Royal College of General Practitioners Research Paper of the Year 2012

The Royal College of General Practitioners Research Paper of the Year Awards celebrate the best research on general practice and primary care. The awards for papers published in 2012 have been announced and highlight outstanding research in seven categories, with one overall Research Paper of the Year chosen from these category winners. Eighty-six papers were submitted to the competition representing the wide range of topics and methods which are relevant to primary care research.

In the Cancer category, the panel selected Fiona Walter's well-conducted randomised controlled trial from Cambridge of the MoleMate diagnostic aid: *Effect of adding a diagnostic aid to best practice to manage suspicious pigmented lessons in primary care: randomised controlled trial*.[1] Interestingly, the research team found that the systematic application of best practice guidelines following a history and naked eye examination (the control group) led to an impressive 96% sensitivity and 91% specificity for detecting suspicious lesions, which was more accurate than the MoleMate system.

In the Diabetes category the winner was Rebecca Simmons *et al*: *Screening for type 2 diabetes and population mortality over 10 years (ADDITION-Cambridge): a cluster-randomised controlled trial*.[2] This paper described the long-term follow-up of patients at high risk of type 2 diabetes who were included in a cluster randomised trial in which practices were randomised to one of three arms: screening for diabetes and intensive multifactorial treatment, screening plus routine care, or a control group with no screening. This was another large, meticulously conducted randomised controlled trial addressing an important research question. The authors concluded that screening for diabetes was not associated with any reduction in mortality, perhaps due to a lower prevalence of undiagnosed diabetes and a lower cardiovascular mortality in the patients in this study than anticipated, including the control arm. This probably reflects improved lifestyles and better management of cardiovascular risk factors, so perhaps this 'negative' trial is in fact a good news story.

The winner of the Mental Health category was Kathrin Cresswell's paper *'There are too many, but never enough': qualitative case study investigating routine coding of clinical information in depression*.[3] This used a range of qualitative methods including individual interviews, a focus group and participant observation to show how different stakeholder groups (clinicians, managers, and clinical coders in primary and secondary care) had different ideas about coding information relating to patients with depression. The findings illustrate how the precision of clinical codes can mask underlying subjective views about the meaning of depression as a diagnosis, the implications of the use of different codes, and the purpose of coding.

The Mental Health panel also highly commended a paper by Nicola Wiles *et al*: *Cognitive behavioural therapy as an adjunct to pharmacotherapy for primary care based patients with treatment resistant depression: results of the CoBalT randomised controlled trial*.[4] Although several previous trials have shown the effectiveness of cognitive behavioural treatment (CBT) in comparison with no treatment, access to CBT is limited and it is usually offered to people in the UK who are already on antidepressants but have not improved. The COBALT trial confirmed that even in this group of 'treatment-resistant' patients, those given CBT in addition to antidepressants had a threefold increase in the odds of responding to treatment.

The different categories for the Research Paper of the Year reflect the different research networks in England. In the Medicines for Children category, the winning paper from Elizabeth Koshy *et al* addressed this question: *Significantly increasing hospital admissions for acute throat infections among children in England: is this related to tonsillectomy rates?*[5] Using data from Hospital Episode Statistics, the authors concluded that the increase in the number of admissions for acute throat infections over the last decade cannot be explained by reductions in the rate of tonsillectomies, or by falls in prescribing rates for antibiotics, but are more likely to be due to an increased number of children having very short stays of a few hours in observation wards.

In the Dementia category, Amanda Connolly *et al* explored the important topic of *Quality of care provided to people with dementia: utilisation and quality of the annual dementia review in general practice*.[6] Their cross-sectional study of the medical records of people with dementia suggested that although 80% of patients had received an annual review of their dementia, the quality of those reviews was variable, with limited evidence of review of prescribing, social care arrangements, or discussion with carers. The authors make useful recommendations about how this situation could be improved.

Some papers make us think again about the most everyday activities, and one example was the systematic review by Chris Clark *et al* that won the Stroke category: *Association of a difference in systolic blood pressure between arms with vascular disease and mortality: a systematic review and meta-analysis*.[7] This showed that a difference between arms in blood pressure is associated with peripheral vascular disease and cardiovascular mortality. This work has attracted much attention and been influential in guidance about the assessment of patients with hypertension.

As in previous years, competition in the Primary Care category was strong. This generic category includes papers that do not fit into the other categories. The runner up was a paper by Deborah Swinglehurst *et al* entitled *Computer templates in chronic disease management: ethnographic case study in general practice*[8] about the way in which computerised templates don't just capture data, they profoundly shape the way in which we think about care for patients with chronic disease and the way in which consultations are conducted. This paper is a deep, insightful, and challenging piece and a superb example of the use of social science methods in primary care.

But the winner of the Primary Care category, and unanimously selected by the panel to also be the overall winner of the Research Paper of the Year award, was Karen Barnett *et al*: *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study*.[9] This beautifully written and presented paper uses epidemiological methods and routine primary care data to highlight messages of fundamental importance. These messages challenge the single disease framework which dominates medicine, and demonstrate the value of generalist, person-centred primary care. The impact of the paper (it has already been cited over 80 times in less than a year), along with its quality and relevance to primary care

Out of Hours

Karen Viagra:

Burma's best kept secret

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make it a very appropriate Research Paper of the Year for 2012.

Chris Salisbury on behalf of the panel of judges,
Chair, RCGP Research Paper of the Year and Professor of Primary Health Care, Centre for Academic Primary Care, University of Bristol.

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REFERENCES

1. Walter FM, Morris HC, Humphrys E, *et al.* Effect of adding a diagnostic aid to best practice to manage suspicious pigmented lesions in primary care: randomised controlled trial. *BMJ* 2012; **345:** e4110.
2. Simmons RK, Echouffo-Tcheugui JB, Sharp SJ, *et al.* Screening for type 2 diabetes and population mortality over 10 years (ADDITION-Cambridge): a cluster-randomised controlled trial. *Lancet* 2012; **380(9855):** 1741–1748.
3. Cresswell K, Morrison Z, Sheikh A, Kalra D. 'There are too many, but never enough': qualitative case study investigating routine coding of clinical information in depression. *PLoS One* 2012; **7(8):** e43831.
4. Wiles N, Thomas L, Abel A, *et al.* Cognitive behavioural therapy as an adjunct to pharmacotherapy for primary care based patients with treatment resistant depression: results of the CoBalT randomised controlled trial. *Lancet* 2013; **381(9864):** 375–384.
5. Koshy E, Murray J, Bottle A, *et al.* Significantly increasing hospital admissions for acute throat infections among children in England: is this related to tonsillectomy rates? *Arch Dis Child* 2012; **97(12):** 1064–1068.
6. Connolly A, Iliffe S, Gaehl E, *et al.* Quality of care provided to people with dementia: utilisation and quality of the annual dementia review in general practice. *Br J Gen Pract* 2012; **62(595):** 78–79.
7. Clark CE, Taylor RS, Shore AC, *et al.* Association of a difference in systolic blood pressure between arms with vascular disease and mortality: a systematic review and meta-analysis. *Lancet* 2012; **379(9819):** 905–914.
8. Swinglehurst D, Greenhalgh T, Roberts C. Computer templates in chronic disease management: ethnographic case study in general practice. *BMJ Open* 2012; **2(6):** e001754.
9. Barnett K, Mercer S, Norbury M, *et al.* The epidemiology of multimorbidity in a large cross-sectional dataset: implications for health care, research and medical education. *Lancet* 2012; **380:** 37–43.

The next patient is a young man, looking down nervously at his traditional Burmese lungi; his gelled hair obscuring his face. He hands over his notes, glancing round at the crowd of people in the operating room, wondering, like us, who they all are. We register his limp and various differentials flick through our overheated heads.

He is told to undress which he does so sheepishly before jumping on the table, which is still wet from wiping off the blood of the previous patient.

Another instruction is barked in Burmese and he reluctantly takes off his underwear too, desperately pulling at his shirt to try and cover himself. Everyone gathers round and gasps. Some people get out their phones and take pictures. The patient lies back on the table, defeated.

Eight days ago he injected his penis with coconut oil, as a self-inflicted 'enhancement' process. We are shocked. Yet the local medics giggle at our wide eyes and open mouths. This is very common here apparently, 'like malaria'. His village was visited by a mysterious man, and he was assured, over several glasses of homemade whisky, that he could improve his marital relations for a fee of 'just' 500 Thai Baht (around £10) and a small injection.

He has certainly achieved enlargement to some extent we think, looking on at the swollen, red, oozing mass before us. He cries out as the first local anaesthetic goes in; there is no other anaesthesia available. To start the procedure, incisions are made around the base, shaft, and finally tip of the foreskin, to facilitate removal of the skin. After 10 days of iodine dressings to the bare muscle, a skin graft from his upper thigh will replace the original skin that was removed. This man will apparently have a 'fully functioning' penis again within 6 months, which seems hard to believe at the moment. He is clearly still in pain despite the anaesthetic.

An hour later he sits up, looking drained. The surgeons are still wiping the dried blood that grips the hair on his thighs, sticking him to the table where it has dripped down. The crowd of spectators (all trainee medics we later learn) move aside. He looks exhausted as he stumbles out into the rain, his limp even worse, clutching his sweat, blood, and tear-stained lungi; he had not tied it properly in his haste to leave. It will be a while before he can wear trousers again.

The clinic's attempts at deterring locals from 'Karen Viagra' include a fine to the patient of 1000 Thai Baht (£20) and literature in several local languages complete with gruesome photos. Stigma and embarrassment maintain ignorance however, and only two patients (in the last 10 years) have approached the surgeon for advice regarding having the procedure, and promptly changed their minds. They often don't hear the horror stories until it is too late, as complications can take up to 5 years to develop.

By the end of our 8 weeks at Mae Tao we think back with fond nostalgia about the horror experienced on that first day. By now 'penis operations' are a bi-weekly occurrence, and no longer a shock, almost equivalent to another case of a common condition, like peptic ulcers or dengue fever. But it should still be shocking. This is a huge, completely avoidable public health problem but despite the clinic's best efforts, the message is not getting through to the local people. We certainly have a new differential to add to our list next time we see a patient with a limp.

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The Mae Tao Clinic
Mae Tao clinic is an exceptional healthcare facility located on the border of Northwest Thailand and the Karen state of Burma. Karen refugees and migrant workers come to the clinic on the Thai border to receive free health care. The clinic also trains medics, some of whom remain at the clinic, while others return to their villages in Burma to work as healthcare professionals.

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Entrance to the surgery department at the clinic.