Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Is there sufficient evidence for encouraging widespread use of HRT to prevent disease?

Sir,

I enjoyed Philip Hannaford's measured and incisive editorial on the use of hormone replacement therapy (HRT) (February *Journal*).[1] We too have been interested in the issue of using HRT for the prevention of osteoporosis, and have conducted an extensive literature search on the subject as part of a project to develop evidence-based audit criteria for osteoporosis in primary care.[2]

Despite the uncertainty over the long-term benefit/risk ratio of HRT that Hannaford points out, the use of HRT for long-term therapy is widespread and rising.[3] This raises an important issue of whether current medical practice in this area is evidence based and how GPs and other members of the primary health care team can make accurate recommendations that reflect the current state of knowledge.

In practice it is helpful to make a distinction between the relatively short-term use of HRT for the relief of climacteric symptoms, such as vasomotor flushing and uro-genital atrophy where the evidence base is strong,[4] and the long-term use for prevention where the evidence is less well established.[1] The cardiovascular benefits conferred by long-term HRT are yet to be firmly established.

The evidence for HRT preventing osteoporosis is derived from observational studies, and the impact of fracture rates is not clear. There is evidence from controlled trials of the effect of HRT on bone mineral density.[5] There are risks of HRT such as breast cancer and of venous thromboembolism. However, until long-term large-scale randomized controlled trials of HRT have been reported, universal HRT for the prevention of disease cannot be recommended. A review of the evidence has led us to conclude that the opportunistic, rather than universal, use of HRT is currently the best approach for women aged 44–55 years.

It is also worth pointing out that, although HRT is currently the main stay for the prevention of bone loss in women, the situation is changing by advances in drug therapy such as bisphosphonates, which have strong evidence of effectiveness from randomized controlled trials.[6] Together with vitamin D analogues, there are now several non-hormonal treatments for the prevention of osteoporosis. However, the benefit/risk ratio of HRT may alter substantially with the advent of selective oestrogen receptor modulators (SERMs), which may not have same adverse effects of conventional HRT.[7]

This debate illustrates the difficulties of making general practice more evidence based, especially when the available evidence is conflicting, uncertain, or simply lacking. Many health care professionals are currently recommending long-term HRT for the prevention of disease. However, the current best available external evidence may not support this practice and caution needs to be exercised when making such recommendations. Regular review of duration of therapy with HRT is essential. Not only is it difficult for health care professionals to use evidence in practice, it is even more challenging to involve patients in evidence-based decision-making in this area. The decision for patients is complex, particularly weighing up the cancer risk with duration of treatment required to confer bone health. Further research needs to be done in this area using formal and systematic methods of decision-making such as decision analysis.[8]

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Do women with HIV infection consult with their GPs?

Sir,

The authors of this report (June *Journal*)[1] advise us that both primary and secondary care services should aim to increase the proportions of HIV-positive individuals with access to primary care. As a direct result of reading this study, we have reviewed HIV attenders in a district genito-urinary medicine department.

Since reporting began in 1982, we have a cumulative total of 74 HIV-positive patients in a clinic that serves a population of 300 000 people. Some of these patients have been extremely sick individuals returning from major centres to receive terminal care.

During the past two years we have been aware of increasing small numbers of heterosexual patients who are HIV positive. We identified that, although 20% of our patients have been heterosexual women (cumulative total), of the 31 patients who are currently attending, 32.2% (approximately 1 in 3) are heterosexual females.

We have looked at the cumulative caseload with regard to registration with GPs. It may be relevant that this unit is a designated VTS SHO training centre for future GPs, and that we have had a specific HIV/AIDS component to the full-time SHO post designated for future GPs for 10 years.[2]

Looking at the cumulative caseload, six of the 74 patients had not been registered with a GP. Seven patients who were with GPs consistently refused consent for us to collaborate and communicate with their GPs using statutory instruments of confidentiality. A further patient was registered for terminal care at home via the patient's family doctor. One patient was in prison and one patient chose to remain under the care of a consultant GU physician in London. The remaining 59 patients were registered and gave consent for their GPs to be contacted.

Throughout the cumulative experience of HIV in this district (Doncaster), just under 80% (almost 4 out of 5 patients) were both registered with GPs and gave consent for communication between specialist and family doctor.

If the clinic attenders at the time of the study who were HIV positive/AIDS patients were considered separately, a different pattern emerges. At the time of the study, only two patients (both male) were not sharing care with a GP. One patient was not registered with a GP and one was registered but did not give consent for exchange of information. Twenty-nine of the 31 patients who were attending the clinic were both registered with GPs and had given full consent for regular correspondence and communication between specialist and primary care physician. Compared with anecdotal reports from GU physicians working in other centres, this seems an extraordinarily high number of patients whose care involves close collaboration between primary care and specialist HIV physicians. If a figure of some 94% of patients is maintained as our cohort expands, this is clearly encouraging.

It is clinical policy and has been a commitment in this clinic for many years to try to actively involve the GP in HIV care. This has clearly been facilitated by the understanding achieved during the SHO training post. Many of these earlier trainees have become established principals in general practice, and commitment and enthusiasm to contribute to HIV care seems to have been initiated by the ex-trainee and subsequently shared with all members of a practice medical staff. (It is recognized that many GPs committed themselves to care for these patients very early in the United Kingdom (UK) HIV experience.)

Our population differs from the national picture described in Madge *et al*'s report, as the authors state that 15% of those infected in the UK are women. In our population, the cumulative percentage of women patients was 20%, and when looking at current clinic attenders 32.2% are women.

Madge *et al* state that 'Women with advanced disease were more likely to inform their GP of their diagnosis, reflecting their increased need for community-based services.' In our experience (recognizing this as a small cohort), women tend to present with very advanced disease and clearly have the increased needs for community-based services identified by the authors.

The question that arises from the brief report relating to women with HIV infection is, how may we continue to develop shared care with GPs? The experience in our centre suggests that close involvement in the training of future GPs offers a sound way forward. The challenge here appears to be one of achieving earlier diagnosis in heterosexual young women whose absence of obvious risk factors may delay identification of their HIV status.

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The role of the GP in the care of people with HIV and AIDS

Sir,

The general practitioner's (GP's) role in the care of people with HIV infection (May *Journal*)[1] is bravely said by King *et al* to include 'a strategy to make HIV care routine for all GPs...in high prevalence districts.'

One of the recurring themes from research into barriers to GP care for HIV is the vicious circle of lack of hands-on experience as perceived by both GPs and patients with HIV, with the consequent reluctance to attend for GP consultation. Many GPs in East London frequently and honestly claim 'to have no HIV-positive patients on my list'. In fact, every principal in this locality will statistically have approximately four (15 551 patients notified with HIV in North Thames region:3776 GPs) *known* HIV positives, and a further two or three who do not yet know their status.

Bearing in mind that people more at risk from HIV infection are likely to be highly selective in the characteristics of the primary care teams with whom they register, it is probable that most group practices with three or more principals will have an upwards of 30 people with HIV infection, half of them undiagnosed and unknown. Further, patients with, or at risk from, HIV infection are likely to gravitate towards a practice with one or two partners. Therefore, prevalence figures are likely to continue to increase as people continue to sero-convert at a steady rate, will increasingly be tested and diagnosed, and are more likely to enter long periods of chronic illness owing to decreased mortality from improved antiretroviral medication prophylaxis against infection.

With the advent of primary care commissioning, and with the inevitable inability of hospital HIV clinics to continue to provide gold-star primary care services, primary care teams in these areas are likely to *have* to find ways of providing increased levels of chronic HIV disease monitoring and management. The nettle yet to be grasped, however, is the transfer of *overall routine* chronic and *stable* HIV management (including monitoring antiretroviral prescribing) from secondary care into primary care. Many shared care schemes over recent years (with a plethora of shared care cards) have been based on goodwill and an admirable desire to increase the involvement of primary care teams. While all the major decisions are taken in secondary care clinics, however, this has largely been a sham exercise for GPs. Only by taking over the holistic management of yet another chronic disease can GPs and primary care teams become conversant with current guidelines and future developments.

There will of course be opposition to this necessary change from all parties: HIV physicians, patients, and primary care teams alike. Considerable support from community specialists, secondary/tertiary care providers, and health authorities will be needed, perhaps with financial incentives along the lines of those being introduced for GP management of drug use.

Time is short. Qualitative and feasibility studies are needed in the next year or two to facilitate this change.

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Tonsillectomy for sore throat?

Sir,

Tom Marshall's systematic review of the benefits and harms of tonsillectomy (June *Journal*)[1] is a welcome addition to the armamentarium of the evidence-hungry general practitioner. We will be able to advise our patients all the better with this information.

I am sure that Marshall's general conclusions — that there is very little evidence to support tonsillectomy as a treatment for recurrent sore throat — are in the correct direction. However, I wonder if an important factor has been missed in the interpretation of the data — the effect of having the painful insult of a surgical operation on one's throat on the subsequent reporting of soreness of the throat.

I can just remember my own tonsillectomy as a small boy. The pain was frightful, and the offer of ice cream as a treat seemed a far from adequate compensation. I am quite sure that in any ensuing estimation of the soreness of the throat during later illnesses would have been enormously ameliorated by the memory of the post-operative pain: 'Now that was a really sore throat.'

The effect of this form of reporting bias would be to exaggerate any benefit of tonsillectomy. Therefore, general practitioners reading this review should interpret the marginal benefits of tonsillectomy reported on subsequent sore throats (both in intensity and frequency, for both would be decreased by such a bias) with extreme caution.

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Urine sample collection

Sir,

The letter by Vernon, Foo, and Plant (June *Journal*)[1] raised a wry smile. A year ago I found my way to Vernon *et al*'s 1994 letter.[2] Having read it, I wrote to National Health Service (NHS) Supplies asking to purchase 10 urine collection pads for use in our practice. NHS Supplies replied that this order would cost £30.53, but were unwilling to accept any order for a cost of less than £350. Their catalogue contained no other item that we wished to purchase. I was unable to obtain the pads through our local Paediatric department.

It is frustrating to repeatedly read Vernon *et al*'s exhortations to use urine collection pads when, in practical terms, these are unavailable to individual general practices. I hope that the procedure packs they mention will prove to be more readily available.

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Urine collection pads

Sir,

Vernon *et al* (June *Journal*) have drawn our attention to the cheapness of urine collection pads. However, a minimum order of £50 must be placed, which removes the cost-saving factor for some practices.

When Cleveland Medical Audit Advisory Group recently produced guidelines for childhood urinary tract infections, this issue was pursued as part of the process of implementation. Hartlepool and East Durham NHS Trust has now agreed to purchase the pads, which are free to GPs. The hospital has also introduced boric acid containers instead of universal containers to help improve sample quality on arrival at the laboratory.

In my own practice we have also been using the pads in the elderly incontinent, which have produced unquantified time savings for the nursing staff.

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Primary care education centres

Sir,

Lindsay Smith proposes that primary care education centres are based on training practices or research practices (May *Journal*).[1] Another option is to base them within the umbrella of the primary care group. Each primary care group is of sufficient size to have at least one person (doctor, nurse, or other primary care team member) able to take a lead in education, and there is likely to be sufficient interest to provide a multidisciplinary group to coordinate education. The primary care education centre could serve not just one, but all practices in the group. Students would have potential access to a greater number of patients and a greater variety of practices.

If primary care groups, with all their potential pitfalls, are here to stay, at least we could make the most of the educational possibilities. In particular, educational cooperation across practices with sharing of educational resources.

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Referral for prostatism: a 'performance indicator' for the gate between primary and secondary care?

Sir,

It is proving particularly difficult to monitor the 'gateway' between primary and secondary care. The recently published National Health Service Executive 'performance indicators' for primary care stated the lack of an available measure. We therefore report a possible approach in an important and common clinical presentation — prostatism. The variation in referral rates is well established but it has always been difficult to define referral 'appropriacy'. The question of 'appropriate' from whose perspective immediately arises: specialist, generalist, patient, or purchaser? It can also be argued that 'appropriacy' can only definitively be measured in terms of 'outcomes'.[1] Differing 'thresholds' for referral have been described[2] but the area is not well researched.

Our work reports to what extent referral letters state the amount of investigation and management that occurs before a referral decision is made. Although many guidelines exist,[3] actual practice varies immensely. There are no studies that analyse what effect this information has on the ability of specialists to prioritize outpatient appointments. The development of medical therapies for benign prostatic hyperplasia (BPH) and the availability, for some practitioners, of post-micturition bladder residual volume and urinary flow-rate estimations make it possible to advise patients that 'watchful waiting' is a realistic option, thereby avoiding a referral.[4] Work using interactive videotapes have already demonstrated the feasibility of this approach.[5] Is there any evidence that practitioners are making use of the management options open to them? In short, can we determine what is the 'appropriate' referral behaviour for prostate disease so that outpatients' appointments can be prioritized?

The collaborating urology department in Cardiff received approximately 40 referrals per month relating to problems of the lower urinary tract in men suggestive of benign prostatic hypertrophy, and 221 referrals were collected consecutively and analysed. A group composed of four general practitioners, an urologist, and a researcher agreed the evaluation criteria.

The most striking feature is the paucity of important information in the referral letters. The findings of physical examination (including the results of a digital rectal examination) were not included in over a third (36%) of referral letters. Helpful information about simple investigations (MSU and renal function) was absent from over two-thirds (77%) of referral letters. Conversely, the PSA test was reported in 60% of referrals despite debate about its usefulness as a screening procedure for prostatic carcinoma. The results of more sophisticated investigations (post-micturition ultrasound scan and urinary flow rates) were included in 4% of referrals. The study reveals a wide variation of referral practice, suggesting that practitioners have very different thresholds for requesting the opinion and intervention of a specialist.

There was a striking absence of information about physical examination, including the results of a digital rectal examination which is a recognized discriminating criterion for the identification of prostatic carcinoma,[6] in over a third of letters. The results of simple tests were absent in over two-thirds of the referrals. Urologists receiving such limited information are placed in the difficult position of being unable to prioritize patients for outpatient visits. This is not so much a question of referral 'appropriateness' or clinical competence but one of clinical performance that may compromise future management. Only 4% of referral letters included the results of the more sophisticated tests.

We are tempted to conclude that many general practice partnerships may benefit their patents and their local urologists by undertaking an in-house audit of referral letters in relation to prostatism after setting an appropriate local standard. The feasibility of managing problems, such as prostatic hyperplasia, more extensively in primary care will be of interest to the emerging visions of managed care.[7] Debate may exist about the core content of general practice but there is little discussion about the need to convey appropriate information to specialist colleagues at the time of referral to aid clinical prioritization in an overstretched service. Although it lacks a psychosocial perspective (description of patients' preferences and 'bother levels'), this study begins to identify minimal normative criteria for BPH referral practice. It could be the forerunner of a 'performance indicator' at the gate between primary and secondary care for an important condition in our ageing society.

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Recognizing meningococcal disease

Sir,

The interesting paper by Granier *et al* (April *Journal*)[1] raises several important issues. First and foremost, meningococcal disease may manifest itself as meningococcal septicaemia,[2] which usually has an absence of the classic signs and symptoms of meningitis but a high mortality.[3] To complicate matters, the media often unwittingly refer to this as 'meningitis'. Thus, if patients are encouraged to attend earlier with non-specific illnesses in case they have meningitis, this may be counterproductive as they may inadvertently be reassured and yet be in the early stages of developing meningococcal septicaemia.

In this rare scenario where a patient dies, this can understandably cause considerable anger and a perception of negligence among the lay public as a diagnosis of 'meningitis' has been missed. As this paper rightly points out, further information should be given to the public about how difficult the diagnosis of meningococcal disease is to make. This will hopefully avert the unnecessary and demoralizing initiation of unreasonable medico-legal proceedings.[4] Finally, in order to produce guidelines to enable earlier recognition of meningococcal disease, research

should concentrate on the accounts of patients and their carers, not just the accounts of doctors whose observations are often momentary during the illness.

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The implementation of evidence

Sir,

Evidence must increasingly become the basis of our clinical decisions and, as relevant research increases in quantity and quality, will increasingly influence our work.[1] But the problem lies not so much in the absence of evidence (indeed we could be forgiven for thinking that there is too much of it), but in its implementation.[2]

Thomas *et al* (May *Journal*)[3] give us a valuable and timely review of recent primary care research publications in which the quality of research focuses on randomized controlled trials (RCTs). They rightly conclude that robust methodological design should be the aim of general practice research, yet nowhere in their classification of studies did they include pragmatic trials.[4] Whereas analytical trials, typically RCTs, investigate a refined health care intervention in an experimental environment on an artificial population, pragmatic trials are carried out in the workplace, accept bias, and describe outcomes that can be extrapolated to everyday practice. While RCTs are essential to establish the effectiveness of an intervention, pragmatic trials are often also required to study how the intervention is taken up by those giving routine care. The point has been well made by Sackett and Wennberg that 'it's time to stop squabbling over the "best" methods', so far as research design is concerned, and that the question should determine the design rather than be adapted to ensure 'methodological correctness'.[5] Methodologically correct studies, of impeccable design and internal validity, often lack applicability in real-life clinical encounters or can only be applied by making assumptions that go beyond a strict interpretation of the evidence.

The guideline and the audit industries have had to adapt to the realization that improvements in knowledge and skills do not come about by mere dissemination of their messages.[2] Implementation has become an overriding issue. Evidence-based practice has likewise to live with the fact that otherwise excellent RCTs have been carried out in atypical, artificial populations, and practitioners cannot be certain that the outcome of the intervention in their own patients will be what the trial shows.[6,7] Moreover, it is often for precisely those complicated patients with multiple problems who tend to be excluded from RCTs that we most need evidence to inform our management. The methodologies of pragmatic trials need to be developed, and the next review of primary care research papers should include a discussion of their importance.

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Developing the Cambridge palliative audit schedule (CAMPAS)

Sir,

There is a continuing need for audit methods in the care of patients with terminal illness to be developed and I therefore welcome the CAMPAS paper (May *Journal*).[1]

We do need to know how long such audits would take in order to judge their practicability. Furthermore, CAMPAS does not seem to include an item about place of death. I believe there is good evidence that his is a major concern of patients and carers,[2] and I should like to see it incorporated in future developments of CAMPAS.

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Correction

We would like to clarify the professional backgound of Dr Anthony S Kessell, a co-author in the paper entitled, Advance directives in the UK: legal, ethical, and practical considerations for doctors (May *Journal*, p1263). Dr Kessel is a specialist registrar in general practice with a research interest in public health, and was active in general practice at the time the paper was written.