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NEWS


Italy looks set to become the latest country to tackle the controversial matter of publishing surgeons’ performance figures. From next year its surgeons will have to make their curriculum vitae and surgical success rates available to the public, the country’s public administration minister Renato Brunetta has announced. Details on precisely how surgeons’ performance will be monitored and presented were not given. Announcing his intentions, Mr Brunetta justified his decision by saying, “If I have to have an operation I have a right to know whether my doctor is a butcher or an efficient operator—if he’s going to kill me or save my life. “This might make waves, but the first to back the plan will be the good surgeons,” he added. The announcement drew a mixed response from the profession. Several leading figures supported the idea of giving the public more information about their surgeons.


A High Court judge in London ruled last week that doctors’ duty of confidentiality “arguably” survives a patient’s death but gave the go ahead “in the public interest” for the disclosure of medical records of dead nuclear plant workers to an independent inquiry. The order by Mr Justice Foskett removed a barrier to the release of the records of dead workers to the public inquiry looking into the removal of hearts, lungs, and other organs from the bodies of employees in the nuclear industry for testing for plutonium after their deaths. The inquiry, conducted by Michael Redfern QC, was set up by the government last year after it emerged that the consent of next of kin might not have been obtained for the body parts of former workers at Sellafield to be removed and analysed. The inquiry covers workers at Sellafield who died between November 1962 and August 1991, and . . .


Doctors should be vigilant for cases of community acquired Staphylococcus aureus infections, the Health Protection Agency has warned this week. Recorded cases of Panton-Valentine leukocidin associated S aureus (PVLSA) infections in England and Wales have risen more than sixfold from 2005 to 2007, when there were 1361 cases recorded. Whether there is a true rise is uncertain, explained Angela Kearns of the agency’s Centre for Infections at the agency’s conference in Coventry last week. “We are seeing a year on year increase in numbers but it could be better recognition.” She said that the agency needed more data to be sure that it was a real and serious rise. The bacteria has a gene that produces a toxin, Panton-Valentine leukocidin (PVL), which destroys white blood cells, making it far more virulent than some other stains. Many strains of PVLSA can be treated with a range of antibiotics, but some are . . .


A pioneering scheme that pays hospitals a bonus for delivering the best quality care is being rolled out across the NHS North West region of England after a trial showed it gave incentives to clinicians in a way that government reforms have failed to do. The scheme, entitled Advancing Quality, has been developed by the strategic health authority NHS North West to improve the region’s poor health and to improve patients’ hospital experience. It pays the best performing hospitals a bonus on top of what they receive through Payment by Results, the national system by which hospitals are paid for the procedures they carry out. In the scheme’s pilot phase, eight trusts in the area were asked to record whether patients admitted for five conditions and procedures—heart attacks, pneumonia, heart failure, hip and knee replacements, and heart bypass operations—were treated according to 34 evidence based clinical standards. These included, for . . .


Care in an acute medical unit—a hospital unit specially designed and staffed for patients with acute medical unvaccinated child younger than 18. In the catch-up campaign in London parents of less than half the children returned consent forms, 80% of children whose forms were returned had already been vaccinated, and only 70% of the rest received the jab. Immunisation coordinators from the London campaign thought that there had been too little time to plan the scheme, with most saying . . .
illnesses—reduces in-hospital mortality and length of stay among people with acute medical conditions, new research indicates. In 2007, overall mortality in people admitted to an acute medical unit at the Chelsea and Westminster Hospital, London, was 1.1% (28 deaths in 2221 patients). In 2005, before the unit was developed, mortality in patients at the hospital with acute medical illnesses was 1.6% (34 deaths in 2096 patients). The average length of stay was 8.8 days before the unit was developed and 6.9 days afterwards, say audit results reported at the international conference of the Society for Acute Medicine, in London on 29 and 30 September. Nearly twice as many people were able to go home within 24 hours of going to hospital after the unit was developed (42% (928 of 2221 patients) versus 23% . . .


The death rate among children and adolescents from Aboriginal and other indigenous groups in Australia has fallen over the past decade, a report has found. However, indigenous people aged between 1 year and 20 years are still twice as likely as other Australians in this age group to die, it says. The report highlights the scale of the challenge faced by Australian federal and state governments, which last year committed themselves to closing, within a generation, the 17 year gap in life expectancy between indigenous and non-indigenous Australians. The push to resolve the crisis in Aboriginal health has also seen an undertaking by the federal government to halve mortality in indigenous children under the age of 5 years within a decade. However, the latest report from the Australian Institute of Health and Welfare indicates that even this ambitious target would leave indigenous children worse off than other Australians, given their . . .


A study in Ethiopia shows profound differences between the health outcomes of children born in urban and rural parts of sub-Saharan Africa, with urban areas conferring a big advantage (Journal of Perinatal and Paediatric Epidemiology 2008 Sep 10, doi:10.1111/j.1365-3016.2008.00974.x). This is thought to be the first occasion that a group of African children have been followed in detail from birth to adulthood, and it gives a useful insight into why only one in four such children survive until their 18th birthday. The research identifies the hazards that face rural Ethiopian children, including death shortly after birth, risks from common infections such as malaria and pneumonia, and nutritional problems. Researchers also found marked local differences between children living in the highlands and the lowlands, and rural versus periurban areas. “Survival varied considerably between Butajira town, the rural highlands, and the rural lowlands . . . The hazard ratio . . .


The number of children admitted to hospital in China after drinking infant formula tainted with melamine has risen to 12 892, with 104 seriously ill. Across the country 39 965 children have already been treated and discharged, China’s Ministry of Health has said. The incident, which has so far claimed the lives of four children, has led to the resignation of Li Changjiang, head of China’s quality watchdog organisation, say reports from the state news agency. A 4 year old girl in Hong Kong became the first known victim outside mainland China when she was discovered on 19 September to have kidney stones as a result of drinking tainted milk. The World Health Organization, which was informed of the problem only on 11 September, has criticised China’s internal communication and food safety systems. “Evidently there is a problem with internal communications, as it seems that some people already knew about . . .


The German parliament is likely to vote in the next few months on a law to reduce the number of late abortions. Current German abortion law allows unrestricted abortions for women up to 12 weeks of pregnancy but requires them to be counselled about their decision, and to wait three days before the operation. After 12 weeks of pregnancy abortions are allowed if the pregnancy or birth poses a risk to the physical or mental health of the mother. This can include abortions performed if the mother learns she would give birth to a baby with severe disabilities. However, in these cases German law does not require counselling and a three day wait. The new law would extend these requirements to all abortions. Its ultimate goal is to reduce the number of abortions performed on the grounds that the baby would be disabled. Hans-Jörg Freese, a spokesman for the German . . .


New worries about a chemical found in many plastic food containers were raised by a report in JAMA and an accompanying editorial (2008;300:1303-10, doi:10.1001/jama.300.11.1303). The study attracted much media attention. It followed a report by the Food and Drug Administration last month that said that the chemical was safe (BMJ 2008;337:a1429) and a report in April by another US government agency, the National Toxicology Program, that raised concerns about the chemical. Bisphenol A is used to make polycarbonate plastic food and drink containers, such as baby bottles.
It is also used in the lining of aluminium cans, in dental sealants to prevent decay, in “carbonless” paper for receipts, and in other household products. Activists claim that the chemical is unsafe because animal studies have shown that it is an endocrine disrupter. They say that many adverse effects occur in animals at concentrations far below the recommended US . . .


The tobacco industry in Germany, working with the popular German daily newspaper Bild, stopped the airline Lufthansa from banning smoking on its domestic flights in the early 1990s, an analysis of internal tobacco industry documents shows. The tobacco company Philip Morris has had to publish thousands of internal documents on the internet as a consequence of a US court sentence against it in 1998. A paper in a German public health journal has used the documents to shed light on the tobacco industry’s successful lobbying strategies in Germany (Gesundheitswesen 2008;70:315-24, doi:10.1055/s-2008-1078752). The documents also show how the German Association of the Cigarette Industry (Verband der Cigarettenindustrie) managed to prevent a ban on tobacco advertising, to persuade the German government to bring action against certain EU guidelines, to keep cigarette vending machines accessible to children, and to prevent the introduction of higher taxes on tobacco products. They . . .

**RESEARCH**


Selection criteria Eligible studies had data on severe pregnancy outcomes for women with and without previous treatment for cervical intraepithelial neoplasia. Considered outcomes were perinatal mortality, severe preterm delivery (<32/34 weeks), extreme preterm delivery (<28/30 weeks), and low birth weight (<2000 g, <1500 g, and <1000 g). Excisional and ablative treatment procedures were distinguished. One prospective cohort and 19 retrospective studies were retrieved. Cold knife conisation was associated with a significantly increased risk of perinatal mortality (relative risk 2.87, 95% confidence interval 1.42 to 5.81) and a significantly higher risk of severe preterm delivery (2.78, 1.72 to 4.51), extreme preterm delivery (5.33, 1.63 to 17.40), and low birth weight of <2000 g (2.86, 1.37 to 5.97). Laser conisation, described in only one study, was also followed by a significantly increased chance of low birth weight of <2000 g and <1500 g. Large loop excision of the transformation zone and ablative treatment with cryotherapy or laser were not associated with a significantly increased risk of serious adverse pregnancy outcomes. Ablation by radical diathermy was associated with a significantly higher frequency of perinatal mortality, severe and extreme preterm delivery, and low birth weight below 2000 g or 1500 g. In the treatment of cervical intraepithelial neoplasia, cold knife conisation and probably both laser conisation and radical diathermy are associated with an increased risk of subsequent perinatal mortality and other serious pregnancy outcomes, unlike laser ablation and cryotherapy. Large loop excision of the transformation zone cannot be considered as completely free of adverse outcomes.


Primary outcomes were the time without fever (<37.2°C) in the first four hours after the first dose was given and the proportion of children reported as being normal on the discomfort scale at 48 hours. Secondary outcomes were time to first occurrence of normal temperature (fever clearance), time without fever over 24 hours, fever associated symptoms, and adverse effects. On an intention to treat basis, paracetamol plus ibuprofen were superior to paracetamol for less time with fever in the first four hours (adjusted difference 55 minutes, 95% confidence interval 33 to 77; P<0.001) and may have been as good as ibuprofen (16 minutes, −7 to 39; P=0.2). For less time with fever over 24 hours, paracetamol plus ibuprofen were superior to paracetamol (4.4 hours, 2.4 to 6.3; P<0.001) and to ibuprofen (2.5 hours, 0.6 to 4.4; P=0.008). Combined therapy cleared fever 23 minutes (2 to 45; P=0.025) faster than paracetamol alone but no faster than ibuprofen alone (3 minutes, 18 to −24; P=0.8). No benefit was found for discomfort or other symptoms, although power was low for these outcomes. Adverse effects did not differ between groups. Parents, nurses, pharmacists, and doctors wanting to use medicines to supplement physical measures to maximise the time that children spend without fever should use ibuprofen first and consider the relative benefits and risks of using paracetamol plus ibuprofen over 24 hours.


Costs to the NHS and to parents and carers. Cost consequences analysis at 48 hours and 5 days
Comparing cost with children’s temperature, discomfort, activity, appetite, and sleep; cost effectiveness analysis at 48 hours comparing cost with percentage of children “recovered.” Difficulties in recruiting children to the trial lowered the precision of the estimates of cost and some outcomes. At 48 hours, cost to the NHS was £11.33 for paracetamol, £8.49 for ibuprofen, and £8.16 for both drugs. By day 5 these costs rose to £19.63, £18.36, and £13.92 respectively. For parents and carers, the 48 hour costs were £23.86 for paracetamol, £20.60 for ibuprofen, and £25.07 for both, and the day 5 costs were £26.35, £29.90, and £24.02 respectively. Outcomes measured at 48 hours and 5 days were inconclusive because of lack of power; the cost effectiveness analysis at 48 hours provided little evidence that one treatment choice was significantly more cost effective than another. At 4 hours ibuprofen and the combined treatment were superior to paracetamol in terms of the trial primary outcome of time without fever; at 24 hours the combined treatment performed best on this outcome. There is no strong evidence of a difference in cost between the treatments, but clinical and cost data together indicate that using both drugs together may be most cost effective over the course of the illness. This treatment option performs best and is no more expensive because of less use of healthcare resources, resulting in lower costs to the NHS and to parents.


Events that occurred overnight and at weekends (out of hours) and events that occurred during surgery hours. Among 359 patients with TIA and 434 with minor stroke, the median (interquartile range) time to call a general practitioner after an event during surgery hours was 4.0 (1.0-45.5) hours, and 68% of patients with events during surgery hours called within 24 hours of onset of symptoms. Median (interquartile range) time to call a general practitioner after events out of hours was 24.8 (9.0-54.5) hours for patients who waited to contact their registered practice compared with 1.0 (0.3-2.6) hour in those who used an emergency general practitioner service (P<0.001). In patients with events out of hours who waited to see their own general practitioner, seeking attention within 24 hours was considerably less likely for events at weekends than weekdays (odds ratio 0.10, 95% confidence interval 0.05 to 0.21): 70% with events Monday to Friday, 33% on Sundays, and none on Saturdays. Thirteen patients who had events out of hours and did not seek emergency care had a recurrent stroke before they sought medical attention. A primary care centre open 8 am-8 pm seven days a week would have offered cover to 73 patients who waited until surgery hours to call their general practitioner, reducing median delay from 50.1 hours to 4.0 hours in that group and increasing those calling within 24 hours from 34% to 68%. General practitioners’ opening hours influence patients’ healthcare seeking behaviour after TIA and minor stroke. Current opening hours can increase delay in assessment. Improved access to primary care and public education about the need for emergency care are required if the relevant targets in the national stroke strategy are to be met.


Urgency according to the Manchester triage system compared with a predefined and independently assessed reference standard for five urgency levels. This reference standard was based on a combination of vital signs at presentation, potentially life threatening conditions, diagnostic resources, therapeutic interventions, and follow-up. Sensitivity, specificity, and likelihood ratios for high urgency (immediate and very urgent) and 95% confidence intervals for subgroups based on age, use of flowcharts, and discriminators. The Manchester urgency level agreed with the reference standard in 4582 of 13 554 (34%) children; 7311 (54%) were over-traiged and 1661 (12%) under-triaed. The likelihood ratio was 3.0 (95% confidence interval 2.8 to 3.2) for high urgency and 0.5 (0.4 to 0.5) for low urgency; though the likelihood ratios were lower for those presenting with a medical problem (2.3 (2.2 to 2.5) v 12.0 (7.8 to 18.0) for trauma) and in younger children (2.4 (1.9 to 2.9) at 0-3 months v 5.4 (4.5 to 6.5) at 8-16 years). The Manchester triage system has moderate validity in paediatric emergency care. It errs on the safe side, with much more over-triage than under-triage compared with an independent reference standard for urgency. Triage of patients with a medical problem or in younger children is particularly difficult.


Cardiovascular events and total deaths. With both methods there was a highly significant association between the level of predicted risk and the incidence of cardiovascular events and of total deaths: up to three quarters of all cardiovascular events and two thirds of
all deaths were reported among people classified as at high or very high risk with either method. The predictive discrimination of the essential method is comparable with the WHO-ISH with C statistics (95% confidence interval) of 0.788 (0.721 to 0.855) and 0.744 (0.673 to 0.815), respectively, for cardiovascular events and 0.747 (0.678 to 0.816) and 0.705 (0.632 to 0.778) for total mortality. The risk stratification of patients with hypertension with an essential package of variables (that is, available and practicable even in the economically less developed areas of the world) serves at least as well as the more comprehensive method proposed by WHO-ISH.

van Dam, R.M., Tricia Li, Donna Spiegelman, Oscar H Franco, and Frank B Hu. (2008). Combined impact of lifestyle factors on mortality: prospective cohort study in US women. British Medical Journal, 337 (7672), 1440. Relative risk of mortality during 24 years of follow-up in relation to five lifestyle factors (cigarette smoking, being overweight, taking little moderate to vigorous physical activity, no light to moderate alcohol intake, and low diet quality score). 8882 deaths were documented, including 1790 from cardiovascular disease and 4527 from cancer. Each lifestyle factor independently and significantly predicted mortality. Relative risks for five compared with zero lifestyle risk factors were 3.26 (95% confidence interval 2.45 to 4.34) for cancer mortality, 8.17 (4.96 to 13.47) for cardiovascular mortality, and 4.31 (3.51 to 5.31) for all cause mortality. A total of 28% (25% to 31%) of deaths during follow-up could be attributed to smoking and 55% (47% to 62%) to the combination of smoking, being overweight, lack of physical activity, and a low diet quality. Additionally considering alcohol intake did not substantially change this estimate. These results indicate that adherence to lifestyle guidelines is associated with markedly lower mortality in middle aged women. Both efforts to eradicate cigarette smoking and those to stimulate regular physical activity and a healthy diet should be intensified.

CLINICAL REVIEW

L Fuccio, L Laterza, R M Zagari, V Cennamo, D Grilli, and Franco Bazzoli. (2008). Treatment of Helicobacter pylori infection. British Medical Journal, 337 (7672), 1454. Helicobacter pylori is one of the most common human infections, and about half of the world’s population carries this organism. Since its discovery in 1984, H pylori has been recognised as a major cause of several upper gastrointestinal diseases.1 2 As with other chronic infectious diseases, several antibiotics must be given simultaneously . . .

Papadakis, M., Greg Whyte, and Sanjay Sharma. (2008). Preparticipation screening for cardiovascular abnormalities in young competitive athletes. British Medical Journal, 337 (7673), 1596. The cardiovascular benefits of regular physical exercise are well established.1 However, a small proportion of young athletes with unsuspected heart disease are at increased risk of exercise related sudden cardiac death.2 The majority of such deaths are attributable to cardiac anomalies,2 3 4 most of which can be identified during life. A range of therapeutic strategies can be implemented to prevent fatalities, raising support for screening young athletes in medical and sporting communities.5 6 7 8 9 The efficacy, cost effectiveness, and impact of false positive tests of preparticipation screening strategies are, however, controversial. This article provides a factual overview of preparticipation screening, as more general practitioners are likely to be confronted with the questions relating to cardiovascular screening in athletes in countries where systematic screening programmes are currently not available.