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Systematic review of Viagra RCTs

We have serious concerns about the quality and timeliness of the review by Burls *et al.*[1] Systematic reviews should be used to accumulate evidence in the field when such evidence is lacking, or when studies on a specific treatment show contradictory results.[2] This is not the case for treatment of erectile dysfunction with sildenafil, of which the effectiveness has been clearly described.[3]

In their review, Burls *et al* included 21 phase II and phase III studies, of which only three studies were published in detail at the time of searching. The time lag between the authors' search and publication of the article was two and a half years, which makes the review outdated. Information on unpublished studies was obtained directly from the drug manufacturer. In our opinion, the potential bias that this may have caused is illustrated by the amount of missing information on outcome measures. Next, the authors state several times that 'where data are presented, statistically significant effects were seen with sildenafil treatment compared with a placebo' or likewise. Questions about statistically non-significant or non-reported findings remain unanswered.

Another important limitation to this review is that the primary outcomes, although clearly defined, was not used to estimate the number needed to treat (NNT). Instead, the NNT was derived from a secondary outcome measure, namely the subjective improvement in erections reported by sildenafil users. No definition of 'improvement' is given in this respect.

Next, the authors present the results from the phase II studies that used penile rigidity as outcome measure. Although clearly noted that a rigidity of 70% of maximal is considered adequate for sexual intercourse, the presented results are on 60% rigidity (the definition for organic impotence). It is unclear why this clinically less relevant measure is taken into consideration.

In addition, the authors' conclusion that 'sildenafil is relatively safe in the short term' also needs to be considered with care, as this conclusion cannot be drawn from the review conducted; data on withdrawals are inconsistently reported.

These limitations are not discussed in any way in the article. We conclude that this review is an accumulation of old and insufficient data surrounding a previously described sufficient treatment effect. Finally, we regret that no disclosure was given of any possible conflicts of interest.

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Improving the outcome in colorectal cases

Summertons' editorial in the January edition of the *BJGP* makes the point that patients often present late with colorectal cancer.[1] A focus on cases referred at early and treatable disease stage might yield some insight into how general practitioners might improve the outcome in colorectal cases. We have previously produced an instrument to score the content of referral letters to colorectal surgeons.[2] The instrument was produced using a two-part questionnaire survey of 125 GPs and nine colorectal surgeons in the Trent region. The instrument offers numeric scores for the various items mentioned in the letter of referral. In theory a referral could score a rather improbable 100 points if the patient had a large number of symptoms, signs and risk factors. In practice the mean score for referrals is 30 points. We examined referrals to a Sheffield teaching hospital from January 1998 to October 2001. We compared 37 cases with Dukes' A (treatable) cancer with 37 cases with Dukes' D (inoperable) cancer. There was no difference in the quality of referrals in these two groups (mean score for Dukes' A = 28 points, mean score for Dukes' D cases = 30 points, mean difference = 1, 95% CI = +4 to –6, $P = 0.67$, *t*-test). GPs were more likely not to document the suspicion that their patient was suffering from a cancer in the group with inoperable disease ($P = 0.2$, χ^2 test). However, GPs were more likely to mention abdominal pain and to record signs on abdominal examination in the Dukes' D cases ($P = 0.01$ and $P = 0.005$, χ^2 test) and more likely to record rectal bleeding and performing a rectal examination in the Dukes A' cases ($P<0.001$ and $P = 0.01$, χ^2 test). We compared the data with a random selection of 37 cases referred to a district general hospital in North Trent where no organic pathology was found.[3] GPs were more likely to document finding a lesion on rectal examination in the Dukes' A cases ($P = 0.009$, Fishers' exact test). In other words, a remarkable feature of the Dukes' A cases was that the GP found a rectal mass on examination. Indeed, rectal bleeding was mentioned more often in cases with Dukes' A than those who had no pathology ($P =$

0.04, χ^2 test), suggesting that these cases were referred after a GP had considered the matter in some detail and decided that a referral was appropriate. When GPs have been encouraged to refer patients with a more thorough pre-referral assessment the quality of referrals have improved on several counts:

1. results of rectal examination and relevant history are more fully documented;
2. the yield of pathology is significantly increased; and
3. in those cases with organic pathology the quality of the documented referral is increased the most.

We make a case for continuing to encourage GPs to refer symptomatic patients at high risk of significant disease and for painstaking assessment of any patient who presents with rectal bleeding in primary care, whether or not referral is contemplated.

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Acute assessment of infants presenting to primary care

The ill infant often presents with non-specific symptoms not directly attributable to their underlying pathology. In secondary care this is reflected in an initial nurse-led assessment, which includes objective measures of respiratory and pulse rates, temperature, weight, and urinalysis.

We undertook a retrospective study of infants presenting acutely to primary care to see whether objective measures were being undertaken. The study was based in a large multi-partner practice in the West Midlands with a practice nurse-led triage system. This decided whether the patient should be seen by a GP, advanced nurse practitioner or sent home with advice.

Ninety-four infants (less than two years old) were presented to primary care triage over a three-month period. Patients were sorted according to presenting complaint. The two most common presentations were for respiratory symptoms (47 patients — 27 notes found) and urinary tract infection (UTI) symptoms, which in this age group included pyrexia, diarrhoea, vomiting, abdominal pain, and offensive urine (23 patients — 18 notes found). The relevant episode for these patients was reviewed to identify if objective measures (as listed above) had been recorded.

We found that objective measures were not routinely undertaken by either a nurse or doctor when indicated by presenting complaint. Only one in three infants with respiratory symptoms and one in five with UTI symptoms had a temperature recorded. In keeping with previous work[1] only one in six infants with UTI symptoms had urinalysis. Only two from either symptom category had weight recorded.

Assessing the severity of illness in infants can be more difficult in the absence of objective measures. It can also lead to a delay in diagnosis, for example, in identifying a child who has a UTI or is failing to thrive. In addition a documented objective assessment is useful in the event of repeated attendance with the same complaint.

With current emphasis on a 'primary care-led' NHS service and the increasing use of triage, further work should investigate which measures are most relevant to primary care and whether an objective assessment would:

- increase parent satisfaction and reassurance;
- identify pathology earlier or which would otherwise be missed;
- make more efficient use of doctor surgery appointments through more appropriate triaging of self-limiting viral illness;
- reliably identify infants who do not require hospital admission;
- reduce referral to secondary care; and
- be cost effective, considering investment in equipment, space, and practice-nurse time and training.

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Reducing benzodiazepine prescribing

While the value of a letter to patients newly prescribed benzodiazepines is recognised by my organisation as one method to reduce intake of benzodiazepines, experience has shown that, in long term users, this strategy as described by Cormack *et al* (1994)[1], and Wylie[2] may be counterproductive, i.e. in those already addicted, as taking tablets very often may bring about withdrawal symptoms in many individuals and this is likely to dissuade them from further attempts at withdrawal.

In February 2000, two GPs new to the practice were appointed at Albion Street Surgery, in the Everton area of Liverpool. This surgery had a very high benzodiazepine prescribing level. The new doctors decided to reduce prescribing of benzodiazepines and invited CITA (Centro de Investigación y Tratamiento de la Adicción, in Madrid) in to help.

The clinic is run as follows. Each patient is seen by the GP who explains that they should reduce from their ben-

zodiazepines and must see the benzodiazepine counsellor before collecting their next prescription. If the patient cannot attend for any legitimate reason then he or she must telephone the surgery explaining the reason for non-attendance. Patients are then prescribed only enough benzodiazepines to last until the day they see the counsellor. Should a patient not attend, a letter will be sent explaining that only one further week's benzodiazepines will be prescribed and a further appointment is made. Should he or she fail to attend again the patient will be asked to see the GP to explain why they have not attended.

The CITA counsellor works a three-hour session. At the first appointment lasting 30 minutes, the programme of withdrawal is described to the patient and in particular the benefits of withdrawing from benzodiazepines. Very often patients recognise symptoms they may be experiencing but have not recognised them as being caused by benzodiazepines, and this provides an incentive to get involved in the programme.

The counsellor explains that it is easier to withdraw from other benzodiazepines by transferring to diazepam, which has been found to be the easiest from which to withdraw. Most patients agree to try this switch although some do resist and insist on using the same benzodiazepine to reduce.

When the changeover takes place we use an equivalent scale that has been found to be effective over the past 15 years. It is a fairly generous transfer rate as it is important that going directly into severe withdrawal does not daunt patients.

In the first 48 hours after the changeover patients are contacted to ensure that they are coping. They also have the number of the CITA helpline to provide reassurance. Patients are seen after a week to be assessed and thereafter usually fortnightly. Reduction takes place every two to three weeks and is normally 1 mg to 0.5 mg at a time, depending on the amount of benzodiazepines being ingested.

Patients are taught relaxation techniques, especially breathing exercises to help withdrawal symptoms; however reassurance to help withdrawal is the most important asset and also the feeling that they are not alone.

The pilot scheme lasted 35 weeks. In this time 58 patients were seen and, of this number, 14 withdrew completely; 49 did this by transferring to diazepam (the recommended method). The total reduction overall was 60%. The range of starting dosages was from 2 mg per day to 30 mg per day (diazepam equivalent). The age range of patients was 27 years to 80 years; 38 women and 20 men took part in the programme.

The programme at the surgery continues after the initial pilot scheme with two three-hour sessions per week.

Although there was initial resistance most patients now admit they are pleased to have this opportunity. The support and interest in their own well-being encourages many to try to come off these highly addictive drugs. They realise that this is a unique opportunity to change their situation and move forward with their lives, coping without benzodiazepines.

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Urgent correspondence?

The address label with the February edition of the Journal had emblazoned on it the word URGENT in uppercase red letters, three centimetres tall. I was instructed to open the journal and read the 'important information' overleaf. Had a cure for cancer been found? Was the suffocating bureaucracy of general practice being abolished at a stroke? Or had Alan Milburn graciously admitted that the NHS is in fact chronically underfunded and mismanaged? Fuelled by these exciting possibilities, I ripped through the polythene like an exam candidate opening his results only to discover that, if I had recently changed address, then I would need to notify the college so that I could be listed accurately in this year's Members' Reference Book. The given closing date for such notification was a mere 64 days away. The journal hadn't been delivered urgently however, as it was franked second class! Come on, let's keep things in perspective.

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Lord of the Rings

Had Liam Farrell in his review of Lord of the Rings[1] written 'And it's much more believable than the Koran, though I suppose that isn't hard,' would the *BJGP* have published it? Despite his assertion, it is precisely because he knows that the Bible's command to turn the other cheek is credible that he can get a cheap laugh without repercussion by expressing anti-religious views.

Rubbishing religious books, Koran, Bible or otherwise, merely massages prejudice in the like-minded, irritates the rest of us, and is inappropriate in a publication that makes the universal claim to be THE British Journal of General Practice.

And yes, I can take a joke...

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Corrections

In the December issue of *BJGP,* it was wrongly stated that John Howe was 'the world's first professor of general practice.' It has been pointed out by several correspondents that it was Richard Scott who was the first *professor* of general practice in the world while the chair in Edinburgh was the first *professorship* of general practice in the world.

We would also like to apologise to readers and to the authors for the incorrect title quoted on the front cover of the January 2002 issue for the brief report on page 33 by Philip M White, Jacqueline C Halliday-Pegg and Donald A Collie. The correct title for this paper should have been: 'Open access neuroimaging for general practitioners — diagnostic yield and influence on patient management.' We regret any confusion this may have caused.