating people treated for Ebola. *BMJ* 2015;350:h140. (14 January.)

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MEDICAL JOURNALS AND INDUSTRY TIES

Requiring anonymised raw data as a condition for publication

The problem of conflict of interests for medical journals will largely go away when they adopt the policy of "publishing the reports of all and sundry, regardless of their commercial interests, subject to the pledge and actual delivery of anonymised raw data on which the report depends for internal and external validity."[1 2]

By extension, authors of instructional materials and education reports could show their lack of bias by citing reports that have pledged and, better still, actually delivered on the promise of providing anonymised raw data. In the beginning, this will be a challenge for medical journals, which traditionally vet manuscripts for publication on the basis of imperfect and sometimes interest conflicted peer reviews.

The challenge now is for medical journals to stop going on about conflicts of interest and to adopt the robust policy of requiring, as a condition for publication, that authors provide access to the anonymised raw data underlying their reports.

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1 Godlee F. Authors' reply to Smith, Forsyth, Coffey and Prendergast, and Soskolne. *BMJ* 2015;350:h42. (8 January.)

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FAILED PHLEBOTOMY? THINK HARVEY

Failed phlebotomy? Think universal precautions

Dorrington and Aronson's article provided useful tips for obtaining a venous blood sample in an antegrade manner, especially from smaller veins on the dorsal aspect of the hand.[1] It provided anatomical and physiological insight into this technique, and highlighted that the technique is not mentioned in the 125 pages of the WHO guidelines on phlebotomy.[2] We envisage that many healthcare workers will now use this technique, especially in challenging cases such as paediatric patients. However, the accompanying illustration shows venous blood being sampled without adherence to the universal precaution of glove wearing, which the WHO guidelines advise many times.[1 2]

The routine use of gloves to prevent transmission of blood-borne viruses in healthcare workers who take blood has been advised and promoted endlessly. Nevertheless, this practice has repeatedly been highlighted as falling below standard, especially with rising seniority.[3 4]

Illustrations in articles in *The BMJ* should promote best practices. We would like to highlight the safety issues with using this illustration in an otherwise extremely informative and educational article.

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1 Dorrington KL, Aronson JK. Failed phlebotomy? Think William Harvey. *BMJ* 2014;349:g5232. (4 September.)

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Failed phlebotomy? Perhaps it's the site used

As someone who teaches clinical skills to medical students I get particularly frustrated by the modern tendency to use the back of the hand for taking blood and then place intravenous cannulas in the antecubital fossa. It is therefore disappointing to see an illustration of blood being sampled from the back of the hand in *The BMJ*.[1]

I continually have to re-educate junior staff on this topic. To obtain adequate samples of blood it is necessary to access a vein with a wall rigid enough to tolerate the negative pressure generated during aspiration. Such veins are universally found in the antecubital fossa, which should be the anatomical site of choice for phlebotomy. These veins can also be used repeatedly, unlike those on the dorsum of the hand. These principles apply to patients of all ages, from neonates onwards, and this practice is recommended in the WHO guidelines on phlebotomy.[2]

The number of times that I see patients of all ages with intravenous cannulas in their antecubital fossae is equally frustrating. Unless a large vein needs to be cannulated for the purpose of fluid resuscitation, the dorsum of the hand should be used. The calibre of the vein is usually immaterial when it comes to infusing fluids, even at quite high rates, and it is far more comfortable for patients to have a hand cannulated than to have an elbow splinted.

Although inserting a needle into a vein in a proximal to distal direction may have benefits, the chance of obtaining a blood sample is maximised by using the most appropriate veins—those in the antecubital fossa.

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