

The more general point relates to the insidious and apparently unstoppable trend towards centrally dictated micromanagement of primary care by government, aided and abetted by expert advisory groups and mediated through the QOF. The Back Pages carry pieces lamenting this trend in every issue (see Mark Vorster's letter and Mike Fitzpatrick's column in the October issue for examples), as does every other current UK medical journal and newspaper. Practice common rooms echo the same tune, and I don't know of a single GP colleague who does not regret at least a part of this takeover of our professional independence.

What can we do about it? I suggest that at the very least we can fight back — at some cost to our own pockets — by declining to comply with those parts of the QOF that offend us the most.

#### Dougal Jeffries

*The Health Centre, St Mary's,  
Isles of Scilly, TR21 0HE  
E-mail: djeffries@onetel.com*

#### REFERENCES

1. Kendrick T. Letter. *Br J Gen Pract* 2006; **56**: 796–797.
2. Jeffries D. Ever been HAD? *Br J Gen Pract* 2006; **56**: 392.

## Malignancy and deep vein thrombosis

Oudega *et al's* neat study of malignancy and deep vein thrombosis (DVT) in the September issue found that 4.4% of patients with a DVT went on to have a malignancy diagnosed in the next 2 years. We have performed a similar — albeit retrospective — study of 813 patients diagnosed with either a primary colorectal ( $n = 349$ ), prostate ( $n = 217$ ) or lung ( $n = 247$ ) cancer during 1998–2002.<sup>1–4</sup> Each case was matched with five controls without the cancer of interest for age, sex and doctor's surgery. We coded the records for 2 years before the diagnosis for both cases and controls. Only 10 of the 813 cases had had a DVT confirmed (nine in the last year), and a further nine of 4059 controls had a DVT (four in the last year). In addition, three cases (one in the last year)

and five controls (two in the last year) had had a pulmonary embolism. Combining the two conditions gives a likelihood ratio for thrombo-embolic disease in the year before a new cancer of 8.5 (95% confidence interval = 3.1 to 22%). These thrombo-embolic conditions occurred in the age group at risk from cancer. The UK population over 40 years of age is approximately 30 million, and these people have approximately 250 000 new cancers, giving an annual risk of developing a new cancer of approximately 0.83%. Using Bayes' theorem, the risk of a new cancer being identified following thrombo-embolism can be estimated to be 6.6%, which is not dissimilar to Oudega's figure.

The key clinical decision is whether to investigate an apparently spontaneous thrombo-embolism for an underlying cancer. On the face of it, a risk of 4.4% (Oudega) or 6.6% (this study) appears to warrant investigation, at least by simple measures.

#### William Hamilton

*Senior Research Fellow, Department of  
Community Based Medicine,  
University of Bristol  
E-mail: w.hamilton@bristol.ac.uk*

#### REFERENCES

1. Oudega R, Moons KGM, Nieuwenhuis HK, van Nierop FL, Hoes AW. Deep vein thrombosis in primary care: possible malignancy? *Br J Gen Pract* 2006; **56**: 693–696.
2. Hamilton W, Sharp D, Peters TJ, Round AP. Clinical features of prostate cancer before diagnosis: a population-based case-control study. *Br J Gen Pract* 2006; **56**: 756–762.
3. Hamilton W, Round A, Sharp D, Peters TJ. Clinical features of colorectal cancer before diagnosis: a population-based case-control study. *Br J Cancer* 2005; **93**: 399–405.
4. Hamilton W, Peters TJ, Round A, Sharp D. What are the clinical features of lung cancer before the diagnosis is made? A population based case-control study. *Thorax* 2005; **60**: 1059–1065.

## Warfarin for atrial fibrillation

In their paper on the safety of antithrombotic therapy for atrial fibrillation, Burton and colleagues point out that patients with atrial fibrillation in the community are older and have more comorbidity than those included in trials.<sup>1</sup> This is very topical as UK GPs go through their registers of patients with atrial fibrillation with a view to maximising their Quality and Outcomes Framework points and related income in 2007.

In August 2006 we examined the medical records of all 43 patients known to have persistent atrial fibrillation in our practice. As in Burton's study, the mean age of the patients was 77 years (range = 56–94 years), but five (12%) were of African origin reflecting our inner city population. Eighteen patients (42%) were on warfarin, 16 on aspirin, two on clopidogrel and seven did not seem to be taking any antithrombotic treatment of whom four were in a nursing home. A questionnaire survey found that only 13 (59%) of 22 responders knew that warfarin or aspirin helps to prevent strokes or blood clots.

As in Burton's study we noted a 'healthy user effect' in warfarin prescribing. Of patients aged <75 years, 71% (12/17) were prescribed warfarin compared with 23% (6/26) of those aged 75 years ( $P < 0.01$ ). However, despite the tendency for GPs to prescribe warfarin for their fitter, younger patients, Burton and colleagues found that the risk of severe bleeding on warfarin, defined as death, intracranial bleeding or hospital admission, was 2.6% per patient year, twice the rate found in clinical trials. Over a fifth of patients on warfarin consulted their GP with at least one bleeding event during up to 5 years follow up. Combining these risks with the additional effort involved in anticoagulant monitoring, it is not surprising if compared to hospital doctors, many GPs have a more conservative approach to starting patients with atrial fibrillation on warfarin.

#### Jasmeet Sidhu

*Final year medical student*

#### Pippa Oakeshott

*Reader in General Practice  
Community Health Sciences  
St George's, University of London  
SW17 0RE  
E-mail: oakeshot@sgul.ac.uk*

#### Acknowledgements

We are very grateful to the patients and staff at the Curran Practice, Manor Health Centre, London SW4 ORE.

#### Competing interests

The authors have stated that there are none.

#### REFERENCE

1. Burton C, Isles C, Norrie J, *et al*. The safety and adequacy of antithrombotic therapy for atrial fibrillation: a regional cohort study. *Br J Gen Pract* 2006; **56**: 697–702.