Letters

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Under pressure

Manning *et al* highlight an important point, well described but less well recognised in clinical practice.[1] Their study demonstrates the practical implications of acting upon blood pressure (BP) values and the variations obtained at different times through various methods adopted to measure BP, especially in this era of the phasing out of mercury sphygmomanometers.[2] However, we take lament over their comments of identifying the white-coat effect group (~30%) to avoid costs of additional treatment. There is an increasing body of evidence to suggest that white-coat hypertension (WCH) is not so benign after all.[3] Indeed, many studies have suggested that WCH was associated with significant end-organ damage.[3]

As an illustrative example; Strandberg *et al*,[4] evaluated prospective data over 21 years of 536 businessmen with cardiovascular risk factors at baseline and found that men with white coat effect of >30 mmHg had significantly higher mortality than the normotensive men. Gustavsen *et al*,[5] contributed further to the debate and suggested that WCH should be regarded as a cardiovascular risk factor. Their study was a follow-up study on 420 patients with hypertension newly diagnosed by their GP and 146 normal controls; where 18.1% of the 420 hypertensives had WCH. With a mean duration of follow-up of 10.2 years, first events were recorded in 18.4% of the WCH group compared with 16.3% in the established hypertension group. The other main finding of this study was an increased cardiovascular risk in WCH compared to normotensive controls.

This has particular inference, given the recent study by Mant *et al* demonstrating that for 80% of the patients in UK primary care, systolic BP was above the targets set by the British Hypertension Society, despite the fact that the practices selected were active in research and the BP control may have been better than in the UK as a whole with notable paucities in aggressive combination therapy.[6] One recent report,[7] on primary care physicians' choices of antihypertensive therapy for subjects with type 2 diabetes diagnosed with hypertension found considerable variation between practices that were not explained by adjusting for age, sex, prevalent coronary heart disease or study year; while trends in drug utilisation were consistent with the evolving evidence base but there were still wide variations in between practices. Indeed, the burden of hypertension on stroke and cardiovascular disease is enormous — 21 400 stroke deaths and 41 400 ischemic heart disease deaths (approximately 42 800 strokes and 82 800 ischaemic heart diseases saved, making a total of 125 600 events saved) each year in the UK.[8]

Thus, the emphasis by most BP management guidelines calling attention to the need for more aggressive treatment targets cannot be stressed any further, given the vast amount of disability-adjusted life-years and mortality associated with the global burden of hypertension, which is indeed a major public health challenge.[9]

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Improving consultations in general practice for non English-speaking patients

Research[1,2] has shown that people forget a considerable amount of the information they are given in medical consultations, and that a significant amount of the information that is remembered will be incorrect.[3] This can have consequences in terms of compliance with treatment regimes, frequent attendance, DNA rates and staff time in providing reminders and rescheduling appointments.

We piloted the use of digital recording devices (DRDs) in a general practice in Sheffield with a large percentage of Somali patients. All Somali patients needing an interpreter were invited to take part in the study and receive a personalised digital recording of information about their health to take home with them at the end of their consultation with a health professional. Participants were contacted 1 week later by trained interpreters who carried out a telephone questionnaire on acceptability and usage. In total 68 recording devices were given out and 58 people were interviewed.

Of the patients who took part, 81% were women, mainly aged >55 years. Older people and those with memory problems felt that the DRD was useful as they were aware that they forgot many things. The DRDs in this study were used mainly to record information about appointments and medication. People who were interviewed

felt that they could be used to record anything that was relevant to their health.

The recording time limits the amount of information that can be stored on the DRDs. One minute is enough to record summary information or details of medication, but if longer explanations are required or a patient is on multiple medications it is not sufficient.

The DRDs can be re-used but their re-use is dependent on patients returning with them at their next appointment. There could be a danger in giving patients multiple devices as messages could get out of date or mixed up. Some form of labelling on the outside of the device could overcome this.

The DRDs used in this pilot were reliable, used frequently and found to be acceptable. It is possible to see that a small investment in DRDs could have an impact on attendance rates and compliance with prescribed medication that, in turn, could contribute to reducing any waste of NHS resources. The cost of the DRDs needs to be considered against the above patient benefits.

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Competing interests

The authors have stated that there are none.

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Ensuring confidentiality

Sokol and Car[1] suggest that identification of patients over the telephone is impossible because others may impersonate patients to request test results, breaching confidentiality. A suggestion is that patients be seen face-to-face and no information be given over the telephone. Besides increasing the amount of work in surgery and inconvenience to patients, I do not believe that this would achieve the objective. It cannot be guaranteed that the person who comes into the consulting room is who they say they are. In fact, worryingly often they are not, either due to mistake (such as deafness), or, quite possibly, by impersonation, and I cannot identify all our practice patients by sight, and never will be able to.

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Written on the body

John Salinsky might like to know that I once completed a dermatology quiz at our local postgraduate centre simply by describing each of the displayed slides in what little remained of my schoolboy Latin. That, so far as I was concerned, was the diagnosis. I came top!

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Competing interests

Failed O-level Latin; but it didn't matter as by then Leeds did not require Latin for admission to the Medical School.

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Sex inequalities

Hippisley-Cox *et al* have reported evidence of sex inequalities in access to care for diabetes in primary care in the UK.[1] We are undertaking a national study of the factors that influence the care of patients with diabetes in Tunisian primary care health centres, including a retrospective medical review of over 2000 patients from 48 centres. Our results suggest that sex inequalities in the care of patients with diabetes are international.

In our study,[2] women with diabetes attending health centres are significantly younger than men, less likely to have type 1 diabetes, less educated, less likely to be working, less likely to be smokers and to drink alcohol and more likely to have cardiovascular disease. Women also have significantly higher levels of systolic and diastolic blood pressure, total cholesterol and body mass index but lower mean creatinine levels than men. These findings were all to be expected. However, Table 1 shows a selection of other data related to access of care suggesting significant differences between the care of men and women. Women are more likely to attend their appointment on time, but the time until their next given appointment is significantly longer. Women are also less likely to have their care recorded in the new disease-specific medical records. This is important, as we have shown that use of these records is associated with improved quality of care.[3]

Sex inequalities in the care of patients with diabetes in primary care are not limited to the UK. We sincerely agree that further work is required to confirm, and if possible, explain these findings, and to seek ways of correcting these inequalities.

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Table 1. Differences between the care of men and women.

Factor	Men (n = 841)	Women (n = 1319)	P-value[a]
Mean age (years)	58.01	60.88	<0.001
Number of visits in preceding 12 months	3.65	3.75	0.07
Mean time until next appointment (days)	81.62	84.58	0.033
Consultations >2 weeks late (%)	27.7	23.3	0.082
New records used (%)	89.3	84.8	0.08
Completion of new records (score of 12 variables)	7.11±4.22	6.68±4.27	0.014

[a]*P-value using logistic regression with sex as the dependent variable and the factor in question plus age and health centre entered as the explanatory variables.*