

LETTERS

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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Healthcare resource groups (HRGs): a casemix currency for GPs

Sir,

A single page on this topic appeared on p.298 of the *May Journal*, without authors or references, unlisted on the contents page, indeed with no way of knowing whether it was an editorial statement, anonymous opinion piece, or announcement from the NHS Executive.

We are given two histograms, both without numbers, confidence intervals, time periods, or any way of finding where they come from. The first compares orthopaedic acute myocardial infarction rates per 1000 list size, apparently between six general practices. Both would provide a good teaching example of how *never* to present data to a serious, informed and critical audience.

It is difficult from this evidence to gain more than a first impression of what is evidently destined to become a new currency for trading across the purchaser-provider split. There are close parallels with the similar tool used in the USA. Diagnosis-related groups (DRGs), which also claimed to have solved the many extremely difficult problems entailed in using clinical data as evidence for rewards and penalties in a managed market.

DRGs became the units used both to evaluate physician performance through Medicare peer review, and to reimburse hospitals for patient care through the prospective payment system.¹ Like all clinical data used to calculate either rewards or penalties, they have been manipulated to maximise hospital incomes, emphasizing cost-sensitive factors like length of stay, and minimizing or ignoring socially sensitive factors like continuity, accessibility and community loyalty to and from local units.²

Readers should look carefully at Figure 2 in this 'paper', with two- to sixfold differences in infarction rates over unspecified periods, calculated from unstated

case numbers and list sizes, and ask themselves whether they can accept that their own work should be measured in this slipshod way. The aim is clear: to devise league tables which compare apparent health outputs by different hospitals and practices serving different catchments, just as schools are now being ranked in league tables of achieved literacy without knowledge of underlying economic and cultural factors. In both cases, the real complexity of case mix, and the difficulties of professional work in poorly resourced and sometimes demoralized populations, can be seriously addressed only by professionals with long personal experience of doing it.

It the purchaser-provider split generates such worthless currency, why not return to our original cash-free economy, based on co-operation between local units at primary, secondary and tertiary levels, serving defined local populations rather than customers from an unlimited marketplace? If the existing political parties find this too difficult we must help them. Finally, how did this paper come to be published in a serious, independent, peer-reviewed journal?

JULIAN TUDOR HART

International Section, Department of Primary Health Care
Royal Free Hospital Medical School
69 Fleet Road
London NW3 2QU

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2. Luft HS. Modifying managed competition to address cost and quality. *Health Aff* 1996; **15**: 23-38.

NOTE: The editor regrets the inclusion of this advertising feature in the *May Journal*, without any indication of its provenance. This was due to an administrative oversight and not to a change in editorial policy. Further information about the advertisement is given on p.348 of the *June Journal*.

Examining the value of eradication therapy for *H. pylori*

Sir,

Rosengren and Polson's paper¹ reinforces existing evidence on the value of eradication therapy for *H. pylori* in patients with known peptic ulcer disease (PUD) in general practice.^{2,3,4} However, areas of uncertainty are evident in Rosengren and Polson's data.

Firstly, 13 (33%) out of 40 patients declined treatment. In a similar study in six practices,⁵ only 27 out of 54 (59%) patients with PUD were given eradication therapy by their GPs. Practitioner feedback suggested that the use of eradication was reduced by a lack of confidence in the benefits of eradication and concerns over tolerability of regimes on the part of the GPs, and not patient refusal. Comparable results were seen in a recent audit of *H. pylori* eradication in other practices (personal communication, Solihull MAAG).

Eradication therapy is very effective in preventing ulcer relapse, with a number needed to treat (NNT) of, at most, 1.5.⁶ Studies showing the effectiveness of *H. pylori* eradication in general practice^{1,2,3} and the availability of shorter, more tolerable eradication regimes, should offer GPs the confidence to recommend this treatment to patients. Media attention towards this subject in the 2 years since this study was performed would be expected to have raised expectations, making eradication therapy more acceptable to patients.

Secondly, only 69% of the patients tested positive for *H. pylori* on a serum ELISA test. The prevalence of *H. pylori* in this group would be expected to be between 85 and 90%. The prevalence of long-term antisecretory therapy (3.9%) and of peptic ulceration (0.7%) were higher than in previous studies,⁷ suggesting that a significant proportion of the peptic ulcer patients may not have actually had an ulcer (we are not told the diagnostic criteria).

In addition, the predictive value of a

test (i.e. how many of the negative testing patients excluded from the study were truly negative) depends on the prevalence of the condition being tested, the relationship being given by Bayes Theorem:⁸

For a negative result: Odds (Negative Predictive Value) = Odds (1-prevalence) x Likelihood ratio, where the Likelihood ratio is (Specificity/1-Sensitivity).

If the performance characteristics of the ELISA test had been given it would have been possible to estimate how many patients were excluded as false negatives. In general, none of the currently available tests for *H. pylori* have sufficient accuracy to significantly alter *a priori* knowledge based on the prevalence of *H. pylori* infection in this group. Given the great benefit and small risk of treatment, we believe that all symptomatic patients with proven histories of peptic ulceration should receive eradication therapy without prior screening for *H. pylori*.

BRENDAN DELANEY
F D RICHARD HOBBS
JOYCE E KENKRE
MADELEINE ROWSBY

The University of Birmingham
Department of General Practice
Edgbaston
Birmingham B15 2TT

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The use of a near patient serological test for *H. pylori*

Sir,
Like Rosengren and Polson (*March Journal*, p.177), I found around half the patients receiving intermittent or continuous repeat prescriptions for ulcer healing drugs in my practice had never been investigated by endoscopy or barium meal. In an evaluation of the use of a near patient serological test for *H. pylori*, we included patients with a typical ulcer history, and offered further investigation or treatment for those showing antibodies to *H. pylori*. Treatment was usually with a one-week course containing omeprazole, metronidazole, and either clarithromycin or amoxicillin.

A typical history required intermittent episodes in which the predominant symptom was well-localized epigastric pain which was relieved by food and antacids, and which woke the patient from sleep at least once during an exacerbation. Patients without these features, or those who also had nausea, vomiting or weight loss, were excluded.

Results of the serological test (Helisal, Cortecs Diagnostic Ltd) were positive for 16 out of 17 patients with a previous duodenal ulcer (DU), and 13 out of 15 with typical symptoms but no investigations.

Prescribing of antacids and ulcer healing drugs was recorded for an equal period before and after eradication therapy in those who had positive tests (for most patients this was 6 months) and the results are shown in Table 1.

Reductions in prescribing were matched by patient's perceptions of the effect of treatment. Questionnaires were posted to patients between 4 and 12 months after their treatment. From the replies, nine out of 13 patients with DU, and nine out of 11 with typical symptoms but no investigation, reported themselves either much better or cured.

This small study suggests that most patients with intermittent symptoms

strongly suggestive of duodenal ulcer disease, who have antibodies to *H. pylori*, appear to benefit from eradication of the organism, at least over 6 months, as much as patients with a proven DU in the past. As the alternative for them would be to wait for symptoms to recur off treatment and then defer ulcer healing treatment until an endoscopy was carried out, this approach was popular with our patients. This pragmatic approach should be investigated further in primary-care-based trials of *H. pylori* detection and treatment.

CHRIS BURTON

Sanquhar Health Centre
Station Road
Sanquhar
Dumfriesshire DG4 6BT

Respiratory drug delivery devices

Sir,
I read with interest the article 'Optimising inhaled drug delivery in patients with asthma' (*December Journal*, p.683).¹ Would that life and 'lung deposition' were so straightforward, but alas, Jackson and Lipworth misunderstand the principles involved. They fail to appreciate that the most important aspect is to allow the patients to choose the device they prefer: something that respiratory-trained nurses have been doing for years. There is no device preferred by all patients, and it is misleading to quote deposition statistics and extrapolate these to clinical practice. The amount of drug deposited in the lung using the same device in different patients varies tremendously: up to ten-fold using sodium cromoglycate.² This variation far outweighs the estimated or meaned figures as quoted by Jackson and Lipworth, and is not dissimilar to the variation seen in the same patient using the same device from one inhalation to the next.

All inhalers have widely varying characteristics, so it is imperative that deposition,

Table 1. Prescriptions for up to 6 months before and after *H. pylori* eradication therapy for patients with a positive serological test (equivalent units: 500 ml antacid, 56 x 400 mg cimetidine, 28 x 20 mg omeprazole).

	Previous duodenal ulcer (n=17)			Typical symptoms only (n=15)		
	Before	After	Reduction	Before	After	Reduction
Antacids	3	0	3	3	1	2
H ₂ receptor antagonists	35	15	20	31	11	20
Proton pump inhibitors	13	9	4	2	0	2
Total	51	24	27	38	12	24