is a joint partnership between the University of Nottingham and EMIS (leading commercial supplier of IT for 60% of general practices in the UK). JHC is also a paid director and co-founder of ClinRisk Ltd that produces software to ensure the reliable and updatable implementation of clinical algorithms within clinical computer systems to help improve patient care. The software which implements the algorithms described in this paper are free for anyone to use under the terms of the GNU lesser GPL3. For those who wish to implement software in a closed source setting, then a license fee is payable to ClinRisk Ltd. CC is associate professor of medical statistics at the University of Nottingham and a paid consultant statistician for ClinRisk Ltd. This work and any views expressed within it are solely those of the co-authors and not of any affiliated bodies or organisations.

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We particularly thank Professor Sir Mike Richards (Department of Health cancer tsar) and Ms Ali Stunt (CEO of pancreatic cancer action) for their support.

We write to congratulate the authors on the RAMBLER II study, we prospectively examined the use of ABPM in 114 Irish general practices over a 1-year period between 1 April 2009 and 31 March 2010. All practices used the dabli® ABPM expert online software system (www.dabli.ie/en/prod_abpm.aspx), which provides online transmission of ABPM data for instantaneous reporting and storage of data. There were 13 303 ABPM recordings from 11 537 individual patients (47.9% female, average age 57.9 [standard deviation (SD) 14.6] years) with an average of 102 (SD 83, median 84) ABPM recordings per practice per year. With most practices having only one device, this suggests that many devices are being used close to capacity even before the revised NICE recommendation was made.

In 6224 (53.8%) ABPMs, the recommended minimum of 14 daytime and seven night-time measurements were obtained. In 8475 (73.2%) ABPMs, at least 13 daytime and six night-time measurements were obtained. The reasons for this shortfall need to be further examined. Having the recommended number of readings had a small but significant impact on both white coat and diastolic averages but not on systolic averages (data available from authors).

Mean systolic blood pressure (SBP) was 139.4 mmHg (SD 14.7 mmHg) and 121.5 mmHg (6.8 mmHg) for day and night respectively; mean diastolic blood pressure (DBP) was 80.8 mmHg (SD 11.1 mmHg) and 67.1 mmHg (10.7 mmHg) for day and night respectively. Mean blood pressure in the first hour of the ABPM (white coat window) was 158.8 mmHg (SD 21.7 mmHg) and 95.1 mmHg (SD 17.1 mmHg) for SBP and DBP respectively. These figures emphasise the real impact of the ‘white coat effect’ in routine practice.

This study emphasises the heavy current workload of ABPM devices, the importance of ensuring that the recommended minima of readings are obtained, and the importance of the ‘white coat effect’ in routine practice.

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Thirty-minute compared to standardised office blood pressure measurement in general practice

We read with interest the study by Scherpier-de Haan et al regarding the use of the 30-minute blood pressure measurement in dealing with the ‘white coat effect’ and the accompanying editorial by Wallace and Fahey. Both highlighted the importance of having an office-based alternative to ambulatory blood pressure monitoring (ABPM). This is most topical as practices react to the 2011 National Institute for Health and Clinical Excellence [NICE] unequivocal recommendation that ‘ABPM should be implemented for the routine diagnosis of hypertension in primary care’.

In the RAMBLER II study, we prospectively examined the use of ABPM in 114 Irish general practices over a 1-year period between 1 April 2009 and 31 March 2010. All practices used the dabli® ABPM expert online software system (www.dabli.ie/en/prod_abpm.aspx), which provides online transmission of ABPM data for instantaneous reporting and storage of data. There were 13 303 ABPM recordings from 11 537 individual patients (47.9% female, average age 57.9 [standard deviation (SD) 14.6] years) with an average of 102 (SD 83, median 84) ABPM recordings per practice per year. With most practices having only one device, this suggests that many devices are being used close to capacity even before the revised NICE recommendation was made.

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This study emphasises the heavy current workload of ABPM devices, the importance of ensuring that the recommended minima of readings are obtained, and the importance of the ‘white coat effect’ in routine practice.

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Tips for GP trainees working in general medicine

We write to congratulate the authors on writing an excellent piece of work that GP trainees on general medical rotations should find very helpful.

Although the article provides good advice on commonly encountered medical problems, we would like to highlight issues relating to pleural problems (point 20: ‘Never let the sun go down on an empyema’). Pleural intervention (including thoracocentesis and drain insertion) is associated with a range of potential complications, and each procedure should be performed by competent (or supervised) medical staff. These procedures are best avoided out of hours. We recommend that in most situations you can ‘let the sun set’ and defer the intervention until the next day.

1. The authors suggest that everyone with pneumonia-associated pleural effusion needs a pleural tap. Diagnostic pleural tap should be guided by clinical need. Up to 40% of pneumonias have associated para-pneumonic effusion (the most common cause of exudative pleural effusion in young patients) and the vast majority will settle with antibiotic treatment. Pleural tap should be considered in the context of persistent sepsis despite antibiotics.
2. While we agree that pleural fluid pH < 7.2 or aspiration of frank pus requires drainage of pleural cavity, we wish to point out that, in the majority of cases, this can be done safely by ‘specialist teams’ within working hours and does not require urgent out-of-hours chest drain insertions.3

3. The National Patient Safety Agency 2008 rapid response entitled Risk of chest drain insertion highlights the potential and sometimes fatal complications from implantable cardioverter defibrillator insertion.4 The current practice in most hospitals is to insert chest drains for pleural effusions using real-time pleural ultrasound guidance during normal working hours.

By highlighting the points above, we hope to emphasise the importance of patient safety in pleural intervention.

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Waterpipe tobacco smoking and cigarette equivalence

The authors of this editorial1 on shisha (waterpipe) guidance tentatively offer 10 cigarettes as equivalent to a shisha session of 45 minutes. In our freely available smoking pack year calculator on the web2 we have taken guidance from a World Health Organization study on waterpipe smoking.3 From this study an 80-minute session of such smoking was compared with 100 cigarettes and thus a 45-minute session would be around 60 cigarettes equivalence. As shisha smokers can use in both personal and group settings we have used a 20-minute session (25 cigarette equivalence) as our baseline in the calculator. Of course this is simply an approximation but hopefully helpful to all the health staff who need to calculate smoking pack years. Smoking pack years is a figure that combines smoking duration and smoking intensity, and one smoking pack year is defined as 20 cigarettes smoked daily for 1 year.

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