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LETTERS



COMSTOCK COMPLETE

REDUCED SALT INTAKE

Sodium reduction is enticing, but what is the full recipe?

Reading the study of the long term effects of dietary sodium reduction on a Friday evening, I wondered whether it could help my hypertensive patients on Monday morning.¹ Unfortunately not: the prescription for sodium reduction is not usable by my fellow general practitioners: "Individual and weekly group counselling sessions were offered initially, with less intensive counselling and support thereafter, specific to sodium reduction."

How do I translate this vague description for my patients? Those rare clinicians diligent enough to track down reference 23 would find a fuller, but still insufficient, description.² It still misses so many details that I (or a dietitian) would need that I don't know how to replicate it. But there is sufficient detail to show that this form of salt reduction is probably impractical in primary care.

The accompanying editor's choice suggests, "You might try talking salt in your next consultation,"³ but that does not seem viable on the basis of either this paper or the previous publications. That is a pity. As a fan of non-drug interventions, I'd like to be able to share them with my patients. But so often the description of what clinicians and patients need to do is so woefully inadequate that it is unusable. If authors are interested in uptake, they need to make interventions practical and provide sufficient details and materials. In the internet world, space limitations are no longer an excuse.

Paul P Glasziou professor of evidence based medicine, University of Oxford, Oxford OX3 8AY
paul.glasziou@dphpc.ox.ac.uk

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sodium reduction on cardiovascular disease outcomes: observational follow-up of the trials of hypertension prevention (TOHP). *BMJ* 2007;334:885-8. (28 April.)

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Health protection requires legislation

Glasziou (previous letter) pleads for a description of what clinicians and patients need to do. It is not simply about adding salt at the dinner table but about understanding the considerable role that players such as the food industry play in public health.¹ Health protection through national fiscal and legislative policies should have a higher priority than health promotion interventions applied to general, primary care, and workforce populations.

The high risk strategy, the traditional medical approach to prevention, identifies individuals at high risk of subsequent cardiovascular disease events who are then offered behavioural or pharmacological interventions. In contrast, the population strategy seeks to control the determinants of incidence in the population as a whole.²

Public health policies need to take into account the role that agriculture, trade, education, the physical environment, town planning, and transport have on cardiovascular disease aetiology. Political action is needed to change urban planning, education, and policies on the agriculture, food, and tobacco industries.³ Until then, interventions such as salt reduction campaigns and pleading to patients to throw away the salt cellar in afternoon surgery will make little difference to population salt levels.

M Justin S Zaman clinical research fellow in epidemiology, University College London, London WC1E 6BT
j.zaman@ucl.ac.uk

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LOCAL COUNCILS AND HEALTH

Public health must be taken more seriously

Blackman discusses the benefits of local councils taking responsibility for health.¹ I see the most effective way to reduce the increase in type 2 diabetes is by encouraging exercise, and there is no better way than to encourage walking and cycling. I therefore sit with the two public health physicians on our council's children's health and obesity task force, which has asked for slower speeds across the city and cycling training.

But these and all other large scale, slow speed, or pro-cycling measures have been rejected by other committees in the council. The transportation department sees its role as preventing traffic jams and accidents and helping industry (and accident rates have dropped at the same time as cycling and walking rates have fallen). And government policies support this.

The planning department approves large hypermarkets with masses of car parking, and large entertainment complexes, which in practice cannot be reached by walking, while allowing many smaller green spaces in the city that are used for improvised sport to be developed into housing.

Our council leader has adopted government policy. Local and national leaders have to take public health and environmental issues a lot more seriously if councils are to act effectively.

David J Kinshuck associate specialist, ophthalmology, Good Hope Hospital, Sutton Coldfield, Birmingham B75 7RR
davidkinshuck@blueyonder.co.uk

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1 Blackman T. Statins, saving lives, and shibboleths. *BMJ* 2007;334:902. (28 April.)

PNEUMONIA FROM VENTILATION

Oral decontamination treats the symptom, not the cause

Oral antiseptics, like semirecumbent positioning and care of the ventilator circuit, merely address the symptom and not the cause of ventilator associated pneumonia (VAP).¹

The pivotal step in the pathogenesis of most cases is aspiration of secretions past the

cuff of the tracheal tube.² Aspiration occurs because of a design defect in almost all cuffs currently available, with leakage along folds in the cuff wall.

Manufacturers are now improving the design of tracheal tubes, ensuring maximal cuff performance and incorporating subglottic secretion drainage ports and antibacterial/non-stick linings. Simply preventing aspiration by cuff improvements may have a substantial impact on VAP and reduce the requirement for topical antiseptics or antibiotics.^{3,4}

Duncan L Wynncoll consultant intensivist, St Thomas' Hospital, London SE1 7EH duncan.wynncoll@gstt.nhs.uk

Peter J Young consultant intensivist, Queen Elizabeth Hospital, King's Lynn PE30 4ET

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DELIRIUM IN OLDER PEOPLE

Approach is now screening, prevention, and recognition

The approach to delirium has shifted from ad hoc treatment to systematic screening and prevention.¹ Management may be improved with primary prevention, early detection, and prompt management.

Preoperative cognitive impairment, as measured by the mini mental state examination or the clock drawing test, is an important predictor for postoperative delirium. Most elderly patients developing postoperative delirium after hip surgery have early prodromal symptoms. Low dose prophylactic haloperidol can reduce the incidence.² Niam et al showed that methods proved to prevent delirium can be useful in routine clinical practice.³

In a large retrospective study only 4% of patients had a recorded diagnosis of delirium, yet an episode may occur in up to 56% of hospitalised older people.⁴ The poor understanding of delirium by staff stems from a historically low educational emphasis in medical and nursing schools. Increasing doctors' and nurses' awareness can be achieved through a brief and inexpensive educational programme, which significantly decreases the prevalence of delirium among

older inpatients, increases recognition of cases, and can be easily rolled out across hospital units caring for older people.⁵

Mehraj Shah staff grade psychiatrist, Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust, Luton LU1 2PJ mehraj.shah@blpt.nhs.uk

Farida Jan senior house officer

Akeem Sule consultant psychiatrist

Competing interests: None declared.

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Delirium should be included in guidelines and curriculums

One critical factor in the underdiagnosis and undertreatment of delirium in the United Kingdom is likely to be its unsatisfactory coverage in core guidelines and curriculums.¹

Delirium is not mentioned in the draft guideline on acutely ill patients in hospital from the National Institute for Health and Clinical Excellence (NICE).² Delirium is also absent from the Joint Committee of Higher Medical Training curriculums for general internal medicine and acute medicine.^{3,4} "Acute confusional states" are mentioned in the latter, but only in the context of minimising distress. In the curriculum from the Royal Colleges of Physicians the sole reference to delirium is in the section on aggressive/disturbed behaviour,⁵ although only a few patients with delirium display aggression. "Acute confusion" appears in the top 20 presentations and the section on medicine in the elderly but with no mention of delirium.

Care of patients would be greatly facilitated if delirium were covered adequately in core guidelines and curriculums. Consistent use of the term delirium and not its multiple, ill defined synonyms would reduce the terminological chaos and diagnostic imprecision which partly underpin the poor rates of recognition.

Alasdair M J MacLulich MRC clinician scientist fellow, Queen's Medical Research Institute, Edinburgh EH16 4TJ a.maclulich@ed.ac.uk

John M Starr reader in geriatric medicine, Royal Victoria Hospital, Edinburgh EH4 2DN

A Peter Passmore reader in geriatric medicine, Queen's University of Belfast, Belfast BT9 7BL

Competing interests: None declared.

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DRUG COST INITIATIVE

Link cost to clinical outcome

The laudable UK initiative to drive the costs of drugs down to affordable levels assumes that there is consistency in drug pricing between producer and recipient countries and that price is a barrier to use.¹

When generics are included in pricing studies and compared with the price per gram of active ingredient, Japan and Switzerland are more expensive than the United States. When price per standard unit (a rough measure of dose, which differs across countries) is compared, Canada, Germany, Switzerland, and Sweden are more expensive than the US. And many governments subsidise research and development of their pharmaceutical and vaccine industries, making international comparisons difficult.²

Other factors contribute to a drug's price when it finally reaches a patient. Some governments procure medicines efficiently but charge much higher prices to patients.³

Yet the problem remains more profound than simply a matter of prices: the fragility of health systems. The UK would help the developing world more by disseminating best practices for disease management through the principle of rational choices between therapeutic alternatives which promise the most advantageous economic value relative to clinical outcome.

Jeremiah Norris director, Center for Science in Public Policy, Hudson Institute, Washington, DC, 2005, USA jnorris289@aol.com

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