

Letters

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Systematic review of service provisions to improve primary care access

We read with interest Chapman and colleagues' limited systematic review.¹ We were concerned to see an error with reference to our paper.² Chapman and her colleagues appear to cast doubt on our finding that patients triaged by telephone were more likely to re-consult ($P = 0.01$) on the grounds that the study was small and that the response rate was poor. However, they appear to have misread our paper. Re-consultation rates were extracted from patient records. A cursory examination of the CONSORT flow diagram in our paper shows the return rate to be 379/388 cases (97.7% of total). We would suggest this is an exceptionally low rate of attrition.

Our study did have a reasonably low patient response rate (186/388 cases [47.9%]) in relation to a postal survey that gathered satisfaction/enableness data, but this was not the main outcome from our study.

In another systematic review of telephone triage, conducted in Canada, of the 10 studies identified as meeting the inclusion criteria, six were randomised controlled trials, and, of these, four were rated the highest quality score. Our trial was one of the four.³

Despite its small size this paper remains one of the few randomised controlled trials in this area, certainly in the UK. The finding that telephone triage significantly ($P = 0.01$) increases subsequent surgery visits in the following 2 weeks suggests that the indiscriminate application of telephone triage to all types of requests for consultation may not be wise and that further investigation is required

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Are Scots with hypertension at high risk of diabetes or impaired glucose tolerance?

The incidence of new onset diabetes among patients with hypertension is unknown, though the prevalence has been said to be between 15 and 18%.¹ In rural Sweden the mean annual incidence of diabetes has been recorded

as 3.46 per 1000 of the total population,² and a prevalence in England of 2.5% has been reported.³

In our practice of 10 778 patients, we have included annual glucose measurement as part of the annual review of hypertensive patients for 6 years. We have studied the incidence of new cases of impaired fasting glucose, impaired glucose tolerance or diabetes mellitus in our patients with hypertension, who do not have established ischaemic heart disease.

Patients registered with the practice, who have hypertension, but did not have established ischaemic heart disease, and who were not known to have diabetes mellitus, impaired glucose tolerance, or impaired fasting glucose, on 1 March 2002, were examined. The incidence of new cases of abnormal glucose metabolism diagnosed in this group over the period 1 March 2002 to 31 August 2003 was determined. Of 568 patients tested 1.4% were found to be diabetic and another 1.6% to have impaired glucose tolerance or impaired fasting glucose.

Three per cent of patients tested in the 18-month period were shown to have abnormal glucose metabolism, giving an annual incidence of 2%. Of these, nine patients (53% of those diagnosed) had had a glucose level of less than 6 mmol/l recorded during the previous 3 years; this and the fact that the practice had a prevalence of diabetes of 3.9% at the start of the study period, suggests that our findings are not just a reflection of previous under-diagnosis.

Early diagnosis of abnormalities of glucose metabolism in patients at increased cardiovascular risk because of hypertension should allow early intervention and risk modification. We believe that glucose measurement should be included as part of the