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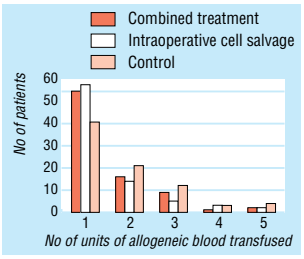
This week in the BMJ

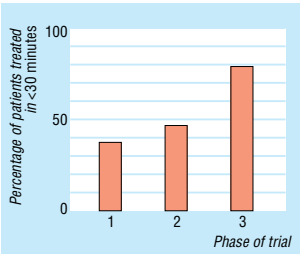
Cell salvage during surgery reduces need for blood



Intraoperative cell salvage reduces the number of patients needing allogenic blood or blood products during coronary artery bypass surgery. In McGill and colleagues' randomised controlled trial of 252 patients having elective coronary bypass surgery (p 1299), 31% of patients in whom intraoperative cell salvage was used required a blood transfusion, compared with 51% of patients in whom no form of mechanical blood conservation was used. Reducing the amount of blood transfused during surgery benefits patients by lowering their risk of contracting bloodborne or other infections or having a perioperative myocardial infarction.

Nurses improve door to needle time

Thrombolysis started by nurses improves door to needle time and may be a way in which the national service framework targets can be achieved. Qasim and colleagues (p 1328) conducted an audit of a three phase study of nurse involvement in thrombolysis of patients admitted with acute myocardial infarction. In phase 1 patients were seen and treated by doctors; in phase 2 they were assessed by nurses and treated by doctors; and in phase 3 they were assessed and could be treated by a coronary care thrombolysis nurse. In phase 3 patients had a median door to needle time of 15 minutes, and 80% were treated within 30 minutes. There were no cases in which a nurse initiated thrombolysis inappropriately.



Rich and poor respond differently to chest pain

People living in a socioeconomically deprived area feel more vulnerable to heart disease than people living in a more affluent area but are no more likely to report chest pain symptoms to their doctor. These findings are from a community based interview study of 30 people from a deprived area of Glasgow and 30 people from an affluent area of Glasgow conducted by Richards and colleagues (p 1308). Barriers to presentation included normalisation of their chest pain, self blame, and fear of chastisement. The authors conclude that these socioeconomic variations in responses to chest pain may contribute to the inequalities in uptake of cardiology services.

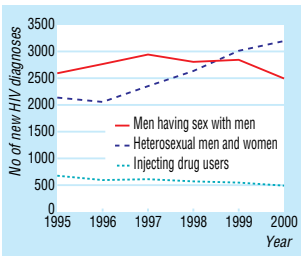
Prescribing in children must improve

Three papers in this issue highlight the problem of unlicensed and off-label prescribing in children. Bücheler and colleagues (p 1311) found that 13.2% of prescriptions for a representative group of children in primary care in Germany were off label. Schirm and colleagues (p 1312) found that labelling of drugs prescribed for children was poor: in 21.3% the use in children was not mentioned in the summary, and 19.7% mentioned use in children but without any indication of age. The authors of both papers argue that efforts to improve the quality of pharmacotherapy in children should not exclude widely marketed and firmly established drugs. Although unlicensed and off-label prescribed drugs do not necessarily carry an actual threat to the health of a child, the risk of adverse drug reactions is high as adequate dosing schemes have often not been assessed, report Jong and colleagues (p 1313). This situation is highly unsatisfactory, and efforts should be made to improve it.

AARON HAUPT/SPL

Europe is complacent over HIV

Trend data by Nicoll and Hamers (p 1324) show that new diagnoses of sexually acquired HIV infections increased by 20% in western Europe between 1995 and 2000, principally among heterosexuals. Outbreaks of syphilis have recently been



reported in several countries and reports of gonorrhoea have increased in France, the Netherlands, Sweden, Switzerland, and the United Kingdom. These preliminary data, the authors say, imply that people may increasingly take sexual risks and that complacency over HIV transmission may have set in among individuals, populations, and some governments in western Europe. Efforts to prevent the transmission of HIV need to be strengthened, and consistent surveillance needs to be established at a European level.

The future is vaccinology

In the next five to 15 years new vaccines and new technology for delivering them will fundamentally change how clinicians prevent and treat disease, with substantial impact on public health. Poland and colleagues (p 1315) describe how advances in current vaccines, such as conjugated pneumococcal and nasal spray vaccines, will provide an efficient way to produce longlasting protective immunity. The future holds the development of new vaccines against non-infectious diseases such as cancer, diabetes, and even nicotine dependence. However, concerns about vaccine safety and a rise in anti-vaccine sentiment are currently adversely affecting the use and development of new vaccines.

Who to screen for hypercholesterolaemia

A modelling analysis by Marks and colleagues (p 1303) found that screening relatives of people with familial hypercholesterolaemia is a cost effective way of detecting cases, whereas blanket population screening is not. Hypercholesterolaemia is

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currently not diagnosed in 75% of people with the condition, and in many it is discovered only after the first coronary event. The estimated cost of family tracing was £3097 per life year gained (or £4914 with genetic confirmation). This represents good value for money compared with common medical interventions, and the authors say that pilot evaluation programmes should be conducted.

Kaiser versus the NHS

The *BMJ* received 75 letters in response to a paper we published comparing the NHS with California's Kaiser Permanente, a not for profit health maintenance organisation. The paper concluded that Kaiser delivered substantially better care to its patients while spending no more per head than the NHS. In the letters section (p 1332) we print seven of these letters and a summary of the rest. Forty six letters comprehensively dismantled the authors' analysis; the message implicit in many of these letters is that the authors and commentators had let their ideology cloud their judgment. Twenty seven supported the paper, offering the explanation that Kaiser's superiority was due to having more of everything: more beds, more doctors, more nurses, and better information technology.

Editor's choice

Tales of discovery, obfuscation, error, and improvement

Asked to describe medical journals to somebody unfamiliar with them, you probably wouldn't say that they are full of stories. But they are, as this issue shows.

The first story tells of attempts to improve the treatment of people with arthritis, but, as with most good stories, there is a subplot that hints at wickedness. Non-steroidal anti-inflammatory drugs (NSAIDs) have long been used to treat the inflammation of arthritis (p 1289). They do this by inhibiting an enzyme called cyclo-oxygenase that is needed for the production of prostaglandins. Unfortunately the same process operates in the stomach and causes harm. Then it was discovered that there were two sorts of cyclo-oxygenase, one more important in joints and the other in the stomach. By inhibiting the one important in joints it should be possible to enjoy the benefits of treating the arthritis without harming the stomach. So COX 2 inhibitors were born and are now widely used.

But one reason they are widely used is because of a misleading trial published in *JAMA* (p 1287). This seemed to confirm in reality what was expected from theory—COX 2 inhibitors had fewer gastrointestinal side effects than NSAIDs. But more complete and longer term data available to the Food and Drug Administration contradicted these results. The authors had departed from the protocol of their study, which, as readers of the *BMJ* know, will often allow you to find whatever results you want. The flaws in the study were publicised in *JAMA*, the *BMJ*, and elsewhere, but, argue our editorialists, the study is much better known than its criticisms. Thirty thousand reprints have been distributed, the study is highly cited, and sales of the particular COX 2 inhibitor have grown from $2623m (£1800m) in 2000 to $3114m in 2001.

A second story is short and poignant (p 1314). A patient waiting for an operation suffered a caustic burn after being given not local anaesthetic eye drops but phenol drops. The drops came in similar bottles. The *BMJ* is keen to share mishaps like this in the hope that it will help minimise them. Please send us examples.

The *BMJ* is also keen to publish examples of improvement like this week's third story. Authors from Princess Royal Hospital in Telford tell how they have been through three phases in treating patients with heart attacks with thrombolytic drugs (p 1328). In phase one patients referred directly by general practitioners were seen in the coronary care unit. The median door to needle time was 45 minutes. In phase 2 all patients were seen by a nurse in the coronary care unit but doctors started treatment. The median door to needle time was 40 minutes. In phase 3 all patients were seen and if appropriate treated by a "coronary care thrombolysis nurse." Now the median door to needle time is 15 minutes and 80% of patients are treated within 30 minutes. The authors tell the story in more detail than in a conventional scientific paper, increasing, we hope, the paper's educational value.

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