
Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

## COVID-19 testing delays and pathology services in the UK

Richard Horton[1] is critical of the UK Government for not following WHO's advice for COVID-19 testing at a much earlier stage of the pandemic and for not securing supply chains for pharmaceuticals, protective equipment, and appropriate human resources.

Following the 2003 severe acute respiratory syndrome outbreak and the 2012 Middle East respiratory syndrome outbreak, it was inevitable that with global population growth, overcrowding in many low-income and middle-income countries, increased cheap air travel, and failure to stamp out wet and live animal markets, new coronaviruses would emerge and spread rapidly. The UK should have prioritised the development and availability of better technology to detect new viruses and manage their spread.

10 years of austerity have left the UK National Health Service inadequately resourced and ill prepared. During the reorganisation of pathology services, recommended by the 2008 Carter report,[2] many hospital laboratories have disappeared with the introduction of so-called hub and spoke models. This has been at the expense of what had previously been a high-quality service for diagnosis, surveillance, and epidemiology. Furthermore, there has been a failure to stockpile laboratory consumables and reagents, despite shortages during the 2009 H1N1 influenza pandemic.[3] What is particularly inexcusable is the shortage of swabs to take samples from patients and health-care workers during the current COVID-19 pandemic. Our reliance on China as a global supplier for such supplies has compromised the UK's COVID-19 response. Many manufacturers, suppliers, and hospital services are inevitably finding it difficult to meet the demand for testing of both patients and staff.

The centralisation of pathology services into a hub and spoke model has resulted in the hub being located at a site distant to some acute services. The reduction in the number of senior scientific staff to reduce costs has failed to increase enthusiasm for what should be an exciting and attractive career for both doctors and scientists. The geographical and intellectual separation of service and academic activities precludes an interactive approach to diagnosis, management, and research. In many medical schools, there has been a reduction in pathology teaching in the undergraduate curriculum, such that students are not interested in some of the major developments in medicine.

The Royal College of Pathologists and the other pathological societies should be more vocal in recognising the importance of their disciplines. It is disappointing that other specialties that are dependent on pathology have not spoken up to express their views at a local or national level in the face of damaging reorganisation and cuts in pathology.

In short, the disciplines that manage infections, microbiology, and virology, have been undervalued and underresourced for a long time. Only if things change will we be able to improve responses to new infections.

I declare no competing interests.

*Jangu Banatvala*
**jangu.banatvala@gmail.com**

School of Medicine and Dentistry, Kings College London, London WC2R 2LS, UK

1 Horton R. Offline: COVID-19 and the NHS—"a national scandal". *Lancet* 2020; **395:** 1022.
2 Carter PR. Report of the review of NHS pathology services in England. 2008. https://www.networks.nhs.uk/nhs-networks/peninsula-pathology-network/documents/CarterReviewPathologyReport.pdf (accessed May 21, 2020).
3 Smith S. Flu onset exposed supply problems. 2009. http://archive.boston.com/news/health/articles/2009/06/15/swine_flu_arrival_overwhelmed_stockpile_of_medical_supplies/ (accessed May 21, 2020).

## Questioning statin therapy for older patients

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Single clinical trials have not yet determined whether statin therapy provides more benefit than harm to people older than 75 years with or without a history of vascular disease. The Cholesterol Treatment Trialists' Collaboration, which alone has access to patient-level data from most trials, is best able to answer these questions. However, we have several concerns about the Article by the Collaboration[1] and the presentation of its results to the media.

First, the collaboration states that "rates of use of statin therapy… are substantially lower in people older than 75 years",[1] but the data in table 2 of one of the two sources cited to support this claim, by Salami and colleagues,[2] show just the opposite.

Second, although the collaboration reports that they have data on 14 483 trial participants older than 75 years, approximating the total denominator of all such participants from the figures in the 2019 meta-analysis gives only 9473 participants for figure 1A and 10 513 participants for figure 5A (by dividing the number of events by % per annum ÷ 100 × median number of years per study). Thus, either the collaborations' calculations are missing 27–35% of the available data or a considerable number of trials had short follow-ups. Although short follow-ups would explain this discrepancy through a difference between the median and mean duration of the studies, we find this explanation untenable because of the magnitude of the difference; it is at least worthy of additional explanation.

Third, the collaboration's data show that annually, 1000 people older than 75 years without a history of vascular disease need treatment to prevent a single major vascular event, and cardiovascular or all-cause mortality data are not presented for this population. These results make informed doctor–patient decisions