

Given the above hypothesis, the quotation from one GP who admitted using the 2-week wait system for patients who didn't fit the criteria, 'in case they go to the back of a long queue'¹ may prove particularly ironic — it may well be this type of behaviour that is turning the 'fast track' into a traffic jam.

Cornford *et al* make a strong case for reviewing cases where patients are 'inappropriately' fast tracked, and for a greater focus on the characteristics of patients who persuade their doctor to use the fast track. We look forward to presenting some data in due course.

ROWAN KENNY

MOYEZ JIWA

South Yorkshire Colorectal Research Alliance (SYCRA).

E-mail: R.Kenny@sheffield.ac.uk

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Screening for type 2 diabetes

I wish to report the results of a screening project for type 2 diabetes performed over a 10-month period in our practice of 9700 patients. Patients presenting to the practice were screened opportunistically for type 2 diabetes if they showed two or more of the following risk factors, using a protocol based on an Australian screening study: aged >40 years, obesity, family history of type 2 diabetes, hypertension, atherosclerosis (coronary heart disease, cerebrovascular disease, or peripheral vascular disease), previous abnormality of glucose tolerance including gestational diabetes, ethnic predisposition, or polycystic ovarian syndrome.¹

Patients were screened by random or fasting venous glucose, and those with blood glucose of ≥ 5.6 mmol/l were intended to have an oral glucose tolerance test. Of the 271 patients, 130 (48%) had an initial blood sugar of ≤ 5.5 mmol/l. Of the remainder, 91 patients (33.6%) proceeded to have oral glucose tolerance tests; 44 (16.2%) had

normal results, 27 (10.0%) had impaired fasting glycaemia or impaired glucose tolerance, and 20 (7.4%) had results within the diabetic range. A further three patients were diagnosed as diabetic on high random blood sugars alone.

Some 47 (17.3%) patients did not proceed to have glucose tolerance tests; in 24 cases this was due to administrative failure. Three patients declined to have the test due to the inconvenience, nine patients were tested for diabetes using an alternative method, and in 11 cases the GP decided not to proceed with further investigation for clinical reasons.

Overall 8.5% of patients screened had type 2 diabetes and a further 9.6% had impaired glucose tolerance, or impaired fasting glycaemia. The clinical workload and demand for appointments was manageable: on average only nine oral glucose tolerance tests were performed every month, and many of the random blood sugars were taken simultaneously with other recommended annual screening blood samples.

Further modification of the protocol is suggested, so that patients in some clinical situations are tested by fasting glucose and haemoglobin A1c (HbA1c) measurement rather than by oral glucose tolerance test.² Allowing some flexibility in interpretation of random blood sugar results according to the prandial state of the patient may also restrict unnecessary glucose tolerance tests.

This project demonstrates a feasible method for screening for type 2 diabetes and its precursors.

MALCOLM J MACRAE

Member of the Highland Islands Health Research Institute, Inverness. General Practitioner Kingsmills Medical Practice, 18 Southside Road, Inverness IV2 3BG. E-mail: malcolm.macrae@GP55817. highland-hb.scot.nhs.uk

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Jury service is bad for your health

Much has been written in the press about air passengers developing deep venous thromboses (DVTs) following long-haul flights. As a result of these reports of 'traveller's thrombosis' and several untimely deaths, those flying for over 4 hours are advised to take prophylactic measures, which include ensuring good hydration, restricting alcohol and caffeine intake, and regularly carrying out simple leg exercises including occasional walks during travel.¹ Those at particularly high risk are encouraged to consider using graduated elastic stockings and taking a single dose of aspirin or low molecular weight heparin before travel.

We recently came across a 47 year-old female hospital cleaner, with a body mass index of 32 but no other risk factors, who developed a calf DVT 2 days after completing 2 weeks of Crown Court jury service. This involved sitting for an average of 6 hours each day with a 45-minute lunch break which, towards the later stages of the trial, was also spent sitting while deliberating over the verdict. A small twist in the tale is the fact that 10 weeks prior to starting the jury service she had undergone two long-haul flights, each lasting 9.5 hours. It would be difficult to ascertain which events were the most contributory to the development of the venous thrombosis, but current evidence suggests that, in cases of traveller's thrombosis, the symptoms usually develop within 4 days of the flight and certainly within 2 weeks.²

Studies have shown that the main effect of prolonged sitting, and certainly a significant factor in the association between air travel and venous thrombosis, is venous pooling in the calf.^{3,4} In addition to these haemodynamic responses, measures of rheologic changes in venous blood during prolonged sitting show that 2 hours of quiet sitting can increase thrombotic tendency locally in the leg, but not systemically.⁵

The patient has subsequently been informed that she may be required for further jury service. This being the case, then she should certainly be advised to take appropriate prophylactic measures. We feel that in any situation