

logical screening. The same may not be true in parts of the world with high rates of latent sexually transmitted infection or where many of those who present with incomplete miscarriage have attempted illegal abortion. In these settings many practitioners will continue to avoid expectant management and use prophylactic antibiotics for both surgical and medical evacuation in order to keep infection rates low.¹³

In areas without these problems a woman with spontaneous miscarriage in the first trimester should be offered a choice of management. Does she wish to have surgical evacuation that will provide a rapid resolution to the problem but has a 1:50 complication rate, or expectant management which—although unpredictable—will probably allow her to avoid admission to hospital? Medical management should speed up her miscarriage and reduce the likelihood of her having surgical intervention to around 5–15% depending on the type of miscarriage. In choosing, she can be reassured that the risks of infection and bleeding are low, whatever her decision.

Andrew Weeks *senior lecturer in obstetrics*

(aweeks@liv.ac.uk)

School of Reproductive and Developmental Medicine, Liverpool Women's Hospital, Crown Street, Liverpool L8 7SS

Kristina Gemzell Danielsson *professor of obstetrics and gynaecology*

Department of Woman and Child Health, Division for Obstetrics and Gynaecology, Karolinska Institutet, S-171 76 Stockholm, Sweden

Competing interests: None declared.

- 1 Nanda K, Peggolia A, Grimes D, Lopez L, Nanda G. Expectant care versus surgical treatment for miscarriage. *Cochrane Database Syst Rev* 2006;(2):CD003518.
- 2 Neilson JP, Hickey M, Vazquez J. Medical treatment for early fetal death (less than 24 weeks). *Cochrane Database Syst Rev* 2006 (in press).
- 3 Trinder J, Brocklehurst P, Porter R, Read M, Vyas S, Smith L. Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial). *BMJ* 2006;332:1235-8.
- 4 Luise C, Jermy K, May C, Costello G, Collins WP, Bourne TH. Outcome of expectant management of spontaneous first trimester miscarriage: observational study. *BMJ* 2002;324:873-5.
- 5 Nguyen TNN, Blum J, Durocher J, Quan TTVQ, Winikoff B. A randomized controlled study comparing 600 versus 1200 µg oral misoprostol for medical management of incomplete abortion. *Contraception* 2005;72:438-42.
- 6 Tang OS, Lau WN, Ng EH, Lee SW, Ho PC. A prospective randomized study to compare the use of repeated doses of vaginal with sublingual misoprostol in the management of first trimester silent miscarriages. *Hum Reprod* 2003;18:176-81.
- 7 Zhang J, Gilles JM, Barnhart K, Creinin MD, Westhoff C, Frederick MM for the National Institute of Child Health Human Development (NICHD) Management of Early Pregnancy Failure Trial. A comparison of medical management with misoprostol and surgical management for early pregnancy failure. *N Engl J Med* 2005;353:761-9.
- 8 Gynuity Health Projects. *Instructions for use of misoprostol for women's health*. www.gynuity.org/pub_b.html#q5 (accessed 19 May 2006).
- 9 Weeks A, Alia G. Ultrasonography may have role in assessing spontaneous miscarriage. *BMJ* 2001;323:694.
- 10 Creinin MD, Harwood B, Guido RS, Fox MC, Zhang J, for the NICHD management of early pregnancy failure trial. Endometrial thickness after misoprostol use for early pregnancy failure. *Int J Gynecol Obstet* 2004;86:22-6.
- 11 Fiala C, Safar P, Bygdeman M, Gemzell-Danielsson K. Verifying the effectiveness of medical abortion; ultrasound versus hCG testing. *Eur J Obstet Gynecol Reprod Biol* 2003;109:190-5.
- 12 Blohm F, Hahlin M, Nielsen S, Milsom I. Fertility after a randomised trial of spontaneous abortion managed by surgical evacuation or expectant treatment. *Lancet* 1997;349:995.
- 13 Weeks AD, Alia G, Blum J, Winikoff B, Ekwaru P, Durocher J, Mirembe FM. A randomized trial of misoprostol versus manual vacuum aspiration for incomplete abortion. *Obstet Gynecol* 2005;106:540-7.

How much and how often should we drink?

Interpret with caution new evidence on frequency and amount of men's drinking

People choose to drink alcohol for all sorts of reasons, from toasting the happy couple to drowning sorrows and numbing pain. Few people choose to drink primarily to reduce their risk of coronary heart disease. However, the paper by Tolstrup and colleagues on p 1244 will be welcomed by many.¹ The authors studied more than 50 000 Danish men and women and report that to gain maximum cardioprotective benefit from alcohol, it doesn't matter how much men drink as long as they drink every day. I can hear the corks popping already, but before pouring the next glass and at the risk of being a wet—or should that be dry—blanket, it is worth bearing several caveats in mind.

Firstly, this finding applied only to men. For women it was the amount of alcohol consumed, regardless of frequency, that was the primary determinant in the relation between alcohol and heart disease. This raises interesting possibilities about gender specific alcohol metabolism. The Danish participants were middle aged and therefore presumably at increased risk of heart disease. The epidemiological evidence on how drinking is related to the risk of heart disease over the life course is scarce and we do not yet know whether cardioprotective benefits accrue over a lifetime or whether, purely from a health perspective, we should defer drinking alcohol until older age, when heart disease is manifest.

The low response rate of 35% (160 725 Danish men and women were invited to participate in the study, and 27 178 men and 29 875 women did participate) means that there may be extremes of drinking which were not captured and that there is a limit to the amount that can be consumed daily. And, as the authors note, residual confounding—the bane of observational epidemiology—may partly explain the findings.

Before advising patients about their frequency of drinking, of course, we must consider the bigger picture in terms of health and social consequences of alcohol consumption. For some alcohol related conditions, it is clear that the pattern of consumption will be of paramount importance. Alcohol related injuries or ethanol toxicity, for example, suggest a degree of inebriation. It is not so clear that chronic diseases such as alcohol related cancers or cirrhosis will be affected by frequency of consumption, as opposed to volume. The limited earlier epidemiological evidence on drinking pattern and cardiovascular disease suggested that pattern of consumption is crucial to whether alcohol confers a positive or negative effect. This hypothesis is supported by the evidence that the physiological effects of regular moderate drinking and binge drinking are markedly different.²

Ideally practitioners should find out not only how much patients consume, but in what context and why.

Research p 1244

BMJ 2006;332:1224-5

A recent report by the UK Mental Health Foundation suggests that among daily drinkers (estimated to be nearly 1 in 10 people in the United Kingdom—about 5 million people) alleviation of anxiety and depression is cited as a common reason for drinking.³ Advising patients on volume and frequency of alcohol would depend on their age and susceptibility to heart disease and, in light of Tolstrup and colleagues' research, perhaps on their sex.

Alcohol is here to stay in our lives. It is not like cigarette smoking, which is being increasingly outlawed. Unlike tobacco, the healthiest amount of alcohol for some people may not be zero. So people need advice and legislation on keeping consumption safe. In the UK, levels of consumption have risen by more than 50% in the past 30 years, accompanied by a rise in alcohol related deaths, particularly from liver cirrhosis.⁴

As a population we are drinking well above the optimum level for health. The evidence suggests that raising the price and limiting availability of alcohol will reduce the average consumption and the prevalence of harmful consumption.⁴ It will be interesting to see the consequences of the recent relaxation of licensing hours and increased availability of alcohol in England.⁵

Clearly, it would be unwise for doctors to advise non-drinkers to start drinking in an attempt to prevent

cardiac disease when there are other strategies, supported by data from clinical trials, that have fewer harmful side effects. However, the general population makes lifestyle decisions on the basis of many factors, not least views expressed in the popular press. Research such as that conducted by Tolstrup and colleagues is widely disseminated in the media and may be used by some people as a justification for their potentially harmful drinking behaviour. Sadly, it is difficult to control the media's sensationalist interpretations of epidemiological findings.

Annie Britton *senior lecturer*

(a.britton@ucl.ac.uk)

Department of Epidemiology and Public Health, University College London, London WC1E 6BT

Competing interests: None declared.

- 1 Tolstrup J, Jensen MK, Tjønneland A, Overvad K, Mukamal KJ, Grønbaek M. Prospective study of alcohol drinking patterns and coronary heart disease in women and men. *BMJ* 2006;332:1244-7.
- 2 McKee M, Britton A. The positive relationship between alcohol and heart disease in eastern Europe: potential physiological mechanism. *J R Soc Med* 1998;91:402-7.
- 3 Mental Health Foundation. *Cheers? Understanding the relationship between alcohol and mental health*. London: Mental Health Foundation, 2006.
- 4 Academy of Medical Sciences. *Calling time: the nation's drinking as a major health issue*. London: Academy of Medical Sciences, 2004.
- 5 Department for Culture, Media, and Sport. Alcohol and entertainment. Licensing Act 2003. www.culture.gov.uk/alcohol_and_entertainment/ (accessed 17 May 2006).

Patient agendas in primary care

Perhaps the main benefit is to encourage patients to voice embarrassing problems

Research p 1238

People often have difficulty in fully expressing their concerns in consultations with doctors¹ and this may adversely affect outcomes. Some issues go unvoiced or are introduced in a "by the way" presentation at the end of the consultation. The temporal order by which patients present their agendas may not reflect their perceived importance or match the doctor's prioritisation. The first item raised may be the most socially acceptable, and the last (or unvoiced) item—such as breast lumps or rectal bleeding—may be the vaguest or most embarrassing.

If they have time doctors may try to counter this by an open question, asking if there are any other problems.² But doctors have to work within time constraints, and a few actively discourage the presentation of more than one problem per consultation. Examining the issue of patients' agendas—their ideas, concerns and expectations—brings out the tension between a patient-centred model of the consultation and the structural constraints of medicine. Against this background, Middleton and colleagues report in this week's *BMJ* (p 1238) a trial of a self completed agenda form in primary care, embedded in a trial of general practitioner education.³

General practitioners were randomised either to attend an educational workshop and learn how to use the patient agenda form or to a control group invited to attend the workshop after the trial. In both arms of the trial, patients who were about to see their general practitioners were randomised to use the agenda form during their consultation or not. Both interventions

had a similar aim—to improve gathering of the patient's agenda by the doctors. The agenda form was a single sheet inviting patients to list their points, related thoughts and questions, and asking whether they wanted a prescription, explanation, investigation, or certificate.

There have now been three large randomised controlled trials of agenda gathering in primary care, although the third—ours—has not yet reported. The other published study was of a leaflet encouraging patients in the waiting room to list issues they wished to discuss (though without writing them down).⁴ Such interventions can serve two broad functions. Patients may use the form to expand on the main problem by outlining their concerns and expectations, or they may list additional problems. If an agenda form allows the patient to elaborate on the problem, doctor and patient may be more likely to reach a common view about what the outcome of the consultation should be.⁵ Such concordant consultations may alter prescribing, investigation, or referral decisions, in either direction.

Some patients may use an agenda form to express their wish for a prescription, which the doctor may not have considered. Conversely, some patients may regard their problem as not warranting a prescription that might otherwise have been issued. Middleton and colleagues' study did not report such outcomes, although Little and colleagues found an increase in investigation and prescribing, but not referral, when such items were specifically requested on the pre-consultation questionnaire.⁶ Middleton and