

# Letters

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## Nurse-led management of hypertension

In their comprehensive review of recent advances in cardiology in primary care, Fahey and Schroeder<sup>1</sup> looked at new models of care including nurse-led management of hypertension. We analysed trials from UK general practices of change in systolic blood pressure after a nurse-led intervention until 2002. These showed a combined reduction in systolic blood pressure of only 3mm Hg — a fall that could just be due to accommodation.<sup>2</sup> By contrast the landmark American Hypertension Detection and Follow-up trial showed that an organised system of regular follow up and review of hypertensive patients using a stepped care approach to treatment reduced not only blood pressure but also mortality over 5 years.<sup>3</sup> The vital difference between this and the British community-based trials is that it included change in drug treatment to achieve target blood pressure.

The introduction of quality payments is encouraging UK general practices to improve management of people with high blood pressure. Although not yet tested in randomised trials, it is likely that this will involve an enhanced role for practice nurses. This could include adherence to protocols, agreed target blood pressure, better prescribing and compliance, and regular follow up.<sup>4</sup> The development of supplementary prescribing by practice nurses will also be important. What a pity that the new NICE (National Institute of Clinical Excellence) recommendations for management of hypertension in primary care fail to include the simple, user-friendly British Hypertension Society ABCD guidelines.<sup>5</sup>

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## Teenage motherhood

Seamark and Lings<sup>1</sup> draw attention to some of the positive consequences of teenage motherhood. Major US research<sup>2</sup> confirms that many teenage mothers make up their initial disadvantages in education and finance.

Seamark and Lings also plead for further research on long-term consequences. This would be valuable in several areas. The role of the teenager's own mother might be vital. In a sample of

100 teenage mothers, the teenager's first response on finding she was pregnant was almost in every case 'what will my mother think?'.<sup>3</sup> Other areas worth looking at are the role of the baby's father, and the best way for stage agencies to provide assistance. Advice from healthcare professionals may conflict with that from the immediate family. Dependence on financial support from the state is almost universal in the immediate period of teenage motherhood.

It would be a pity if such research opportunities were lost. The common 'solution' to the 'problem' of teenage pregnancy in earlier decades — shotgun marriages — has passed into history with no attempt having been made to evaluate its costs and benefits.

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## Analysis of 'one-stop' referral system for ophthalmic minor operations by GPs

Currently most ophthalmic units receiving referral letters for minor

operations from GPs book patients in to clinics before placing them on a waiting list.

As part of an initiative programme to reduce waiting times at King's College Hospital in London, GPs were given an opportunity to book patients with eyelid pathology directly onto the minor operations list over a 6-week period. We audited this data retrospectively.

There were 85 subjects (50 males and 35 females) with a mean age of 41.6 years (range 16–75 years). The referring diagnoses were divided into three categories: chalazion/cyst (80% of referrals); skin tag/papilloma (16%); and unknown aetiology (4%). When compared with the diagnoses made by the senior attending ophthalmologists, there was a 34% diagnostic discrepancy. The main discrepancy (65% of cases) occurred in the skin tag/papilloma group (referred initially as cysts). The unknown group contained skin tags/papillomas (66%), and cysts (34%).

Analysis of the final outcome revealed that 26% of patients did not require (or want) surgery; these patients were discharged. The proportion of those discharged was directly related to the length of time between referral and the appointment, which averaged about 3 months.

The clinical diagnosis of benign eyelid lesions at ophthalmic departments has been shown to be fairly accurate when compared to histological samples,<sup>1</sup> in particular for chalazia (up to 94%). However, where discrepancy occurs the lesions often have a premalignant or malignant aetiology.<sup>2,3</sup>

The accurate diagnosis of ophthalmic conditions is clearly in the best interests of all parties involved, and would optimise the use of resources in the treatment of conditions considered suitable for management as 'minor ops'. Improvement in this arena has been demonstrated by organising workshops in some units. Furthermore, it appears that including ophthalmology as part of vocational training is the best way of achieving this aim.<sup>4</sup>

The direct-access pilot scheme was not shown to be an efficient way of conducting the minor operations service.

A picture of the lesion may help the ophthalmologist decide where and when to list the patient. In addition, targeted training/workshops for GPs, and a telephone interview with the patient a week prior to their visit in order to confirm the continued presence of a troublesome lesion, may reduce the day-of-surgery discharge rate.

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## The problems with choice

Mike Fitzpatrick<sup>1</sup> is correct. The perverse truth is that inequity is a necessary precondition for choice to be meaningful.

The choice evangelists try to repel their critics by quietly conflating consumer choice with moral choice and rights talk. It is important, therefore, to distinguish between consumerism (the preoccupation with, and increase in, consumption), and moral choice (the patient's inalienable authority to give and withhold consent).

If patient choice drives quality and empowerment, to where is it driving it? A state of equity, and satisfaction for all, by way of the necessary evil of market forces. Who said Marxism was dead?

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## The stethoscope and cross-infection revisited

Jevons first reported methicillin resistant *Staphylococcus aureus* (MRSA) in 1961<sup>1</sup> and it has now become a serious cause for concern in UK hospitals. Indeed, it has even entered the political arena.<sup>2</sup> In 2003, a search for MRSA using www.yahoo.com yielded 153 000 results; this has now risen to 329 000 references.

Last year, a letter of mine was published here; it detailed a bacteriological examination of my practice stethoscope, which showed that it did not carry MRSA bacteria over a 2-week period.<sup>3</sup> I have since examined 50 stethoscopes chosen at random. They were in daily use by doctors in general practice in the London area drawn from the membership of the Independent Doctors Forum. Their stethoscope bells and diaphragms were imprinted on blood agar medium plates, which were then incubated for 24 hours at 37°C. The Doctors Laboratory examined those culture plates that grew bacteria and identified these bacteria, further testing staphylococci to establish if they were MRSA species.

Of the 50 stethoscopes examined, 13 carried no bacteria at all, 15 carried mixed skin flora, and coagulase negative staphylococci were isolated in 22. Not one of these 50 stethoscopes carried MRSA. This can be contrasted with previous studies, and particularly with a paper by Smith *et al.*,<sup>4</sup> which showed that in 1996 in the hospital environment, MRSA frequently colonised stethoscopes used on medical and surgical wards. They found 68 out of 200 stethoscopes (34%) to be positive for MRSA; comparing this with my results, a <sup>2</sup> test gives  $P < 0.001$ , which is highly significant.