Letters

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Plight of elderly people who are made homeless in hospital

EDITOR—Having lived a year in a residential home, a 79 year old man developed a chest infection and was admitted to this hospital. He was given intravenous antibiotic treatment and supportive care and recovered over the next week, returning to his previous state of mobility. The residential home was contacted to arrange return transfer, but its staff asked to reassess him first. The assistant manager visited, and the next day the nursing staff was told that the manager had found the patient's mobility to be inadequate and therefore he could not return to the home. He was homeless in hospital.

The ward physiotherapists reassessed him and considered him to be safe and fully recovered. He considered the residential home to be his home and he wished to return there. We explained this to the staff, but they were resolute. We asked the assistant manager about her assessment, and specifically about her qualifications, since her assessment and ours differed greatly. She had no formal qualification in assessing patients, yet her decision could completely change our patient's life. We subsequently contacted the home's matron, who eventually accepted his return some three weeks after our initial contact.

This is the third patient we have treated over the past three months whose discharge back to a residential or nursing home has been blocked by its staff. We believe that such decisions are morally and ethically indefensible.

We contacted the local executive director of social services for clarification of the legal situation when residents from nursing or residential homes are admitted to hospital. The contract between purchaser and provider states that the provider can terminate the placement contract only when "in the reasonable opinion of the provider, the user's condition has deteriorated beyond the ability of the provider to give proper care." Four weeks notice must be given, with the provider giving reasons in writing to the user and the purchaser.

This process was clearly not followed for our patients, and we suspect that these cases are not isolated. Frail elderly people are particularly vulnerable: their rights remain intact in theory but their ability to enforce them in practice is significantly reduced. We have great expectations for change in geriatrics with the publication of the *National Service Framework for Older People*,[1] but it should have emphasised the needs of those in care homes.

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Health needs of asylum seekers and refugees

Specific treatments are effective in cases of post-traumatic stress disorder

EDITOR—Burnett and Peel described the social and family background regarding asylum seekers and refugees in Britain.[1,2] Unfortunately their articles make many confusing generalisations and have several inaccuracies regarding mental health.

Burnett and Peel say that the most therapeutic event for a child can be to become part of the local school community.[2] Everybody would agree that schools can promote children's psychological development, but it is important to bear in mind the higher rate of psychiatric disorder in refugee children than in their peers. Even among refugee children who had largely not been exposed to war the rate of psychiatric disorder was found to be almost twice as high as among peers of the same age.[3] It is likely to be even higher among those who have been exposed to war and experienced recent flight and settlement. Our experience of work in inner London schools is that many refugee children are impaired with a range psychological problems and disorders, and benefit from mental health intervention.[4]

Burnett and Peel are inappropriately negative about diagnosing post-traumatic stress disorder, claiming that the disorder is hard to diagnose in people from diverse cultures, and that recovery is intrinsically linked to the reconstruction of social networks. This disorder has been shown in numerous studies to be remarkably similar across cultures. Investigation of children who had survived years in Cambodia in the concentration camps set up by the country's former ruler Pol Pot, but who had settled in the United States, showed the longstanding nature of post-traumatic stress disorder.[5] When first assessed in adolescence, 50% had post-traumatic stress disorder and 48% had depressive disorder. When reassessed 12 years later, 35% had post-traumatic stress disorder and 14% had depression. Whereas the post-traumatic stress disorder is relatively persistent, the depression has diminished significantly, in association with settlement and development of social ties. These data showing the different course of the disorders also support the validity of the diagnostic categories. Exposure to single incident stressors may also result in surprisingly persistent post-traumatic stress disorder.

In practical terms, the reasons for making a psychiatric diagnosis—like a diagnosis in any branch of medicine—include the selection of appropriate treatments. Many randomised controlled trials have shown that specific psychological treatments such as cognitive and behavioural approaches using exposure are effective for post-traumatic stress disorder.[6] These treatments may complement general supportive measures with refugee families and communities.

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Head injury needs to be taken into consideration in survivors of torture

Editor—Burnett and Peel raise important issues about the physical and psychological problems of survivors of torture.[1 2] We would like to add a further observation we have noted—that frontal lobe syndromes need to be sought in such patients.

Tortured patients may be referred to neurological outpatients with multiple symptoms, often presented in a chaotic fashion. Such patients' symptoms may easily be wrongly ascribed to psychological factors when they are due to cognitive difficulties secondary to head injury. Many have received repeated forceful blows to the head but do not recount this unless directly asked. Screening neurological examination may show only subtle changes. "Bedside" cognitive testing can, however, show profound frontal deficits.[3]

Patients we have seen include several who complained of minor symptoms such as daily headache or mechanical back pain. On attempting to take a history they were uncooperative with the medical interview to the point of inappropriateness; general examination gave normal results, but cognitive examination showed distractibility, perseveration, motor programming deficits, and concrete thinking.

As patients with frontal syndromes may show apathy, aggression, inappropriate social behaviour, and impulsivity they may be perceived as irascible and difficult rather than as brain damaged. Such patients need to be identified and referred for appropriate treatment as there is evidence for the efficacy of neurorehabilitation even late after head injury, especially for cognitive training.[4]

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Violence towards female prostitutes

Violence in sex work extends to more than risks from clients

Editor—Church et al report that violence by clients was strongly associated with street prostitution in three British cities.[1] Although they say that violence in sex work has seldom been the focus of public and academic interest, it has been extensively documented in much of the historical and contemporary literature.[2–3] Moreover, they simplify the situation by focusing exclusively on violence by clients. In a survey we conducted in London (1989-91), 112 (58%) out of 193 women reported previous assault; these women worked in all sectors of the industry, including 57% of indoor and 68% of street workers. Women reported that 40% of recent assaults were by clients.

Survey data are defined by the pre-existing knowledge and concerns of the investigators. We interpreted material from our survey in the light of prospective research to avoid replicating our own perceptions about violence. This study design also enabled measurement of incident violence and estimates of mortality. Different types of violence were experienced from the state, family, strangers, and clients. The most harrowing entailed the occasional removal of prostitutes' children by the state, and domestic violence. But in addition, everyday arrests, imprisonment, fines, and police raids led women to move within the industry to minimise their risks. Thus, some women reported a positive choice to work in saunas or on streets after experiencing violence in other work sectors because of the apparent protection of operating in a public place with colleagues.[4]

Prospective research showed, therefore, that London street workers could not be readily differentiated from others over time. Church et al discuss the service implications of excessive mortality but cannot provide relevant data from their survey methods; nor do they cite any. We have previously reported a death rate 12 times higher than expected in London.[5] Two women were murdered; neither worked on streets, and the one case that was resolved implicated a boyfriend, not a client. As we concluded, the two murders provide extreme examples of common experiences among prostitutes, who face high rates of violent assault in their personal and their professional lives. The health risks of this occupation are both direct and indirect; occupational studies of, and services for, prostitutes cannot be confined to the risks posed directly by exchanges with customers.

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We should listen to working women

Editor—The findings from the survey Church et al conducted of women prostitutes indicate the extent of (sexual) violence faced by those who sell sex.[1] We applaud Church et al for highlighting the risks posed to prostitutes, who are frequently blamed for causing health problems, when their own health needs are overlooked. Church et al note that prostitutes who work outdoors in particular routinely confront clients who are verbally, sexually, and physically violent towards them.

In our qualitative research with women involved in street prostitution we observed similar experiences.[2] It is, however, worth noting that prostitutes do not just experience violence from clients. They also are in danger from pimps, who subject women to physical and verbal abuse to ensure they continue seeing clients and bring in money. In addition, women involved in street prostitution experience high levels of verbal (and physical) abuse from those who pass through the red light area. We observed for ourselves the seemingly endless hatred directed at street prostitutes from those who see them as an easy target.[2]

Considering that many prostitutes begin working when young, or are still children, it may be that previous physical or emotional abuse has led them to engage in prostitution—and enables others (pimps and clients) to continue to take advantage of them. As Church et al state, prostitutes' needs are often overlooked, and improved services are needed to help them. Such services need to address physical and psychological health and be more widespread, as many prostitutes feel marginalised and therefore find accessing health services difficult.

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Management of prisoners with HIV infection

Prevention would be better than care

Editor—Edwards et al point out that the main cause of HIV in prisoners is injecting drug use.[1] Work done in Scottish prisons indicates that 4% of the male prison popula-

tion have continued their previous community injecting practices and 8% of male prisoners start injecting in prison.[2 3]

Measures for reducing viral transmission in the community, such as needle exchange, are not available in British prisons. It is possible, therefore, that many of the prisoners referred internally had contracted HIV by sharing injecting equipment while incarcerated. The recommendation by Edwards et al that HIV status should be confirmed in all prisoners should therefore be qualified with a recommended frequency. Although, as Edwards et al point out, prison provides an opportunity for inmates to receive care for bloodborne viral disease, which is provided, it also provides an opportunity for prevention which is not provided beyond advice and bleach tablets. I demonstrated the feasibility of a behavioural technique by using buprenorphine in a secure delivery device successfully to prevent injecting in a Scottish prison in 2000; further evaluation of this (or any other harm reduction measure) has been eschewed by those who have the administrative authority to address this important issue. It is admirable that King's College Hospital provides care for prisoners with HIV, but prisoners will continue to be at risk until the government admits that prisons are state sponsored culture media for bloodborne viruses.

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Real commitment to prevention is needed

Editor—Edwards et al show that the specialist management of HIV within prisons can be of a standard equivalent to that outside, and that most HIV infection is related to injecting drug use.[1] Many injecting drug users pass through the prison system, and of these a high proportion will continue to inject.[1–3] The prevalence of bloodborne infections is much higher in prisons, and this facilitates their transmission onwards into the community.

Prevention of bloodborne infection in prisons is not of an equivalent standard to that in the community. What is needed is a commitment to implement proved harm reduction strategies such as education about safe injecting practices, needle exchange schemes, opiate replacement programmes, and the free distribution of condoms without prescription. Current prison service policy, which is the responsibility of the British Home Office, does not facilitate these interventions.

I have participated in providing a training course in communicable diseases and their prevention to prison staff from English prisons. The course is run by Camden and Islington Community Health Services NHS Trust, and funded by Her Majesty's Prison Service. Over the past few years about 90% of English prisons have sent teams to be trained. Unfortunately this training is about to cease, and no plans are in place to replace it. Many of the staff attending have shown a commitment to prevention but are frustrated by a lack of political will to change policy. Harm reduction strategies in prisons are controversial and in conflict with prison rules and the safety of staff and prisoners. Without adequate funding and leadership in policy change there will be no change in the current situation. It is encouraging that the care of HIV infection in prison is being funded and is successful. A real commitment to prevention is now overdue.

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Physical health of people with severe mental illness

Adequate staffing and shared commitment are needed

Editor—In their editorial Phelan et al correctly highlight the importance of general practitioners assessing the physical health of patients with severe mental illness.[1] Although we share their belief that the success of this is reliant on practices identifying these patients, our research suggests that this task is far from straightforward.

Our three year study was sited in an English health district where the NHS trust and health authority had collaborated in establishing registers of cases of severe and enduring mental illness in over 60 general practices.[2] The aim was to identify all practice patients with severe mental illness as a first step in raising their profile in practices. Each practice had been allocated a named community mental health nurse, and these link nurses were given a key role in developing the mental health registers in consultation with general practitioners and practice staff. During the study we carried out 42 in depth interviews with the professional staff participating in drawing up and maintaining the mental health registers in six sample practices.

The most striking finding was the difficulty encountered in achieving consistency in defining the characteristics that constitute severe mental illness. Criteria for mental health registration in all practices were drawn from the definition of severe mental illness given by the Department of Health.[3] This definition is based on the dimensions of safety, informal or formal care, diagnosis, disability, and duration of illness, but we found it to be susceptible to widely varying interpretation by all participants.[4] A second common feature was the impact of pressure of work and staffing shortages on establishing registers: the time consuming procedure of collating accurate and up to date patient data and establishing agreement on inclusion on the register was frequently sacrificed to more pressing matters.

Improving the physical health of severely mentally ill patients is a complex issue. The introduction of mechanisms, such as practice based mental health registers, to help in identifying needy patients is important but will be achieved only as part of an overall strategy that entails adequate staffing levels and shared commitment to the task.

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General practitioners play a valuable part

Editor—The editorial by Phelan et al draws attention to the need to link mental health services with primary care services in order to improve general health outcomes.[1] The Australian national survey of mental health and wellbeing found that over the previous year 81.3% of people with psychosis had seen a general practitioner at least once, and 30.5% had seen a general practitioner on two to five occasions.[2] These data suggest that people with psychotic disorders are at least able to access their general practitioner in a country with national health insurance that does not discriminate against persons with mental illness.

As Phelan et al suggest, however, attending a general practitioner may not be sufficient to ensure adequate attention to physical as well as mental health needs. We completed a survey of 142 patients with psychotic disorders attending a community mental health clinic. We accessed data of individual patients from the national health insurance commission to identify attendances at general practices. All subjects gave written informed consent, and the Wolston Park Hospital ethics committee approved the study. Consistent with the national data, 86% of the patients had seen a general practitioner in the previous year. While 72% were satisfied

or very satisfied with this service, a third (32.4%) had five or more different general practitioners in the previous five years (people are free to attend the general practitioner of their choice in Australia). Over the previous five years, the 142 subjects had had 6151 occasions of contact with a general practitioner (4907 surgery based consultations, 1244 home or hostel visits). Of the surgery based consultations, 97% were of less than 20 minutes' duration, whereas the remaining 3% took 20-40 minutes.

It is encouraging that most patients with psychotic disorders seem able to access care from general practitioners and that there is a high level of overall satisfaction with the care that they receive. Some people with psychosis, however, seem to change general practitioners often. The reasons for this finding are not clear and are a concern to the Australian government. The data also provide empirical support for the observation that most contacts between patients with psychosis and general practitioners may be too short to undertake thorough physical assessments and mental state assessments.[1]

General practitioners have the capacity to improve outcomes for patients with psychosis. They can provide a one stop shop for many physical and mental health needs. They are accessible, and attendance is less stigmatising. The Australian government has announced that it will review the reimbursement for general practitioners' consultations with patients with mental illness and is supporting improved mental health training for general practitioners.[3]

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Risk of suicide related to income level in mental illness

Psychiatric disorders are more severe among suicide victims of higher occupational level

Editor—Agerbo et al reported that people with a history of mental illness and a high income are at greater risk of committing suicide than their counterparts with a lower income.[1] The authors, and Gunnell in a commentary on their paper, suggested that possible explanatory factors for this finding were the presence of a more severe mental illness or the stigmatising effects of psychiatric admission; they called for further studies measuring the severity of the psychiatric illness.

Because Finland has one of the world's highest death rates from suicide[2] and most of the population is treated in public hospitals (regardless of socioeconomic status) we examined this issue. We explored whether suicide victims with senior occupations or higher socioeconomic status, or both, more commonly had mental disorders or psychoses or misused alcohol or drugs than did other people. We also investigated whether the method of suicide was somehow related to the occupation.

We used a large, prospectively collected, 13 year database of all suicides (1296 males, 289 females) during 1988-2000 in northern Finland (the province of Oulu). Details of the database and study protocols have been reported.[3] The lifetime diagnoses of the suicide victims, based on psychiatric admissions and relevant codes from the international classification of diseases, were extracted from the Finnish hospital discharge register until the end of 1999. Our definitions for psychotic disorders were identical with those of Agerbo et al.

The proportion of admissions due to psychoses was higher in people in senior positions or with a high level of education than in other employed people (table). Thus Agerbo et al's findings were supported. In addition, these patients had more days of hospital treatment; this perhaps indicated more severe manifestations of psychoses, as suggested by Gunnell.[1] The proportion of admissions with any psychiatric disorder was highest among retired people; that in the people with the most senior jobs, however, did not differ from that in the other occupational groups. The admissions due to alcohol or drug misuse did not differ between occupational groups.

Violent methods of suicide are associated with low impulse control.[4] In our study the method of suicide was less commonly violent in the highest occupational group. This might reflect non-impulsiveness in these suicides. It seems possible therefore that people in high income groups are more determined and that, because of the stigmatising effect, their suicides are better planned than those of people from lower income groups.

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Direct association between social status and risk of suicide was not found in Germany

Editor—Agerbo et al report that in Denmark people with a history of mental illness and a high income are at greater risk of suicide than lower income groups.[1] In his accompanying commentary Gunnell says that relative poverty is typically associated with an increased risk of suicide; hence residual confounding may underlie the findings. We do not agree that there is a general inverse association between socioeconomic status and mortality from suicide; cultural factors and their influence on risk of suicide must be considered.

We used cases of suicide reported on death certificates in Germany in 1998 to estimate the risk of suicide for two population

Proportion of suicides by psychiatric morbidity, and method of suicide among different occupational groups. Values are numbers (percentages). Test for significance is Pearson's χ^2 test unless stated otherwise

Occupation	Admission due to psychosis*	Median (interquartile range)	Admission due to alcohol or drug misuse	Admission due to any psychiatric disorder	Violent method of suicide†
Senior position or high level of education (n=87)	15 (17.2)	127 (51-226)	5 (5.7)	31 (35.6)	57 (65.5)
Other worker (n=729)	71 (9.7)	88 (30-261)	60 (8.2)	293 (40.2)	519 (71.2)
Self employed (n=43)	3 (7.0)	49	4 (9.3)	15 (34.9)	33 (76.7)
Farmer (n=69)	7 (10.1)	22 (18-90)	5 (7.2)	22 (31.9)	60 (87.0)
Unskilled or unemployed (n=188)	33 (17.6)	106 (24.5-209)	20 (10.6)	80 (42.6)	137 (72.9)
Student (n=98)	7 (7.1)	31 (23-92)	5 (5.1)	22 (22.4)	86 (87.8)
Retired (n=371)	119 (32.1)	121 (44-536)	41 (11.1)	223 (60.1)	267 (72.0)
Total (n=1585)	255 (16.1)	95 (31-95)	140 (8.8)	686 (43.3)	1159 (73.1)
Significance test	χ^2=102.7, df=6, P<0.001	χ^2=12.52, df=6, P=0.051‡	χ^2=6.3, df=6, P=0.390	χ^2=69.9, df=6, P<0.001	χ^2=21.9, df=6, P=0.001

*Definition of psychosis was identical with that of Agerbo et al.[1] †Hanging, drowning, shooting, wrist cutting, jumping from a height. ‡Kruksal-Wallis one way analysis of variance, by ranks.

Relative risk of suicide (95% CI), Germany, 1998

	Crude risk	Risk adjusted for age		
		All people*	Men*	Women*
Non-Germans *v* Germans	0.41 (0.37 to 0.45)	0.48 (0.44 to 0.53)	0.42 (0.36 to 0.47)	0.59 (0.48 to 0.72)
Former East Germans *v* former West Germans	1.15 (1.10 to 1.20)	1.20 (1.14 to 1.25)	1.23 (1.17 to 1.30)	1.12 (1.03 to 1.23)

*Mantel-Haenszel estimates combining five year age strata.

subgroups: the 7.4 million residents of non-German nationality and the 12.7 million residents of the former East Germany. The residents of non-German nationality, many of whom are from Turkey, make up 9% of the total population of Germany; as a group they have lower socioeconomic status, rising unemployment, reduced access to health care, and problems of cultural adaptation. The residents of the former East Germany constitute 18% of the total German population; their access to clinical care does not differ substantially from that of people in the former West Germany.

The table shows the relative risk of suicide for non-German nationals (424 cases) versus Germans (11 214 cases) and former East Germans (2363 cases) versus former West Germans (8851 cases). Non-German nationals are at a lower risk of suicide relative to Germans at all ages, despite their lower socioeconomic status. Germans in the former East Germany have a higher relative risk. This cannot be a consequence of the economic decline in the former East Germany after reunification in 1990 since the relative risk was highest in those aged over 84 (1.79 (95% confidence interval 1.42 to 2.24) in men; 1.93 (1.44 to 2.56) in women). Moreover, suicide rates have been higher in the former East Germany for at least 50 years yet have declined since the mid-1980s.[2]

The association between socioeconomic status and nationality and place of residence in our dataset is merely ecological. Nevertheless, our findings indicate that there must be factors modifying the association between socioeconomic status and risk of suicide. Nationality might imply a different cultural or religious acceptability of suicide (for example, in Turkish Muslims). Likewise, suicide may have been culturally more acceptable in the former East Germany.

Our findings show that the association between socioeconomic status and mortality from suicide is not always inverse and is far from straightforward.

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Neomycin should not be used to treat hepatic encephalopathy

EDITOR—In their clinical review on portal hypertension Krige and Beckingham mention neomycin as treatment for hepatic encephalopathy.[1] Although neomycin has been used as a standard treatment of hepatic encephalopathy for almost 40 years, there is no evidence that the drug is effective. The only randomised, placebo controlled study found no benefit of neomycin compared with standard treatment alone.[2] Also, the combination of neomycin with lactulose was not superior to placebo.[3] On the basis of these negative studies and the potential for serious adverse effects of this drug, neomycin should not be prescribed for hepatic encephalopathy. Other antibiotics, including paromomycin, metronidazole, vancomycin, and rifaximin, are better tolerated, and several randomised controlled trials support their efficacy.[4 5]

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Long term anticoagulation or antiplatelet treatment

Only warfarin has been shown to reduce stroke risk in patients with atrial fibrillation

EDITOR—The conclusions of Taylor et al about the use of aspirin for atrial fibrillation are misleading and potentially dangerous for clinical practice.[1]

Firstly, when considering anticoagulation or aspirin for the management of heart failure it is appropriate first to compare each against placebo. Overall, aspirin has no effect compared with placebo in preventing thromboembolic events or death among patients with atrial fibrillation, whereas warfarin exerts a significant reduction in both outcomes compared with placebo.[2]

Secondly, Taylor et al excluded a key study, stroke prevention in atrial fibrillation (SPAF) III, from their analysis.[3] This study showed that full dose warfarin versus low dose warfarin combined with aspirin exerted a significantly greater reduction in stroke (1.7% *v* 5.6%; P = 0.0007) with a trend to reduced total mortality (5.9% *v* 7.2%).[3]

Thirdly, the *BMJ* has previously published the mortality data from the aspirin (28 deaths) and placebo (30 deaths) arms of the AFASAK study, allowing mortality in the warfarin arm (13 deaths) to be calculated.[4] Thus, the all cause mortality data from AFASAK is available contrary to the assertions of Taylor et al. Only warfarin has been shown to reduce the risk of stroke in atrial fibrillation, and only warfarin seems to reduce mortality in patients with atrial fibrillation. If the risk associated with atrial fibrillation is considered low enough to warrant treatment with aspirin then there is insufficient evidence to recommend any antithrombotic treatment at all.

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Competing interests: None declared.

1 Taylor FC, Cohen H, Ebrahim S. Systematic review of long term anticoagulation or antiplatelet treatment in patients with non-rheumatic atrical fibrillation. *BMJ* 2001;322: 321-6. (10 February.)
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Inclusion criteria determine results of review

EDITOR—We agree with Taylor et al that questions remain unanswered over the relative benefits of anticoagulation and antiplatelet treatment for non-rheumatic atrial fibrillation.[1] Uncertainty remains over the optimum treatment of elderly patients, who were underrepresented in the anticoagulation trials, and in whom pathophysiological reasons and empirical evidence suggest higher risk of haemorrhage on warfarin.[2] There is also uncertainty over the generalisability of the trials to primary care.

Our community based Birmingham atrial fibrillation treatment of the aged (BAFTA) study, which is funded by the Medical Research Council, will randomise 1240 patients aged 75 or over to warfarin (target international normalised ratio 2.5) or aspirin (75 mg) and follow them up for an average of three years to address these issues.

The way the review has been conducted has, however, led to conclusions that overstate the case against warfarin. Two trials that included direct comparisons between warfarin with aspirin were excluded. The European atrial fibrillation study (EAFT) was excluded because it was difficult to interpret, although data for the 455 patients who were randomised to anticoagulation or aspirin are available on the *Cochrane Library* and in the *Lancet* paper that is cited.[3] The stroke prevention in atrial fibrillation (SPAF) III study, which was not cited, will have been excluded because it evaluated combined use of anticoagulation with antiplatelet drugs.[4] Both these studies found significant benefits of warfarin in adjusted dosage over aspirin (in combination with fixed low dose warfarin in SPAF III).

Excluding these trials will have affected the results. A systematic review published in 1999 that included the same trials as Taylor et al, but also included EAFT (but not SPAF III) reported a relative risk reduction of 36% (95% confidence interval 14-52%) for stroke (ischaemic or haemorrhagic) for patients on warfarin as compared to aspirin.[5] Thus, inclusion criteria can have a substantial impact on the results of a systematic review. This creates a problem where the eligible studies are well known (as in this case) and the review is planned after the results are available, since the impact of different criteria can be predicted in advance.

With hindsight, it is difficult to say what the "correct" inclusion criteria should be, but where important studies are left out, these should be highlighted, since their results may influence how people choose to interpret the results of the review. Until more data are available from prospective randomised trials such as BAFTA, we would advocate caution in denying anticoagulation to patients with atrial fibrillation who are at high risk.

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Garbage in equals garbage out

Editor—The systematic review by Taylor et al illustrates how the usefulness of a meta-analysis is limited by the quality of the studies included in the analysis.[1] They say that they assessed the quality of the reviewed trials based on the level of concealment of random allocation, degree of blinding used, and losses to follow up. This is not good enough. These criteria have more to do with the statistical validity of the trials than the equally important issue of their clinical validity. A critical aspect is whether the trials approximated clinical practice with regard to the characteristics of patients with non-rheumatic atrial fibrillation.

In this case, the decision to include the flawed PATAF study severely weakens any findings on meta-analysis.[2] The PATAF study has been extensively criticised on numerous grounds—for including a high proportion of low risk patients with lone atrial fibrillation, excluding patients with chronic heart failure, and arbitrarily excluding all patients aged 78 years or older from the standard anticoagulation arm of the study, and for a lack of statistical power.[3] Furthermore, the PATAF study had a high dropout rate, ranging from 20% to 32% for the three treatment arms—a fact that was not included by Taylor et al in their table 1. Clinicians should be wary of applying the implications drawn from the results of this imperfect meta-analysis to the care of their patients with atrial fibrillation.

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Drug name was incorrect

Editor—With reference to the article by Taylor et al, the drug used in the Studio Italiano Fibrillazione Atriale (SIFA) II trial is indobufen and not indoprofen.[1] Indobufen is a reversible cyclo-oxygenase inhibitor. Currently, a large trial is comparing indobufen with aspirin in primary and secondary prevention in patients with non-rheumatic atrial fibrillation.

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Giving warfarin always depends on balancing risks

Editor—As the originators of the AFASAK 1 and 2 trials we are happy that the field of anticoagulant preventive treatment in atrial fibrillation still attracts as much attention as shown by Taylor et al.[1] In the 12 years elapsed since AFASAK 1 was published we have spent most of our professional careers teaching and harassing the medical community that the margin between benefit and risk of anticoagulation treatment may be uncomfortably narrow[2] and that therefore the final, individual decision on whether to give warfarin or not always depends on balancing the expected reduction in stroke risk against the expected risk of bleeding.

This point of view has always been advocated in the Danish guidelines for anticoagulant treatment in cardiology. The aspirin dose in the AFASAK 1 study was 75 mg. This dose has been shown to be as effective as higher doses. The risk reduction with aspirin in the AFASAK 1 study of 18% (non-significant) is comparable to the effect obtained by aspirin in studies of secondary stroke prevention.

The atrial fibrillation investigator's studies included a true head to head analysis and reached very reliable conclusions.[3 4] Some critics have expressed doubt about the effects of aspirin in this setting at all.[5]

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Patients at risk of stroke should be given warfarin

Editor—Taylor et al have produced a thorough analysis of head to head studies of the relative benefits and risks of anticoagulation and antiplatelet agents.[1] We believe, however, that their conclusions are influenced by their own hypotheses, potentially endangering patients who would benefit from warfarin at adjusted dosage.

The main reason to give anticoagulants to patients with atrial fibrillation is not to increase life expectancy; it is to prevent stroke. As several guidelines suggest, it should not be normal practice to treat all

patients with atrial fibrillation with long term warfarin.[2–4] Patients at low risk are better served with aspirin. Despite the inclusion of a substantial proportion of such patients, they still show a significant benefit in favour of anticoagulation for stroke prevention. Taylor et al dismiss this as modest but then highlight a non-significant increase in major bleeding as an important harm. Reasons could be postulated for the exclusion of many of the trials, and not just for the one that weakens their argument. Taylor et al also raise the question of cost of anticoagulation services, while not mentioning the large hospital, community, and social costs of stroke, particularly as the large cortical infarcts associated with atrial fibrillation tend to be particularly severe and disabling.[5]

When we see patients with atrial fibrillation, we assess their risk of stroke and of bleeding, clinically and by the judicious use of echocardiography. We explore the potential for cardioversion, ablation or surgical treatment. If their risk of stroke is high, we would still advise them to take warfarin.

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How do we decide between warfarin and aspirin?

Editor—Taylor et al think that there is little to choose between the two treatment options for patients with atrial fibrillation—antiplatelet treatment and anticoagulation—except cost.[1] Different conclusions are drawn from analysis of a systematic review of a very similar data set recently published in the *Cochrane Library*.[2] The reviewers conclude that the evidence strongly supports the use of warfarin in atrial fibrillation for patients at average or greater risk of stroke, although there is a risk of haemorrhage. Although not definitively supported by the evidence, aspirin may prove to be useful for stroke prevention in subgroups with a low risk of stroke, with less risk of haemorrhage than with warfarin.

In these reviews it has not been possible to prove beyond reasonable doubt that aspirin is more efficacious than placebo or less efficacious than anticoagulant drugs. The disadvantages of using a 5% significance level to decide if we can be sure about results was highlighted earlier this year in the *BMJ*.[3] Non-significant trends are open to subjective interpretation when results are handled dichotomously in this way. Moreover, aspirin is certainly more convenient than anticoagulation, but the cost argument employed by Taylor et al is flawed as the costs of caring for patients with stroke (or those with major bleeds) has not been considered.[4]

The directions of the differences found in trials randomising patients to warfarin or aspirin are the same as those found in the placebo controlled trials. If non-fatal strokes are compared with major bleeds the pooled odds ratios are almost reciprocal from the meta-analysis of the head to head trials. In practice therefore the trade off for individual patients depends on their assessed risk of having a stroke or a major bleed. In most trials included non-fatal strokes are roughly twice as common as bleeds, and therefore since both outcomes are rare the odds ratio behaves like a risk ratio. This means that in comparison with antiplatelet treatment, if 100 such patients are given anticoagulation for two years, roughly two non-fatal strokes will be prevented and one extra major bleed will occur.

In practice, the decision to prescribe anticoagulation or antiplatelet treatment therefore needs to be individually assessed and discussed with each patient. Some may well choose aspirin, but this needs to be on the basis of the risks that they face of having a stroke or bleeding, not on whether the pooled results of a meta-analysis reach 5% significance.

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Author's reply

Editor—Cleland and Kaye consider antiplatelet drugs ineffective in atrial fibrillation, citing a non-systematic review in support, although a recent Cochrane systematic review shows efficacy.[1] Direct head to head comparisons are the only way of making unbiased evaluations of efficacy, as direct comparisons are of limited value. Total mortality data for the warfarin arm of the AFASAK 1 trial can be derived from the published data on the aspirin and control arms, but the result—a significant reduction in total mortality in the warfarin arm—is inconsistent with the statement in the primary publication that an intention to treat analysis showed no difference in either vascular or total mortality.[2]

The BAFTA trial should be helpful, although it may be speculated that the choice of a low aspirin dose (75 mg, similar to that used in AFASAK 1[2]) may bias towards anticoagulation. The target sample size of 1240 participants is disappointingly small. About 5000 patients would be needed adequately to power a trial to detect a 25% advantage in fatal cardiovascular events of warfarin over aspirin. Peterson and Jackson confuse the internal validity of a trial with its generalisability—whether the patients randomised are representative of those seen in clinical practice. None of the trials included in our meta-analysis, including PATAF,[3] were adequately powered.

PATAF losses to follow up were zero, as stated in our paper, which is the relevant trial quality indicator and not withdrawals from treatment. In British anticoagulation clinics, the majority of patients with atrial fibrillation have no past history of thromboembolism and are being treated with adjusted dose warfarin. Combined fixed low dose warfarin with aspirin, evaluated in SPAF-III, is seldom used and is not relevant to the question of adjusted dose anticoagulation versus antiplatelet drugs. The pooled relative risk of combined fatal and non-fatal outcomes in those trials studying predominantly patients without a history of transient ischaemic attacks or stroke was 0.74 (95% confidence interval 0.52 to 1.07, random effects, significant heterogeneity), although this falls to 0.85 (0.68 to 1.05, fixed effects, no heterogeneity) if the lower quality AFASAK 1 trial is excluded. Similar treatment effects that do not achieve significance are seen for non-fatal stroke with and without the inclusion of AFASAK 1 trial—0.74 (0.50 to 1.10) and 0.85 (0.56 to 1.30) respectively. The wide confidence intervals suggest that the evidence is consistent with anticoagulation halving non-fatal strokes or increasing them by a third. Anticoagulants may be more effective than antiplatelet drugs in secondary prevention. The primary publication of the European atrial fibrillation trial (EAFT)[4] did not present data allowing direct comparison of patients randomised to aspirin and warfarin, which resulted in its exclusion in our review. No details of specific non-fatal and fatal outcomes have been provided in an outdated Cochrane review of this trial.[5] Both the EAFT and the Studio Italiano Fibrillazione Atriale (SIFA) trial[6] were concerned with secondary prevention and for combined fatal and non-fatal outcomes, their pooled relative risk is 0.72 (0.56 to 0.93), although the findings of each trial are different.

All of us would wish to avoid a debilitating non-fatal stroke, but ascertainment of non-fatal strokes, particularly in non-blinded trials, may be difficult and potentially biased, hence our preference for fatal vascular events as the main outcome, as these are easier to count accurately and without bias. Godtfredsen et al believe that the margins of benefit and risk are narrow but ignore the options of improving our very imprecise estimates of these benefits and risks by organising bigger adequately powered trials,[7] of asking about patients' treatment preferences,

and considering the costs of treatment in their approach to decision making.

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A longer version of this letter is published on bmj.com

Competing interests: None declared.

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Distressed women take contact tracing seriously

Editor—As a genitourinary physician, I give unexpected diagnoses to young women every working day in my clinic. They do not expect to have chlamydia or gonorrhoea in a stable relationship—it could come from the previous boyfriend. They do not expect to have a sexual infection if they do not currently have a sexual partner—chronic infection does not have to hurt. They may be yearning for a baby, and they are terribly distressed when they realise that their tubal infection could have been overlooked for years because of a lack of screening.

Of course having a sexual infection is upsetting. But even though they are upset, most women actively cooperate with contact tracing and thus reduce transmissible infection in the community.[1]

Our health advisers reviewed the effectiveness of contact tracing for gonorrhoea in our genitourinary medicine clinic during 1999-2000. Only one of 28 women index patients declared her contact untraceable, in contrast with 39 out of 73 male index patients (R Chown et al, spring meeting of the Medical Society for the Study of Venereal Diseases, Belfast, May 2001). The infected women found in the survey of France et al also showed a commendably high success rate in contact tracing despite their distress.[2]

Healthcare workers and others concerned with putative chlamydia screening programmes can work with distressed women to a constructive end point—reducing the prevalence of chlamydia—and hence remove a source of distress to their sisters in the future. We can be sympathetic, but fear of upsetting women by an unpalatable truth should not deter the screening process.

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1 Catchpole M. Sexually transmitted infections: control strategies. *BMJ* 2001;322:1135-6. (12 May.)
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Communicable disease control must remain at local level

Editor—We doctors are becoming used to learning about important government policies through the media, and so I was not surprised to learn of the probable demise of my own health authority in this way in a recent news item.[1]

I believe, however, that the Department of Health needs to think carefully about what will happen to communicable disease control when the number of authorities is reduced. The 30 remaining "strategic health authorities" will monitor the performance of local health services and provide a link with the Department of Health.

Each authority will cover an average population of 1.5m. Control of infectious disease and environmental hazards depends entirely on close working relationships with colleagues in primary care, local councils, school health, and other local agencies. In North Cumbria we have seen the importance of this close working in recent years when we faced a large outbreak of *Escherichia coli* O157, as well as with the current outbreak of foot and mouth disease. Clearly, communicable disease control must remain at a local level.

The chief medical officer has been working on a strategy for communicable disease control for about three years. It is time that the Department of Health showed its cards and told the profession what its plans are.

It is interesting that the same issue of the *BMJ* carries Smith's editorial on unhappy doctors.[2] I can only speak for myself, but the uncertainty caused by the long awaited review of the chief medical officer coupled with the government's preference for conducting much of its business through the media do little for my mental health.

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1 Wise J. Milburn proposes to decentralise the NHS. *BMJ* 2001;322:1083. (5 May.)
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Reviewing screening mammograms with newly diagnosed patients is another unnecessary burden

Editor—Paterson wrote about the unnecessary burden placed on patients with newly diagnosed cancer in discussing cancer registration.[1] Patients are shocked at the diagnosis of cancer and have to work hard to get to grips with the news and its implications. When their participation is appropriate in treatment decisions—for example, in early stage breast cancer—they need to urgently understand the issues as treatment often cannot start until the type of surgery has been chosen. Talking about cancer registration is an irrelevant distraction at this time.

In addition, doctors must also talk to patients who have previously had screening mammography about the already established, routine process of review of the films and ask whether they wish to be informed about the outcome of that review; the discussion and the patient's decision must be documented. This is another unnecessary burden. It has another dimension, as well as being a distraction and a source of misery. If the clinician concerned with diagnosis and treatment has to undertake the exercise, it associates him or her with the issue of failure of the screening process and thereby erodes the confidence the patient needs to develop with her clinician just at the crucial initial stages of their relationship.

Were doctors consulted about this? The instruction seemed to come as a hurried response to adverse publicity about cervical screening, anticipating the knock-on effects on breast screening. Alternative approaches should be considered. For example, the issue could be addressed in writing, at a time separate from the diagnostic and treatment consultations, the letter signed by a representative of the breast screening programme other than the patient's surgeon. We as surgeons are very willing to answer patients' questions about possible or actual missed diagnoses and will continue to answer such queries made during early consultations. Like Paterson, however, we are unwilling to add a further unnecessary burden to patients with newly diagnosed cancer.

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1 Paterson ICM. Consent to cancer registration—an unnecessary burden. *BMJ* 2001;322:1130. (5 May.)