

Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to jhowlett@rcgp.org.uk, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Letter from a Dutch uncle

As I read the inner cover of September's *BJGP* I noted once again the preponderance of researchers whose surnames contain an almost implausible combination of vowels or suspicious frequency of diphthongs. Not for the first time and, like a bygone Eurovision Song Contest, the Dutch scored highest on the Original Papers count.

I am happy to read and learn from articles originating elsewhere in the world and delight in the cosmopolitan culture of this proud journal. I do wonder though as to why quite so many articles appear from the Benelux and Scandinavian countries. Perhaps ours is truly the pinnacle of publishing excellence that Danish researchers can only aspire to. I have a nagging suspicion though that many such papers are received on the back of rejections from reviewers elsewhere on the continent.

I am curious that an antibiotic study should exclude 'families that had not mastered the Swedish language'¹ and yet its intended readership is not subject to such denial. I am bemused by the relevance of studying prescribing habits that stray from those of the Dutch College of General Practitioners' guidelines.² I am perplexed that our Editor must 'again' apologise to 'non-UK readers' for content found elsewhere within the *BJGP*.³ I know the *BMJ* struggles with the word 'British' in its title and has considered abandoning it for something more 'international.' Perhaps it delayed because the *Icelandic Medical Journal (IMJ)* got there first (by almost a century!) with those particular initials.

May I suggest that the, otherwise helpful, little coloured box: 'How this fits in' should be extended to mention the country in which the study was conducted

and how it relates (or literally translates) to British general practice.

It is not a safe assumption that research findings anywhere within these ever expanding European boundaries apply throughout or even elsewhere. Many cultural and practical differences exist and in a medical context alone these would include incompatible or different: X-ray facilities and guidelines; Ethics committees; Notification of diseases; Organisation of health services; Politics and pharmaceuticals, Hospital management; Out-of-hospital care; Bed availability and usage; Infrastructures and Attitudes. I appreciate this has a most unfortunate acronym but I do hope my point is not lost in translation.

Veel Geluk

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The use of cardiovascular risk factor information in practice databases

Tom Marshall¹ shows how routinely collected general practice data can help identify patients at risk of cardiovascular disease (CVD). Practice-held information

could become an important resource for targeting preventive care, particularly when combined with automated software, as he suggests. However, there are a number of issues highlighted by his paper.

Marshall has excluded those already on blood pressure and cholesterol lowering therapy from his modelling. Such patients should ideally have their risk estimated using 'pre-treatment' values. However, these values are often unavailable in general practice databases. The Coronary Heart Disease National Service Framework² recommended using the hypertension register as a rich source of high-risk cases, where there is a potential for further reduction in risk even if blood pressure control has been achieved. We believe that such patients should be included in any automated search strategy.

We have designed a new software tool, the 'e-Nudge', which has been programmed by the clinical software company EMIS. Currently being trialled in the West Midlands,³ the e-Nudge works both opportunistically (through screen alerts when high CVD-risk patients' notes are opened), and systematically through the creation of continually updated lists available to practice teams. It works on the assumption that 'most recent' values will generally be lower than 'pre-treatment' values in patients on drug therapy. While neither approach is perfect, this maximises the usefulness of general practice data for case finding.

Tom Marshall assumes that once the at-risk population is identified, opportunistic case-finding is effectively random. However, risk factors for CVD are also predictors of consulting rates, which increase with age,⁴ and in socioeconomic groups IV and V⁵ in which smokers are more common. The likelihood of a patient in Marshall's higher risk deciles consulting will therefore be greater than average, increasing the efficiency of opportunistic screening, so