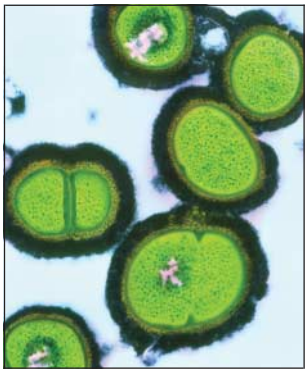
Ring fencing reduces hospital infection



DR KARI LOUNATMAA/SPL

A simple infection control strategy may reduce postoperative infections in orthopaedic patients. Biant and colleagues (p 149) analysed the effect of ring fencing of beds, screening for methicillin resistant *Staphylococcus aureus* (MRSA) before admission, and a code of dress and behaviour on the orthopaedic ward in a district general hospital in Essex. After implementation of the strategy, postoperative infection decreased significantly; no new cases of MRSA infection occurred; and 17% more patients were treated without increasing the numbers of surgeons, beds, or operating sessions.

POEM*

Peak expiratory flow rate does not predict exacerbation of asthma

Question Does measuring peak expiratory flow rate predict asthma exacerbations?

Synopsis This non-randomised controlled study was conducted in an interesting setting: 36 pharmacies spread over a geographical area to study the effect of care provided by pharmacists to patients with asthma. Randomised by pharmacy, patients received either a peak flow meter with instructions from the pharmacist on how to use it, a peak flow meter with written instructions, or usual care (no peak flow monitor given). The 660 patients were evaluated at enrolment and at 6 and 12 months using the McMaster asthma-specific quality of life questionnaire and measured peak expiratory flow rate (PEFR). Patients also were telephoned monthly to obtain their PEFR measurement and information about any recent emergency department visits and hospitalisations. During the follow up, 13% of the patients experienced at least one exacerbation of asthma. A PEFR of less than 50% of predicted at baseline predicted an exacerbation over the following 12 months, but change in PEFR was not a better independent predictor than quality of life scores. By contrast, the quality of life scores were independently predictive of an exacerbation at both four months (hazard ratio 0.63; 95% confidence interval 0.46 to 0.87) and 12 months (hazard ratio 0.66; 0.54 to 0.82).

Bottom line Routine measurement of peak expiratory flow rate does not predict subsequent exacerbations of asthma. Therefore, routine measuring of lung function in this way is not useful. A peak flow meter has a role in asthma management, but spot checking in the office, other than to evaluate technique, is not helpful.

Level of evidence 1b (see www.infopoems.com/levels.html). Individual inception cohort study with >80% follow up; or a clinical rule not validated on a second set of patients.

Tierney WM, Roesner JF, Seshadri R. Assessing symptoms and peak expiratory flow rate as predictors of asthma exacerbations. *J Gen Intern Med* 2004;19:237-42.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Health information for all by 2015?

In my increasingly desperate search for originality in editor's choice I've come up with something devilishly simple: choose something from the *Lancet*. I urge you to read "Can we achieve health information for all by 2015?" by Fiona Godlee and others, which was posted on the *Lancet* website on 9 July (http://image.thelancet.com/extras/04art6112web.pdf). This move isn't quite as crazy as it seems as the article is free, hugely important, written in part by a *BMJ* employee, and coincides with a meeting held this week in BMA House.

The meeting marked the tenth anniversary of our first meeting to bring together and learn from groups who were trying to improve the flow of health information to the developing world. The meeting spawned the Health Information Forum, which played a central part in producing the *Lancet* paper. It was commissioned by the World Health Organization in preparation for the Mexico Summit on Health Research in November.

Ten years ago the supply of health information to the developing world was appalling. Many medical schools had no current journals. Textbooks were out of date, stolen, or destroyed. Internet access was almost non-existent. Worse, major international bodies like WHO didn't see information supply as essential. It was more a "nice to have."

Today—despite the explosion of the internet and the commitment of WHO and others to fix the problem—things are not much improved. "Overall," says the *Lancet* article, "there is little if any evidence that the majority of health professionals, especially those working in primary health care, are any better informed than they were 10 years ago." The 10/90 gap, whereby less than 10% of health research is concerned with the conditions that account for 90% of global disease, may well be a 1/99 gap when it comes to health information. Doctors in the rich world are drowning in information; health workers in rural Africa have no more than 10 years ago. Journals may be more part of the problem than the solution.

The article discusses ways to close the "know-do gap," the huge gap between what evidence shows is best practice and what practitioners actually do. If you haven't heard this phrase, you can rest assured that you will do so repeatedly, not least because the developed world also has a substantial "know-do gap." (Indeed, I have one personally, as, I'm sure, do most of you.)

Closing the gap requires not exhortations for everybody to try harder and spend more money but some "systems' thinking." The article describes an information cycle that identifies 13 steps that have to do with identifying health information needs (a commonly missed step), adding to the body of knowledge, synthesising the knowledge, and then localising it. The model is helpful, and with WHO's lead and help from the broader community the goal of health information for all by 2015 is "realistically achievable."

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