or if her social circumstances/medical comorbidities change?

There are also other advantages in sending ‘unsolicited mail’ to our patients that Dr Greenhalgh overlooks. For example, such offers of screening, even if they are declined, can serve to remind infrequent attenders of the existence of their GP and encourage attendance for other problems.

Dr Greenhalgh refers to a few of her patients ‘who have negative attitudes towards proactive care’ and one patient in particular who felt that ‘her biometric data in the absence of symptoms are none of anyone’s business’.1 Surely it is our role as primary care clinicians to challenge attitudes of this sort and, so far as it is reasonable, encourage all patients to participate willingly and actively in taking responsibility for their long-term health, rather than allowing a select few to opt out of health checks on a default basis.

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Symptoms and risk factors to identify people with suspected cancer in primary care

Julia Hippisley-Cox and her team have made great progress in their continuing process of helping GPs estimate a patient’s risk of cancer.1,2 I do suggest caution in the use of their current QCancer® risk calculators3,4 for three reasons though.

First, the risk calculators don’t as yet include important data such as the doctor’s clinical examination findings or recent negative results of screening by mammography, cervical smears, and colonoscopy.

Second, predictive values of symptoms, signs, and test results (indicants) depend on the context in which the data were collected.5 Predictive values for indicants in the QCancer risk calculators were derived and validated using coded data recorded during general practice consultations. These predictive values therefore don’t necessarily apply to data recorded by patients themselves or by doctors on checklists, nor to uncoded indicants. This isn’t made clear to members of the public visiting the QCancer website who are told: ‘You can use this calculator to work out your risk of having a cancer as yet undiagnosed by answering some simple questions’.3,4 Nor is it made clear to doctors who are told that ‘the template would then help structured data entry of other related symptoms including significant negative findings and the results generated automatically’.1,2

Third, a digital risk score replacing or accompanying the traditional analogue clinical note will have unpredictable, perhaps undesirable, consequences. Diagnosis and risk assessment are improved by looking at the clinical information available from different angles. These calculators provide an additional perspective. How clear a view they give us is questionable.

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Authors’ response

Thank you for the opportunity to respond to Dr Wilfred Treasure’s letter referring to our two papers.3,4 The QCancer® algorithms are an evolving set of risk algorithms to quantify the risk of a previously undetected cancer. They are intended to support clinical decision making and we are currently carrying out a pilot to inform how best to implement them. The algorithms currently combine multiple risk factors and symptoms to give a global risk of cancer and risks of individual cancer types. Dr Treasure is correct in saying that the QCancer algorithms do not currently include results of clinical examinations; it’s possible these could be added in a future version of the tool should the relevant data be coded in the clinical record. However, as we say in the paper, QCancer is intended for use in a primary healthcare setting to help doctors assess which patients to send for investigations such as colonoscopy. Therefore the tool does not include the results of colonoscopy or other diagnostic tests as that is not the purpose of the tool.

In response to Dr Treasure’s second point we agree that the predictive values are based on data recorded during general practice consultations. The information on the QCancer website states the following: ‘This website is primarily intended for doctors and nurses working in general practice and for academics who are interested in the underlying research. Patients are welcome to read this information and use the calculator together with their doctor so that any symptoms or concerns can be addressed within a healthcare setting. All medical decisions need to be taken by a patient in consultation with their doctor. QCancer works out the risk of a patient having a current but as yet undiagnosed cancer-taking account of their risk factors and current symptoms. It does not give a diagnosis of cancer, but a risk’.

The paper offers possibilities on how QCancer can be implemented into clinical settings as Dr Treasure points out. The paper is not a detailed guide on the implementation but does offer several possibilities including the use of structured templates. Such templates are already commonly used to assist in data entry across a wide range of clinical areas including risk-assessment tools and their use is likely to improve the ascertainment and recording of positive and negative symptoms over time. This will enhance both the medical record in its primary purpose but also future updates of the QCancer tool.

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The use of written material in consultations

The November and December issues of the BJGP have featured interesting studies on the use of written information in consultations. First the University College London study1 in the November issue described patients’ experiences of presenting health information from the internet in GP consultations. Then in the December issue a Dutch study2 reported the effectiveness of physician-targeted interventions to improve antibiotic use for respiratory tract infections.

The findings of these studies are important as they affect the way all of us consult. While it is reassuring that patients prefer information from a physician than a written resource, and I agree that there is no substitute for effective individualised face-to-face communication, I worry that these results dismiss the role of written information and potentially conflict with the growing interest in telemedicine. I will continue to be an advocate for patient education and the use of written resources as a supporting tool. Good communication-skills training needs to remain high on the GP training agenda, but with the inclusion of how to acknowledge the information presented by patients and how to use written information to enhance our explanations rather than replace them. With patient satisfaction surveys becoming an integral part of the revalidation process, further research into this area will no doubt be important for improving patient care and successful professional development.

Developments in telemedicine are likely to increase in the future due to its potential to be more cost effective than more traditional models of care. I expect telemedicine to be challenging due to the need to make treatment decisions remotely. As anyone who has experience in telephone triage will appreciate, the use of careful history taking, safety netting, and good record keeping is likely to be even more important in an electronic setting. And if we have evidence that patients prefer face-to-face explanations, should we be directing our research in telemedicine into where it will be most effectively used? Are there situations such as chronic disease management and routine outpatient follow-up where telemedicine would be more relevant? I look forward to developments in the use of technology in health care but hope that patient preferences and the clinical challenges are fully appreciated when telemedicine is more extensively introduced.

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Problems with hypertension guidelines

Congratulations to Schofield et al3 on their thought-provoking paper looking at hypertension and ethnicity. Three points occur. How useful are NICE guidelines, and in terms of an ethnic population, how accurate are they? Also in an era of austerity could they be harmful to patient care? Adherence to NICE recommendations was relatively low in the inner-city population studied. No evidence was found of significantly poorer control in patients on any of the ‘incorrect’ treatments. In 20064 and 20115 the National Institute for Health and Clinical Excellence (NICE) has stratification of antihypertensives. Other contemporaneous guidelines disagree. The 2007 and 20096 European Society of Hypertension (ESH) and European Society of Cardiology (ESC) concluded all diuretics, ACE inhibitors, calcium antagonists, angiotensin II receptor blockers (ARB), and beta-blockers were suitable for the initiation of and maintenance of antihypertensive treatment. ESH argued the traditional ranking of drugs into first, second, third, and subsequent choice with an average patient as reference has little scientific justification.

The American Joint National Committee 7 (JNC) (2003) soon to be superseded by JNC 8 concluded that thiazide diuretics were unsurpassed in preventing the cardiovascular complications of hypertension. Australian 2010 guidelines contradicted NICE arguing that in uncomplicated hypertension ACE inhibitors, dihydropyridine calcium channel blockers were equally effective as a first-line treatment. The World Health Organization (WHO) in 2007 published a document offering a further variation. Given that non-adherence made no difference to blood pressure control and the differing opinions of other authorities, how useful are the current NICE guidelines?

The area of ethnicity is interesting in blood pressure guidelines. Schofield points out that lower renin levels in young black people reduce the response to ACE inhibitors. This is well known. Studies have traditionally neglected both ethnic minorities, and that 50% of the population who happen to be female. The ALLHAT study was correctly praised for having ratios of 47% female, 35% black American, and 19% Hispanic. ALLHAT provided part of the justification for NICE’s recommendation for thiazide diuretics if calcium channel blockers were ineffective for black people of African–Caribbean descent of any age. But ALLHAT looked at patients of 55 years or older, the mean age was 67 years. It provided no evidence for those under 55 years. It didn’t look at black British people. Johnson observed that many black British people may belong to what is now viewed as an emergent ‘mixed’ origin population of the UK that can be genetically significantly different from black Americans. The evidence for NICE guidelines in ethnic minorities I would argue is weak and may answer Schofield’s question as to why GPs and patients in this study opted for...