We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

ANTONIA REEVE/SPL

THROMBOPROPHYLAXIS

Prophylaxis for medical inpatients is not entirely proven

I have three concerns with Fitzmaurice and Murray's editorial.[1] Firstly, a recent meta-analysis on anticoagulant prophylaxis to prevent symptomatic venous thromboembolism (VTE) in 19 958 hospitalised medical patients showed only modest benefit.[2] The numbers needed to treat were 345 (absolute risk reduction 0.29%) to prevent one pulmonary embolism (PE) and 400 (0.25%) to prevent a fatal PE. The difference in symptomatic DVT prevention did not reach significance, and neither did an increase in major bleeding (0.14% absolute increase). Before rushing to use prophylactic anticoagulants in medical patients, clinicians should remember this and target only high risk medical patients (see table[1]).

Secondly, Fitzmaurice and Murray report that VTE causes 25 000 potentially preventable deaths. However, this is merely an estimate that is based on extrapolation from European data.[3] The authors of the Department of Health's report indicate that the data on VTE in hospital patients are not sufficiently robust to enable secure conclusions to be drawn and the department is urged to initiate research to establish an accurate measure of death from VTE.[3] Furthermore, the meta-analysis indicated that anticoagulant prophylaxis had no effect on all cause mortality.[3]

Thirdly, to date, no studies have assessed the cost effectiveness of anticoagulant prophylaxis to prevent symptomatic VTE in hospitalised patients.[2] The authors of the meta-analysis comment that because anticoagulant prophylaxis in medical inpatients has potential harm, increases healthcare costs, and is associated with modest treatment benefit in terms of absolute risk reduction, its use should be selective and limited to higher risk medical patients. Perhaps this is why NICE has produced a report only in surgical patients.[4]

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1 Fitzmaurice DA, Murray E. Thromboprophylaxis for adults in hospital. *BMJ* 2007;334:1017-8. (19 May.)
2 Dentali F, Douketis JD, Gianni M, Lim M, Crowther MA. Meta-analysis: anticoagulant prophylaxis to prevent symptomatic venous thromboembolism in hospitalised medical patients. *Ann Int Med* 2007;146: 278-88.
3 House of Commons Health Committee. *The prevention of venous thromboembolism in hospitalised patients*. Second report of session 2004-5. London: Department of Health, 2007.
4 National Institute for Health and Clinical Excellence. Venous thromboembolism: reducing the risk of venous thromboembolism in patients undergoing surgery. London: NICE, 2007. http://guidance.nice.org.uk CG46.

A mess for medical patients

I share many of D'Costa's concerns about the ease with which we slide between the evidence for surgical and medical prophylaxis.[1] We are in a strong position with evidence of efficacy to provide prophylaxis for high risk medical patients, and the "high risk" criteria mandated by D'Costa seem almost identical to the list from the National Institute for Health and Clinical Excellence (NICE) for surgical patients at risk. This debate should move on and medical patients with easily identified risk factors receive prophylaxis of a comparable level to their surgical comparators.

One of the references in the editorial and carried by the *BMJ* is troubling me.[2] This study, which confirmed efficacy of fondaparinux in medical patients with risk factors, was placebo controlled. Surely this should have been run as a non-inferiority study against enoxoparin 40 mg?[3] The excess of deaths in the placebo group was unacceptable and avoidable and should end the debate over whether at risk medical patients should receive prophylaxis at all.

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1 Fitzmaurice DA, Murray E. Thromboprophylaxis for adults in hospital. *BMJ* 2007;334:1017-8. (19 May.)
2 Cohen AT, Davidson BL, Gallus AS for the ARTEMIS Investigators. Efficacy and safety of fondaparinux for the prevention of venous thromboembolism in older medical patients: randomised placebo controlled trial. *BMJ* 2006;332:325- 9.
3 Samama MM, Cohen AT, Darmon JY, Desjardins L, Eldor A, Janbon C, et al. A comparison of enoxaparin with placebo for the prevention of venous thromboembolism in acutely ill medical patients. Prophylaxis in Medical Patients with Enoxaparin Study Group. *N Engl J Med* 1999;341:793-800

Concern over guidelines

Many orthopaedic surgeons would disagree with Fitzmaurice and Murray.[1] Firstly, there is currently no evidence from published studies that thromboprophylaxis reduces mortality in patients undergoing elective hip or knee replacements. Secondly, there is much concern regarding the attempted prevention of what the authors themselves call a "silent" disease. While orthopaedic surgeons have not traditionally been seen as the pioneers of holistic medicine, we are reticent to expose our patients to increased risks from treatment for a condition only identified by a radiological test. The NICE guidelines own statistics emphasise this point by documenting the incidence of venous thromboembolism (VTE; radiologically diagnosed deep vein thrombosis and pulmonary embolism) after hip replacement without prophylaxis as 44% and the symptomatic VTE incidence in the same group as only 0.51%.[2]

Thirdly, we are disappointed by the lack of appropriate secondary outcome measures in the NICE analysis. No mention is made of wound haematoma, wound discharge, or joint infection. If these are not thought to be important issues then the millions of pounds spent every year attempting to prevent infection in hip replacement are clearly ill spent.

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Competing interests: None declared.

1 Fitzmaurice DA, Murray E. Thromboprophylaxis for adults in hospital. *BMJ* 2007;334:1017-8. (19 May.)
2 National Institute for Health and Clinical Excellence. Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients undergoing surgery. April 2007. http//guidance.nice.org.uk/CG46.

Effective implementation of thromboprophylaxis strategies

We recently completed an audit of thromboprophylaxis for surgical patients at a major oncological centre.[1] Despite a high awareness of the risks, over 50% of our patients were not receiving their risk appropriate prescriptions of low molecular weight heparin. Correct use of mechanical prophylaxis was achieved in over 80% of patients. The practice of thromboprophylaxis varied substantially between different clinicians. Often no clearly designated doctor, surgeon, or anaesthetist was responsible in the team for implementing prophylaxis.

Patients should be classified into the risk categories suggested by the National Institute for Health and Clinical Excellence (NICE) at the earliest opportunity, such as in pre-assessment clinics, with local hospital protocols suggesting the most suitable prophylactic strategy and who should implement it. This will give a greater number of patients the benefit of evidence based risk reduction.

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1 Fitzmaurice DA, Murray E. Thromboprophylaxis for adults in hospital. *BMJ* 2007;334:1017-8. (19 May.)

Improving use

We work in a hospital that implemented a thromboprophylaxis protocol for medical patients in 2004.[1] In line with the recent recommendations of the UK government's Health Select Committee, the protocol states that every medical patient admitted to the hospital should have a risk assessment for venous thromboembolism and be prescribed thromboprophylaxis with low molecular weight heparin if indicated. When the protocol was introduced it was widely publicised within the hospital and made easily accessible to doctors in the patient's bedside file and on the hospital intranet.

In the year after the protocol had been introduced we audited all cases of hospital acquired venous thromboembolism, to assess concordance with the protocol. We found that only 18% of medical patients who had an indication for thromboprophylaxis according to the protocol were prescribed an appropriate dose of low molecular weight heparin. Furthermore, out of six patients who died due to pulmonary embolism, only two had received low molecular weight heparin, although it was indicated in all six.

Maybe a new approach to the problem is required. Electronic alerts to the need for thromboprophylaxis have been shown to be effective in increasing doctors' use of thromboprophylaxis and reducing rates of venous thromboembolism.[2] This system, however, requires complete electronic records of patients' risk factors for venous thromboembolism. An alternative approach might be to mandate thromboembolism risk stratification and linked action as part of the standard admission procedure.

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1 Fitzmaurice DA, Murray E. Thromboprophylaxis for adults in hospital. *BMJ* 2007;334:1017-8. (19 May.)
2 Kucher N, Koo S, Quiroz R, Cooper JM, Paterno MD, Soukonnikov B, et al. Electronic alerts to prevent venous thromboembolism among hospitalized patients. *N Engl J Med* 2005;352:969-77.

MULTIMORBIDITY'S MANY CHALLENGES

A research priority in the UK

Further to the three research areas Fortin et al identify for investigation,[1] four additional aspects of multimorbidity are also relevant. Firstly, acute conditions also contribute to comorbidity, and there is no reason for their exclusion. Secondly, comorbidity is of particular relevance to primary care, which is person focused and not disease focused.[2] Thirdly, research on the mechanisms through which comorbid conditions interact is important for understanding the genesis of multimorbidity as well as its management; and fourthly, the implications of comorbidity matter in the assessment of quality of primary care and its financial restitution. The current financial incentives for general practitioners to provide high quality care focus almost exclusively on single conditions,[3] increasing the likelihood of fragmented care.[4]

Measuring comorbidity with the adjusted clinical group can help with all of these issues (http://acg.jhsph.edu.edu).

In the United Kingdom current specific collaborative research initiatives are focusing on multimorbidity in primary care, including the National Institute of Health Research's School for Primary Care Research, founded in October 2006 as a partnership between the leading academic centres for primary care research in England (www.nspcr.ac.uk). The school's main aim is to increase the evidence base for primary care practice, and one of its five core research programmes focuses specifically on comorbidity research.

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Competing interests: None declared.

1 Fortin M, Soubhi H, Hudon C, Bayliss EA, van den Akker M. Multimorbidity's many challenges. *BMJ* 2007;334;1016-7. (19 May.)
2 Starfield B. Threads and yarns: weaving the tapestry of comorbidity. *Ann Fam Med* 2006 Mar-Apr;4(2):101-3.
3 Roland M. Linking physician pay to quality of care: a major experiment in the UK. *N Engl J Med* 2004;351:1448-54.
4 Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. Financial incentives to improve the quality of primary care in the UK: predicting the consequences of change. *Primary Health Care Res Dev* 2006;7:18–26.

POLITICAL ILLITERACY

Many, but not all

While doctors' current lack of political activity irritates Tudor-Hart, he wonders whether newer members of the profession may be less reticent than their forebears.[1]

I hope so: a handful of us intend to stand at the next general election. We know that medical practitioners standing on an independent health ticket can be successful in getting elected to parliament—not once but twice in Dr Richard Taylor's case.

A recurrent theme of some my correspondents has been the supposition that an election campaign would have to be coordinated by the BMA or the LMCs, but I question that. A loose confederacy of independents would be far harder for existing politicians to combat and would introduce a long overdue diversity and excitement into national politics. Rudolph Virchow would be proud of us if we formed an effective parliamentary bloc.

Imagine if every constituency had an independent health candidate. You never know—we might win.

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Competing interests: SF is taking steps to stand at the next general election.

1 Hunter DJ. Why are so many people politically illiterate? BMJ 2007;334:1007. (12 May.)