

those attempting such projects could read about the experience of others.

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Identifying relevant studies for systematic reviews

EDITOR.—We agree with Kay Dickersin and colleagues' recommendations regarding the need for improved reporting of randomised controlled trials by authors and improved indexing of such trials in electronic databases.¹ We wish to make two additional points on the basis of our experience of searching for randomised controlled trials related to stroke.

Firstly, there is a need for improved indexing in Medline (and other databases) of the medical subjects as well as the terms used to identify trials. For example, the MeSH term that covers stroke is CEREBROVASCULAR-DISORDERS but this is imprecise as it also covers many conditions not related to stroke (such as vascular dementia and migraine). In addition, the term CEREBROVASCULAR-DISORDERS is not used consistently for all stroke trials, especially for trials relating to prevention and rehabilitation. After studying the text and MeSH headings of several hundred stroke trials, which we had identified using a variety of methods, we have had to add 13 further MeSH or free text terms to maximise the sensitivity of our search. This further reduced the precision: the search with maximal sensitivity (87% of the articles in Medline that related to stroke trials) had a precision of only 10%. When this search was applied to all journals in Medline over six years about 10 000 articles were retrieved, each of which had to be assessed.

Secondly, given the problems with electronic searching of Medline and the practical difficulties of organising hand searching of all journals likely to include relevant trials (we think that at least 300 journals have included stroke trials), we suggest that several overlapping search strategies should be used to ensure that as many as possible of the available randomised controlled trials are included in systematic reviews. The Cochrane Stroke Review Group uses several such strategies: hand searching 15 major journals and the proceedings of major meetings on stroke; electronic searching of Medline, Embase, the Index to Scientific and Technical Proceedings (a database of conference proceedings available through the Bath Information and Data Services), and two dissertation databases; searching of the Ottawa stroke trials registry; reviewing the bibliographies of trials and other relevant articles; and contacting drug companies and colleagues. Each of these methods has retrieved trials that would have been missed if a single search strategy had been used.

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Pressure sores

Clinical trials best way of assessing different mattresses

EDITOR.—R K Vohra and C N McCollum's review on pressure sores contains two misconceptions.¹ Firstly, the authors state that measurement of the interface pressure is the best method of comparing the efficacy of pressure relieving supports, whereas clinical trials have shown that it is a poor indicator.^{2,3} Deep periosteal pressures are considerably higher than the interface pressure,⁴ and animal studies have repeatedly shown that the initial ischaemic necrosis that causes deep sores occurs in subcutaneous tissues, not in the skin.⁵

Secondly, the authors share the common confusion concerning the different actions of low pressure and alternating pressure supports: "in a comparison of alternating air, static air, and water mattress overlays on sacral and heel pressures . . . mean pressures were significantly higher for the alternating air mattress than the other surfaces; they should therefore be avoided."

Low pressure mattresses are soft supports that aim at distributing the weight as widely as possible and thus at preventing high pressures over bony prominences, which cause distortion of tissue and ischaemia. In contrast, alternating pressure mattresses are designed to be sufficiently firm to lift the patient off the bed and to support him or her while adjacent cells inflate and deflate underneath the body, constantly changing the areas of high pressure. They mimic the alternate high and low pressures that occur in normal people as a result of changes of position in response to pain due to pressure, which permit reactive hyperaemia and reoxygenation of the tissues and thus prevent ischaemic necrosis. Averaging the pressures in alternating pressure mattresses to enable them to be compared with low pressure supports is therefore meaningless.

Only clinical trials can show which system works best for different types of patient. A recent randomised trial in a district general hospital comparing alternating pressure mattresses with similarly priced constant low pressure mattresses (for example, fibre fills, slit foam, static air, water, and low air loss overlays) showed the alternating pressure mattresses to be considerably more effective.¹

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Carers should provide informed, cohesive approach

EDITOR.—I hope that R K Vohra and C N McCollum's review on pressure sores will be read by the people who chair curriculum committees of medical schools.¹ Pressure sores are seldom included as a specific topic for instruction to

medical students. This accounts for widespread ignorance on the subject among doctors both in hospitals and in the community. It has always struck me as extraordinary that a condition that affects between 5% and 10% of all patients in hospital should not be a matter of top priority for teaching of medical students.

One point that the review fails to emphasise is the need to establish satisfactory preventive measures in the community before patients are discharged from hospital. One of the commonest causes of the high rate of recurrence of pressure sores is the failure of communication between carers in hospital and carers in the community.

As a surgeon with an interest in pressure sores, I seldom agree to close a pressure sore until I know that future prevention of the same sore is assured. This often means that special equipment has to be purchased and so proves expensive, but, in the long term, prevention of sores is much cheaper than treatment and the cost of providing the equipment for prevention is equivalent to that of only a two or three week stay in hospital. Demarcation disputes often delay the decision on who should fund the equipment: the hospital believes that the community should do so and the community believes that the hospital should. It would be in everybody's interest if each health authority set aside money for the provision of equipment for patients with pressure sores that could be called on by both hospitals and the community.

Finally, I agree with the authors that a wide range of topical dressings and applications is marketed with, usually, little evidence of efficacy. This can be summarised in the aphorism "it matters far more what you put a pressure sore on than what you put on a pressure sore."

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Assessing risk of suicide

Samaritans' scoring system helps develop judgment

EDITOR.—H G Morgan's article on the role of doctors in preventing suicide emphasises the need for training in assessing the risk of suicide and responding appropriately.¹ Samaritan volunteers in training are taught always to ask about suicidal feelings and to assess the risk in detail. A rough and ready scoring system is sometimes used to help develop sound judgment based on thorough inquiry; it is mainly useful for training purposes.

The scoring system was based partly on a booklet about assessing the risk of suicide published by the New York Suicide Prevention Center (which was much too detailed and elaborate for day to day use) and partly on advice from the Los Angeles Suicide Prevention Center, which emphasised the importance of whether there is a suicide plan and, if so, its nature and intended timing in the assessment of the immediate risk. Sudden deaths (by hanging, shooting, or jumping), which are final, are distinguished from slower deaths (by overdosing, for example), in which rescue is possible if the chosen place and time favour it. Other risk factors—historical, social, and medical—are then scored as features that increase the immediate risk or warn of longer term risk for those not in imminent danger (table). The table thus offers reminders about what to ask: Any plan? What? When? Where? Are the means available? Ever tried before? How seriously? Preparations (making a will, giving things away, etc)?

The score that results offers guidance for an appropriate response: a score of 7 or 8 in the first