Tom Nolan’s research reviews—7 July 2022

Tom Nolan clinical editor; sessional GP, Surrey

Culture club

This week’s Education pages in The BMJ include a guide to the uncertainties and complexities of a seemingly simple question: how long do you stay infectious for after covid-19 (www.bmj.com/content/378/bmj-2020-061402)? Viral culture is seen as a reasonable surrogate for infectiousness but impractical for clinical use. A small study of 66 people with covid-19 during the delta and omicron eras looked at how long it took to convert to culture-negative infection—that is, probably not infectious—after onset of symptoms or a positive PCR test. It found that plenty of people in the study still had positive cultures beyond five days after developing symptoms: the median number of days to culture conversion was six days for delta infection and eight days for omicron.


Code of conduct

When a new incentive scheme comes along in primary care it usually comes with a new code to remember to add to patients’ clinical notes. Codes used to get printed out and stuck to the edge of every computer monitor, but there are now so many that the printout has been replaced by computer templates. Because we forget to (or don’t want to) use templates, on-screen popups appear to remind us to use the templates, and the simple and seemingly unintrusive idea to incentivise clinical activity by adding codes to patient notes has become a monster that eats up half of your appointment time and all of your enthusiasm.

In the US, primary care physicians seem to be coding for only a fraction of the prevention and coordination work that they do—and losing out on bucket loads of cash in the process. Researchers used national survey data and claims data to estimate the potential and actual use of codes used for billing prevention and coordination work in the notes of Medicare patients. They estimate that a primary care physician could add around $200 000 to their practice’s income each year by billing for half of the number of patients eligible for prevention and coordination work and conclude that “attempting to codify each distinct activity done by a primary care physician...may not be an effective strategy for supporting primary care.”

Too right!

Ann Intern Med doi:10.7326/M21-4770

Attention please

An unblinded randomised trial set in US oncology centres found small improvements in measures of quality of life, physical activity, and symptom control in people with metastatic cancer who completed weekly electronic symptom monitoring compared with usual care. The authors acknowledge that “it is possible that the additional attention received by the intervention group, rather than the intervention components, explained the benefits reported here”; that minimal clinically important differences are not established for the outcomes measured; and that being aware of which group patients were assigned to could contribute to the differences seen. I think whether I found completing a weekly survey of my symptoms helpful would depend a lot on what my “usual care” looked like, in particular how accessible primary and secondary care support is.

JAMA doi:10.1001/jama.2022.9265

Ratings wars

Websites rating individual doctor haven’t taken off in the UK as they have in the US, where, according to a new study in JAMA Internal Medicine, over half of US doctors have been rated on at least one of the four main doctor rating platforms. Clearly these ratings are a serious business, as demonstrated by this study—an automated Google web search of over a million physicians—of how physician ratings vary with time. The main findings are that online ratings are, on average, over five years old, and over 40% of reviews within the last three years are meaningfully different from the individual physician’s average rating.


Tenecteplase and thank you

Tenecteplase, a genetically modified variant of alteplase, is quicker to prepare than alteplase and can be given as a bolus—useful properties in the context of treating acute stroke—but is it as safe and effective? A pragmatic, multicentre, open-label randomised trial of patients presenting with acute ischaemic stroke within 4.5 hours of symptom onset has found tenecteplase 0.25 mg/kg to be non-inferior to alteplase 0.9 mg/kg in terms of recovery rates. Excellent functional outcomes were achieved in around a third of patients in both the tenecteplase and alteplase arms of the study. Safety outcomes, including death at 90 days and intracerebral haemorrhage, were similar in both groups.

Lancet doi:10.1016/S0140-6736(22)01054-6

Competing interests: None declared

Provenance and peer review: Not commissioned, not peer reviewed.