Improving cancer outcomes

With regard to earlier detection of cancer in primary care, I was surprised to see no discussion about the value of recording detailed smoking histories as a way of adding diagnostic information to patients’ presenting symptoms. Although this was probably outside the remit of the editorial, I have found detailed smoking history recording (total dose and duration of exposure) valuable in my everyday consultations.

Smoking is a major cause of preventable ill-health, especially cancer, and I believe it is vital to record smoking history on primary care computer systems in a way that is both easily visible and searchable. At present, such smoking recording seems to be based on traditional methods that were used in the pre-computer medical records era, and here I specifically refer to the iSoft Premiersoftware system. In this computer programme the health practitioner can record the type of smoker, an amount for cigarette smoking, and the date smoking stops. This type of data collection is inadequate for modern general practice as it fails to inform the GP of the smoking dose or exposure that an individual patient has received, and it is not computer searchable.

At our surgery, smoking exposure is recorded as ‘smoking pack years’ (smoking 20 cigarettes a day for 1 year is one ‘pack year’) on all ever-smokers with a freetext comment attached to the Read Code, for example, 15 cigarettes a year for 27 years. This has been our recording method for over 5 years and as a GP I find this smoking information useful in thinking about patients’ presenting symptoms and in intuitively assessing their cancer risk. Thus in order to aid smoking-induced disease prediction, I propose that all UK general practice software systems should include ‘smoking pack years’ and ‘duration of smoking’ that should be highly visible and searchable.

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Validity of diagnoses in the General Practice Research Database

The article by Khan and colleagues highlights the strength of the General Practice Research Database (GPRD) as a research-quality database providing accurate diagnostic data to researchers on a wide range of conditions, and for millions of patients. While the search strategy for this study was broad and inclusive of prescription data, procedures, and smoking in addition to diagnoses, the authors did not identify as many articles as expected.

We published a similar systematic review of the validity of diagnoses in the GPRD and found over 200 relevant publications, compared to the 49 articles identified in this study. There are two explanations for this difference. First, many validations were not mentioned in the title, abstract, or keywords of the articles and we therefore broadened our search to all studies using GPRD data. Second, our review included studies that validated diagnoses using algorithms, manual review of electronic records, and sensitivity analysis in addition to those methods included by Khan et al. Despite these differences in scope, our results were broadly similar and showed high validity of GPRD diagnoses, with a median positive predictive value across diagnoses of 89% (range 24–100%).

While our study was larger, Khan and colleagues assessed one important aspect of validity that we did not: the accuracy in timing of diagnoses. For some research