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Outcomes of conduct problems in adolescence: 40 year follow-up of national cohort. Colman, I., Joseph Murray, Rosemary A Abbott, Barbara Maughan, Diana Kuh, Tim J Croudace, Peter B Jones.


Lung cancer deaths from indoor radon and the cost effectiveness and potential of policies to reduce them. Gray, A., Simon Read, Paul McGale, and Sarah Darby.


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Assessment and management of non-visible haematuria in primary care. Kelly, J.D., Derek P Fawcett, and Lawrence C Goldberg.

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NEWS


The availability of essential drugs for children in central Africa is poor, a new study shows. In only three of 14 countries surveyed were more than 50% of the drugs that are considered essential—as indicated by national lists and standard treatment guidelines—available from central medical stores. “If the availability of these essential medicines for children is as poor as is suggested by the results of this study, we have a lot to do to understand what is happening in the supply systems for medicines in these countries before we can improve them,” say the authors, from the World Health Organization and the University of Newcastle, Australia (Bulletin of the World Health Organisation, www.who.int/entity/bulletin/volumes/87/08-053645.pdf). The authors looked at the availability and cost of the drugs in Cameroon, Chad, the Republic of the Congo, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Mali, Nigeria, Rwanda, Senegal, Uganda, Tanzania, . . .


A woman’s risk of getting breast cancer, the stage at which it is diagnosed, and the treatment she gets all vary with ethnic background, a new UK study has found. But the researchers found, after adjusting fully for age, level of socioeconomic deprivation, stage of disease, and treatment received, that survival from breast cancer did not vary significantly (British Journal of Cancer doi:10.1038/sj.bjc.6604852). The researchers, from King’s College London, analysed data on 35 631 women who received a diagnosis of breast cancer in southeast England between 1998 and 2003. The ethnic groups they looked at were white, Indian, Pakistani, Bangladeshi, black Caribbean, black African, and Chinese. They found that white women had the highest age standardised incidence of breast cancer and Bangladeshi women had the lowest. Incidence rate ratios calculated with that among white women as the baseline were all significantly lower: Indian 0.68 (95% confidence interval . . .


The group Physicians for Human Rights-Israel has called for doctors with expertise in forensic medicine, medical crises, and public health to take part in an independent fact finding mission to Gaza after a ceasefire in the region. The non-governmental organisation, which works to protect medical human rights of people in Israel and in the Palestinian territories occupied by Israel said that the mission would have several objectives. It would try to learn about the weapons that caused the types of injuries seen in the Gaza Strip during Israel’s three week offensive, which started on 27 December, the extent and nature of attacks on medical facilities and teams, and difficulties experienced evacuating wounded and dead people. Also under investigation would be the impact of the assault on the health of people in the area. Claims that Israel has been using new weapons and violated internationally accepted standards regarding hospitals and health . . .


Radiation workers’ risk of developing a range of cancers rises with increasing exposure to ionising radiation, a UK study has found. The study confirms previous findings but also shows that this group benefits from a “healthy worker effect,” with a lower overall death rate than in the general population. The study looked at cancer incidence and mortality in 174 541 people in the National Registry for Radiation Workers, which was set up in 1976 to assess the effects of protracted exposure to low dose radiation in the workplace. They include workers at nuclear power stations, people working with atomic weapons and medical isotopes, and researchers working with radioactive materials. The latest results show that the incidence and mortality from leukaemia (apart from chronic lymphocytic leukaemia) and all other malignant neoplasms apart from leukaemia (that is, solid cancers) rose significantly with an increasing dose of radiation exposure (British Journal of . . .


The trial of two Iranian doctors on secret charges has caused a storm of protest from medical practitioners worldwide. Arash Alaei and Kamiar Alaei, two brothers known internationally for their groundbreaking work as HIV and AIDS physicians, had been held without charge for more than six months before their appearance at Tehran’s Revolutionary Court at the end of December. They were summarily convicted of “communicating with an enemy government” and other as yet undisclosed charges and were still awaiting the verdict as the BMJ went to press. The advocacy group Physicians for Human Rights says that the two were “denied fundamental requirements of due process,” because the prosecutor refused to disclose all the charges against them and denied their right to confront the charges and defend themselves. It says that the trial “also sends an ominous signal regarding the Iranian government’s crackdown on international scientific exchange.” The two doctors have . . .

A prominent Palestinian gynaecologist who works in Israel and lives in Gaza, and who is a long term supporter of Arab-Israeli coexistence, lost three daughters in air attacks on his home at the end of last week. Ezzeldeen Abu al-Aish, a gynaecologist at Sheba Medical Center, Tel HaShomer, in central Israel, had been trapped in Gaza, where his family lives, since the Israeli offensive began three weeks ago. On the afternoon of Friday 16 January he was at home with his family in the northern Gaza Strip when the house was hit by an Israel Defense Forces shell, killing three of his eight children and a niece. Dr Abu al-Aish, who has been giving frequent updates of the situation in Gaza to the Israeli media, has been heard on national Israeli television weeping with grief. He telephoned Israel Channel 10 news reporter Shlomi Eldar, and for several minutes his voice . . .


The UK government has announced that it is setting up a confidential inquiry into premature deaths among people with learning disabilities to provide evidence for clinical staff and improve commissioning. The NHS is one of the key priorities in the Valuing People Now report, a cross governmental strategy aimed at improving the lives of one of society’s most excluded groups. In the report, published on Monday, the government accepts all 10 recommendations made by Jonathan Michael, former chief executive of Guy’s and St Thomas’s Hospital, after his independent inquiry last year into access to health care for people with learning disabilities. These include the introduction of mandatory training in learning disabilities at undergraduate and postgraduate level, improved data collection, plus rigorous evaluation of services through a Public Health Observatory in learning disabilities. And all trust boards will have to show how they have adapted their services to make them accessible . . .


The first national study of the health of US prison inmates shows that they are much sicker than other Americans of the same age and have poor access to health care. Better health care for prisoners would benefit the community, because about 12 million inmates are released each year, thus bringing their health problems and infections into the community, the report says. The authors of the study, carried out by the Cambridge Health Alliance and Harvard Medical School, write: “The prison population of the United States has quadrupled in the past 25 years and the country now incarcerates more people per capita than any other nation” (American Journal of Public Health doi:10.2105/AJPH.2008.144279). About 750 per 100 000 US adults are in prison, about five times the proportion in the United Kingdom (148 per 100 000). Most inmates are male, aged younger than 35, disproportionately from black and . . .


Germany’s national organ procurement organisation is demanding more power after a decline of almost 9% in organ donation in 2008. About 12 000 patients are
waiting for a transplant in Germany, and dialysis patients often have to wait 5-6 years for a new kidney. The national organ body, Deutsche Stiftung Organtransplantation (DSO), says that the decline is partly because of the indifference of hospitals to transplantation—they are meant to register potential donors, but often fail to do so—and partly because of a change in the law on tissue donation in 2007, which said that hospitals and tissue banks have to fulfil stringent new criteria, similar to those governing the drug industry (BMJ 2006;333:774 doi:10.1136/bmj.333.7572.774-d). The organisation thinks that nothing will change until the government gives it more power. “By introducing appropriate measures the number of organ donations could be doubled,” says Günther Kirste, the organisation’s medical director.


The government has announced new legislation that will allow funds to be given to patients so that they can directly purchase their own healthcare services. Pilot schemes of personal health budgets are due to start this summer in selected areas in England. The Health Bill 2009 will pass through the House of Lords over the next few months and is the next step in the implementation of the health minister Ara Darzi’s review of the NHS (BMJ 2008;337:a645, doi:10.1136/bmj.a645). Commenting on the bill Lord Darzi said, “Building on the experience of social care, the bill allows the further development of ways to give patients greater personalisation and control over the health care services they receive.” The Department of Health said that there will be three broad categories of personal budget. The first is a notional personal budget where patients are given a budget constraint and are aware . . .


Health systems in poor countries, especially in Africa and south Asia, need to be substantially strengthened to improve care of the newborn and to reduce mortality in women during pregnancy and childbirth, a Unicef report says. “Every year more than half a million women die as a result of pregnancy or childbirth complications, including about 70 000 girls and young women aged 15 to 19,” said Ann Veneman, Unicef’s executive director. “Since 1990, complications related to pregnancy and childbirth have killed an estimated 10 million women,” she said. The report says that most maternal and neonatal deaths can be averted through interventions that have been proved to work. Essential services that are needed, it says, include better nutrition and safe water, sanitation, and hygiene facilities; adequate antenatal care; skilled assistance at delivery; basic and comprehensive emergency obstetric and newborn care; postnatal care; neonatal care; and integrated management of neonatal . . .


The situation is horrific and getting worse by the hour for civilians trapped in Israel’s military onslaught in the Gaza strip, senior UN officials have said. With the number of casualties, especially women and children, rising sharply, they have called on the international community to take effective action to stop the attacks. John Ging, director of operations in Gaza for the UN Relief and Works Agency for Palestine Refugees in the Near East, said on 13 January, “The horrific consequences of this conflict . . . still continue. People are still being killed [and] injured. The destruction is going on, and it continues to go on day by day.” Mr Ging said that the numbers of casualties are difficult to establish or verify, but he said that the Palestinian Ministry of Health and human rights organisations on the ground have reported that more than 900 people have been killed, among . . .

RESEARCH


Mental disorder, alcohol abuse, relationship difficulties, highest level of education, social class, unemployment, and financial difficulties at ages 36-53. 348 adolescents were identified with severe externalising behaviour, 1051 with mild externalising behaviour, and 2253 with no externalising behaviour. All negative outcomes measured in adulthood were more common in those with severe or mild externalising behaviour in adolescence, as rated by teachers, compared with those with no externalising behaviour. Adolescents with severe externalising behaviour were more likely to leave school without any qualifications (65.2%; adjusted odds ratio 4.0, 95% confidence interval 2.9 to 5.5), as were those with mild externalising behaviour (52.2%; 2.3, 1.9 to 2.8), compared with those with no externalising behaviour (30.8%). On a composite measure of global adversity throughout adulthood that included mental health, family life and relationships, and educational and economic problems, those with severe externalising behaviour scored significantly higher (40.1% in top quarter), as did those with mild externalising behaviour (28.3%), compared with those with no externalising behaviour (17.0%). Adolescents who exhibit externalising behaviour experience multiple social and health impairments that adversely affect them, their families, and society throughout adult life.

Combining physical examination with pulse oximetry screening had a sensitivity of 24/29 (82.8% (95% CI 64.2% to 95.2%)) and detected 100% of the babies with duct dependent lung circulation. Five cases were missed (all with aortic arch obstruction). False positive rate with pulse oximetry was substantially lower than that with physical examination alone (69/39 821 (0.17%) v 729/38 413 (1.90%), P<0.0001), and 31/69 of the “false positive” cases with pulse oximetry had other pathology. Thus, referral of all cases with positive oximetry results for echocardiography resulted in only 2.3 echocardiograms with normal cardiac findings for every true positive case of duct dependent circulation. In the cohort study, the risk of leaving hospital with undiagnosed duct dependent circulation was 28/100 (28%) in other referring regions versus 5/60 (8%) in West Götaland (P=0.0025, relative risk 3.36 (95% CI 1.37 to 8.24)). In the other referring regions 11/25 (44%) of babies with transposition of the great arteries left hospital undiagnosed versus 0/18 in West Götaland (P=0.0010), and severe acidosis at diagnosis was more common (33/100 (33%) v 7/60 (12%), P=0.0025, relative risk 2.8 (1.3 to 6.0)). Excluding premature babies and Norwood surgery, babies discharged without diagnosis had higher mortality than those diagnosed in hospital (4/27 (18%) v 1/110 (0.9%), P=0.0054). No baby died from undiagnosed duct dependent circulation in West Götaland versus five babies from the other referring regions. Introducing pulse oximetry screening before discharge improved total detection rate of duct dependent circulation to 92%. Such screening seems cost neutral in the short term, but the probable prevention of neurological morbidity and reduced need for preoperative neonatal intensive care suggest that such screening will be cost effective long term.


Estimated number of deaths from lung cancer related to indoor radon, lifetime risks of death from lung cancer before and after various potential interventions to control radon, the cost per quality adjusted life year (QALY) gained from different policies for control of radon, and the potential of those policies to reduce lung cancer mortality. The mean radon concentration in UK homes is 21 becquerels per cubic metre (Bq/m³). Each year around 1100 deaths from lung cancer (3.3% of all deaths from lung cancer) are related to radon in the home. Over 85% of these arise from radon concentrations below 100 Bq/m³ and most are caused jointly by radon and active smoking. Current policy identifying and remediating existing homes with high radon levels is, however, neither cost effective (cost per QALY gained £36 800) nor effective in reducing lung cancer mortality. Policies requiring basic preventive measures against radon in all new homes throughout the UK would be cost effective and could complement existing policies to reduce smoking. Policies involving remedial work on existing homes with high radon levels cannot prevent most radon related deaths, as these are caused by moderate exposure in many homes. These conclusions are likely to apply to most developed countries, many with higher mean radon concentrations than the UK.


The incidence of infection in the chloramphenicol group (6.6%; 95% confidence interval 4.9 to 8.8) was significantly lower than that in the control group (11.0%; 7.9 to 15.1) (P=0.010). The absolute reduction in infection rate was 4.4%, the relative reduction was 40%, and the relative risk of wound infection in the control group was 1.7 (95% confidence interval 1.1 to 2.5) times higher than in the intervention group. The number needed to treat was 22.8. Application of a single dose of topical chloramphenicol to high risk sutured wounds after minor surgery produces a moderate absolute reduction in infection rate that is statistically but not clinically significant.


The primary outcomes of interest were the arrhythmic end points of appropriate implantable cardiac defibrillator intervention and sudden cardiac death. The secondary outcomes were all cause mortality and death from cardiac causes. Subgroup analyses included the effect of formulations of EPA and DHA on death from cardiac causes and effects of fish oil in patients with coronary artery disease or myocardial infarction. 12 studies totalling 32 779 patients met the inclusion
Most patients received simvastatin (n=1167, 33 mg daily) or atorvastatin (n=211, 49 mg daily). We observed an overall risk reduction of 76% (hazard ratio 0.24 [95% confidence interval 0.18 to 0.30], P<0.001). In fact, the risk of myocardial infarction in these statin treated patients was not significantly greater than that in an age-matched sample from the general population (hazard ratio 1.44 [0.80 to 2.60], P=0.23). Lower statin doses than those currently advised reduced the risk of coronary heart disease to a greater extent than anticipated in patients with familial hypercholesterolaemia. With statin treatment, such patients no longer have a risk of myocardial infarction significantly different from that of the general population.


5056 (17.7%) patients had a repeat admission for an ADR. Repeat ADRs were associated with sex (hazard ratio 1.08, 95% confidence interval 1.02 to 1.15, for men), first admission in 1995-9 (2.34, 2.00 to 2.73), length of hospital stay (1.11, 1.05 to 1.18, for stays 60% of comorbidities were recorded and taken into account in analysis. In contrast, advancing age had no effect on repeat ADRs. Comorbid congestive cardiac failure (1.56, 1.43 to 1.71), peripheral vascular disease (1.27, 1.09 to 1.48), chronic pulmonary disease (1.61, 1.45 to 1.79), rheumatological disease (1.65, 1.41 to 1.92), mild liver disease (1.48, 1.05 to 2.07), moderate to severe liver disease (1.85, 1.18 to 2.92), moderate diabetes (1.18, 1.07 to 1.30), diabetes with chronic complications (1.91, 1.65 to 2.22), renal disease (1.93, 1.71 to 2.17), any malignancy including lymphoma and leukaemia (1.87, 1.68 to 2.09), and metastatic solid tumours (2.25, 1.92 to 2.64) were strong predictive factors. Comorbidities requiring continuing care predicted a reduced likelihood of repeat hospital admissions for ADRs (cerebrovascular disease 0.85, 0.73 to 0.98; dementia 0.62, 0.49 to 0.78; paraplegia 0.73, 0.59 to 0.89). Comorbidity, but not advancing age, predicts repeat admission for ADRs in older adults, especially those with comorbidities often managed in the community. Awareness of these predictors can help clinicians to identify which older adults are at greater risk of admission for ADRs and, therefore, who might benefit from closer monitoring.


During follow-up, 108 of the 302 participants died; 32% (35/108) of deaths were from cardiovascular causes. Classic risk factors did not predict cardiovascular mortality when used in the Framingham risk score (area under receiver operating characteristic curve 0.53, 95% confidence interval 0.42 to 0.63) or in a newly calibrated model (0.53, 0.43 to 0.64). Of the new biomarkers studied, homocysteine had most predictive power (0.65, 0.55 to 0.75). Entering any additional risk factor or combination of factors into the homocysteine prediction model did not increase its discriminative power. In very old people from the general population with no history of cardiovascular disease, concentrations of homocysteine alone can accurately identify those at high risk of cardiovascular mortality, whereas classic risk factors included in the Framingham risk score do not. These preliminary findings warrant validation in a separate cohort.


In January 1990, 413 (21%) of the patients had started statin treatment, and during follow-up another 1294 patients (66%) started after a mean delay of 4.3 years. Most patients received simvastatin (n=1167, 33 mg daily) or atorvastatin (n=211, 49 mg daily). We observed an overall risk reduction of 76% (hazard ratio 0.24 [95% confidence interval 0.18 to 0.30], P<0.001). In fact, the risk of myocardial infarction in these statin treated patients was not significantly greater than that in an age-matched sample from the general population (hazard ration 1.44 [0.80 to 2.60], P=0.23). Lower statin doses than those currently advised reduced the risk of coronary heart disease to a greater extent than anticipated in patients with familial hypercholesterolaemia. With statin treatment, such patients no longer have a risk of myocardial infarction significantly different from that of the general population.

Summary points
The terms visible haematuria should replace macroscopic or gross haematuria, and non-visible haematuria (both symptomatic and asymptomatic) should replace microscopic haematuria or dipstick positive haematuria
Urine testing for haematuria should be performed for clinical reasons only—current evidence does not support opportunistic testing
The test of choice for diagnosing haematuria is urine dipstick analysis of 1+ are positive score
Transient or spurious causes of haematuria need to be excluded- All patient aged ≥40 with haematuria should be investigated for urological disease
All patients with no identified urological cause should be monitored long term


Summary points
Risk prediction tools based on the Framingham score are the most widely used for determining individuals’ absolute risk based on clinical risk factors, although newer tools are better calibrated
The clinical label metabolic syndrome and abnormalities on the resting electrocardiograph do not add prognostic information beyond that obtained by traditional risk factors
Exercise stress electrocardiography that generates a positive or negative result based on ST deviation alone is not predictive, although scores that integrate several electrocardiographic and clinical variables may be predictive in patients at intermediate risk
Laboratory biomarkers, even in the form of multimarker panels, are not helpful in refining clinical risk estimates
Imaging of subclinical atherosclerosis with computed coronary angiography can identify patients at significantly increased risk, but only a small proportion of patients screened fall into this group.