

Care for Stroke training programme for stroke survivors and carers. Working in partnership with local health, social care, and charitable organisations, weekly sessions are delivered in a relaxed informal and friendly environment over 6 weeks, and guest speakers talk about life after stroke, support for carers, communication, aids and adaptations, active living and healthy lifestyles, and goal setting. The course is endorsed by the UK Stroke Forum Education and Training, and has QISMET registration.

While community and voluntary organisations cannot take the place of clinical care when clinical care is needed, they can provide wide and varied support to people in their own communities. With the right support and encouragement from commissioners, health and social care professionals, community-based organisations really can be the genie in the bottle; give it a rub and see what happens. A wealth of local knowledge is available; good links and referral processes with other community organisations can truly empower people to self-manage and increase activation levels. Health and social care colleagues do not have all of the answers, time, or resources to truly do justice to increasing levels of activation in people with LTCs, nor to promote self-management and self-care. However, working in partnership with community organisations can provide the synergy needed to develop and sustain changes to improve health outcomes. We just need to get on with the job.

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Improved support required to increase breastfeeding rates

Rosie Sayers¹ article is an interesting discussion on the impact of our wider culture on the acceptability of breastfeeding in public and suggests this as an important cause of low breastfeeding rates in the UK.

However, from my own personal and professional experience, I believe lack of effective support to overcome low confidence

and common problems encountered when establishing breastfeeding (for example painful nipples and concerns about insufficient milk supply) is at the core of the issue.

According to UNICEF, 81% of UK mothers in 2010 initiated breastfeeding demonstrating that women are generally motivated to breastfeed, however, by 6 weeks only 17% were exclusively breastfeeding.² Increasingly mothers are discharged from hospital shortly after giving birth and usually before breastfeeding has become established. While mothers routinely have two to three follow-up home visits from midwives and health visitors, they report that these encounters are often rushed due to over-stretched resources with little continuity and that they commonly receive conflicting information. Women with breastfeeding difficulties are directed to drop-in clinics or seek information from organisations such as the National Childbirth Trust (NCT) or Le Leche League. This fragmentation of advice and follow-up can be overwhelming to new mothers and it is understandable why formula feeding is often seen as the most reliable option. A Cochrane review of breastfeeding support³ showed that, while all forms of extra support increased the length of time women continued to breastfeed, support that is only offered if women seek help themselves is unlikely to be effective, and suggested that predictable, scheduled, ongoing visits were key to extending the time that women breastfeed.

While the UK has made real progress in increasing rates of breastfeeding initiation, the focus of attention needs to shift to providing improved support to those mothers who want to continue doing so. In addition to the wider cultural factors highlighted in Rosie Sayers' article, focusing on issues including the nature, frequency, and continuity of long-term support as well as availability of effective information is central to tackling low breastfeeding rates in the UK.

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REFERENCES

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Corrections

In the September 2012 *BJGP*, the article by Shephard EA, *et al*. Clinical features of bladder cancer in primary care. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654560, the authors reported PPVs for patients presenting with one attendance with haematuria. They regret this should have been the value for one OR MORE. In Figure 2 (the Risk Assessment Tool) all haematuria combinations increase by a factor of 1.6–2.0. In particular, haematuria in those aged ≥ 60 years has a PPV of 3.9% [95% CI = 3.5 to 4.6] as opposed to the published figure of 2.6 [95% CI = 2.2 to 3.2]. In those aged 40–59 years it is 3.1% [95% CI = 1.0 to 9.8]. The online version has been corrected.

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In the print February issue of the *BJGP* (pages 78–79), the article Moore M, *et al*. Amoxicillin for acute lower respiratory tract infection in primary care: subgroup analysis of potential high-risk groups. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677121, the Results section was incorrectly published. We apologise for this error. This impacts significantly on the originally published article and only the online version of the article should be cited. Further to this, subsequent changes to the Results and Discussion sections were requested by the author and the corrected version is now available online. Correct Results for the print issue are as follows:

"Of the 2061 participants 595 (28%) were aged ≥ 60 years and 310 (15%) had chronic lung disease (asthma or COPD). Groups were well balanced at baseline. Subgroup analysis for the three outcomes identified the following:

- No pre-specified subgroup was significantly more likely to benefit from antibiotic treatment in terms of symptoms rated moderately bad or worse. The result was of borderline significance for those with green sputum and there was modest impact on the median or interquartile range of symptom duration.
- Those with comorbidities (lung disease, heart disease, diabetes, or prior hospital admission) experienced a significantly greater reduction in symptom severity between days 2–4 (Interaction term -0.28 $P = 0.003$; estimated effect of antibiotics -0.28 [95% CI = -0.44 to -0.11] $P = 0.001$) (Table 1).
- No subgroup was significantly more likely to develop new or worsening symptoms."

An additional sentence has been added to the penultimate paragraph of the Discussion:

"There was some evidence of modest benefit in non-smokers and those with shorter prior duration of illness although neither group was pre-specified."

The online version is correct and can be accessed at: <http://bjgp.org/content/64/619/e75.full>

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