Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **http://www.bjgp.org/letters**

Editor's choice

We were interested to read the article by Glew and colleagues on opt-out testing for HIV.[1] In 2009, our team demonstrated the feasibility and acceptability of opt-out point-of-care (POC) HIV testing in general practice. Building on these data we have undertaken a cluster randomised controlled trial of opt-out POC HIV testing in primary care. In the RHIVA2 trial, all general practices in Hackney were invited to take part.[2] Forty of 45 practices were randomised to either intervention (testing) or control (usual care). Intervention practices received education and training to promote and deliver opt-out POC HIV testing to new registrants. The trial data are very encouraging. We observed a POC testing uptake of 45% (4978 of the 11 180 rapid tests offered were accepted). Intervention practices identified more patients with newly diagnosed HIV than control practices. Furthermore, patients in the intervention practices were diagnosed with higher baseline CD4 counts than in the control group.

We recommend that HIV testing be introduced in UK general practices located in high HIV prevalence areas.

Werner Leber, Heather McMullen, Jane Anderson and Chris Griffiths,

Queen Mary University of London.
E-mail: werner.leber@nhs.net

REFERENCES

1. Glew S, Pollard A, Hughes L, Llewellyn C. Public attitudes towards opt-out testing for HIV in primary care: a qualitative study. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677103.
2. Leber W, McMullen H, Marlin N, et al. Point-of-care HIV testing in primary care and early detection of HIV (RHIVA2): a cluster randomised controlled trial [conference abstract]. *Lancet* 2013; 382: S7.

DOI:10.3399/bjgp14X679969

What did the questionnaire say?

It is a cause for serious concern that many at-risk patients in Holland use OTC NSAIDs, presumably without knowing the risk they take.[1] However, the authors do not indicate in their paper whether their questionnaire asked only about oral preparations. Topical NSAIDs are very popular in the UK and it is likely that they are much safer (though perhaps also much less effective), and if some of the patients in this survey used these, the results would be less worrying. The wording of the questionnaire is therefore crucial, but is not disclosed even in the online version of the article. Nor do the authors indicate which NSAIDs their sample admitted to using, and there are huge differences in gastrointestinal risk between the different drugs.

Arnold Zermansky,

GP, Visiting Senior Research Fellow, University of Leeds, Leeds.
E-mail: arnold.zermanskyl@nhs.net

REFERENCE

1. Koffeman AR, Valkhoff VE, Celik S, *et al.* High-risk use of over-the-counter non-steroidal anti-inflammatory drugs: a population-based cross-sectional study. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677815.

DOI: 10.3399/bjgp14X679981

Authors' response

In the first questions of our questionnaire we did not make the distinction between oral and topical preparations expressly clear,[1] although the Dutch word for 'painkiller' was used, which would suggest an oral formulation. However, in later questions we explicitly asked participants about the number of tablets/capsules/sachets/suppositories used per day. The use of NSAID gel was not an option. This question was answered by all but one of the 35 OTC NSAID users in the general population, and all but one of the 33 OTC NSAID users in the high-risk sample. It is possible that these two participants failed to complete this question because they had used topical NSAIDs. Even if this were the case, the prevalence of OTC NSAID use would still be 29% in the general population and 12% in the high-risk sample.

With regards to the types of NSAIDs used by the participants,[1] these are reported in the results section of our paper: 54% concerned ibuprofen, 28% high-dose acetylsalicylic acid, 9% diclofenac, and 9% naproxen. In the high-risk sample, these percentages were: 53% high-dosed acetylsalicylic acid, 29% ibuprofen, 11% diclofenac, and 8% naproxen.

Those interested may contact the corresponding author directly, as we are happy to supply a copy of the original questionnaire and a translation into English.

Aafke Koffeman, Vera Valkhoff and Patrick Bindels,

Erasmus MC, Rotterdam.
E-mail: a.koffeman@erasmusmc.nl

REFERENCE

1. Zermansky A. What did the questionnaire say? *Br J Gen Pract* 2014; **64(623):** 276.

DOI: 10.3399/bjgp14X679993

Assessment of risk communication

Lyndal Trevena discusses the influence risk communication has on patients' perceptions of risk and the importance of clear, effective communication in order to aid good quality decisions and shared decision making.[1]

Having recently made a successful application for GPVTS, I feel there is a place for assessment of risk communication skills as early as selection into the training programme, as this is such a key competency needed in general practice. Although the selection process effectively assesses both communication skills and clinical problem solving skills separately, the assessments do not integrate these two aspects. Evidence shows that using quantitative information improves the accuracy of risk perception, but there is a delicate balance between presenting this information appropriately to the patient, and overloading them with statistics and jargon that they would find difficult to process.[2] This skill could be assessed, for example, in a simulated scenario where the candidate is given statistics such as Number Needed to Treat for a particular medication. The

candidate is then required to explore the patient's ideas, concerns and expectations, and by using any significant information gleaned from that discussion explain the need for the medication, incorporating any statistics provided on the candidate sheet. In this way assessment of risk communication can be incorporated into a station assessing other skills such as empathy and problem solving, reflecting 'real world' clinical practice more accurately.

Trisha Sri,

Academic Foundation Trainee in General Practice, St George's Hospital, London.
E-mail: trishal@cantab.net

REFERENCES

1. Trevena L. Assessing, communicating, and managing risk in general practice. *Br J Gen Pract* 2014; **64(621):** 166–167.
2. Stacey D, Legare F, Col NF, *et al.* Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2014; **1:** CD001431.

DOI: 10.3399/bjgp14X680005

Communicating risk

Harmsen *et al*'s interesting paper[1] on risk communication relates closely to work published 13 years ago in this journal. Misselbrook and Armstrong[2] used a hypothetical scenario to look at the effect of giving patients the same statistical information in different ways: 75% said they would accept medication if given the absolute risk reduction, whereas only 44% would if given a 'personal probability of benefit model'. This is echoed by Harmsen *et al*'s finding that giving information in a form chosen to be as comprehensible as possible reduced the subsequent uptake of preventative medication; what their study adds, as they say, is supporting evidence based on 'real patients'.

Given the current controversy about statins, this paper is particularly timely in highlighting the tension between being patient-centred and promoting population benefit. Within the extensive literature about this tension, two particularly useful contributions are Summerskill's account[3] of a GP consultation about statins, and Gupta's[4] discussion of the ethical and cost-effectiveness issues involved. These issues are central to considering how evidence-based medicine and shared decision-making interact.

Louisa Polak,

GP and PhD student, North Hill Medical Group, Colchester, and London School of Hygiene and Tropical Medicine.
E-mail: louisa.polak@lshtm.ac.uk

REFERENCES

1. Harmsen CG, Kristiansen IS, Larsen PV, *et al.* Communicating risk using absolute risk reduction or prolongation of life formats: cluster-randomised trial in general practice. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677824.
2. Misselbrook D, Armstrong D. Patients' responses to risk information about the benefits of treating hypertension. *Br J Gen Pract* 2001; **51:** 276–279.
3. Summerskill WSM, Pope C. 'I saw the panic rise in her eyes, and evidence-based medicine went out of the door.' An exploratory qualitative study of the barriers to secondary prevention in the management of coronary heart disease. *Fam Pract* 2002; **19(6):** 605–610.
4. Gupta M. Improved health or improved decision making? The ethical goals of EBM. *J Eval Clin Pract* 2011; **17(5):** 957–963.

DOI: 10.3399/bjgp14X680017

In general practice, doctors record higher blood pressures in the presence of students

The authors of the interesting review come to the conclusion that the white coat effect is greater for blood pressure measurements made by doctors than by nurses.[1] In our trial, patients were randomised into a 'trainee' group (n = 133) and a 'no trainee' (n = 129) group. The blood pressure was measured at two subsequent contacts. In the 'trainee' group, a student was present at the first visit only. In the 'no trainee' group, both visits were without a student. At the first visit, systolic pressure was higher in the 'trainee' group than in the 'no trainee' (control group) (139.5 versus 133.1 mmHg, P = 0.004), with a similar trend for diastolic pressure (80.2 versus 77.8 mmHg, P = 0.07). From the first contact to the follow-up visit, blood pressure decreased in the trainee group by 4.8 mmHg systolic (P<0.001) and 1.7 mmHg diastolic (P = 0.03), whereas the corresponding changes in the control group were −0.1 mmHg (P = 0.90) and +1.5 mmHg (P = 0.03). Thus, the between group differences in these trends averaging 4.7 mmHg (95% CI = 1.5 to 7.9, P = 0.005) systolic and 3.2 mmHg (95% CI = 1.1 to 5.3, P = 0.003) diastolic were statistically significant. We concluded that in teaching-practices, the presence of a doctor-in-training has a significant pressor effect when an experienced GP measures a patient's blood pressure.[2] If confirmed, the findings imply that doctors should be cautious to initiate or adjust antihypertensive treatment when blood pressure readings are obtained in the presence of a student.

Jan Matthys,

University of Ghent, General Practice, Belgium.
E-mail: jan.matthys@ugent.be

REFERENCES

1. Clark CE, Horvath IA, Taylor RS, Campbell JL. Doctors record higher blood pressures than nurses: systematic review and meta-analysis. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677851.
2. Matthys J, De Meyere M, Mervielde I, *et al.* Influence of the presence of doctors-in-training on the blood pressure of patients: a randomised controlled trial in 22 teaching practices. *J Hum Hypertens* 2004; **18:** 769–773.

DOI: 10.3399/bjgp14X680029

White coat hypertension: is it all just in the look?

I have recently done a study for my regional science fair on white coat hypertension in 50 random patients at a local cardiovascular clinic. Participants' blood pressure was measured by a cardiologist, a nurse, and a cardiovascular technician. Each healthcare provider measured blood pressure in the same manner twice, one measurement with a white lab coat, and one measurement without a white lab coat in a randomised order. Participants had an automated 24-hour ambulatory blood pressure monitor (ABPM) reading which served as the control for this study. The difference between the average reading of the systolic blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the cardiologist was 23.7 mmHg with a white lab coat and 13.3 mmHg without a white lab coat (P<0.001). The difference between the average reading of the systolic blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the nurse was 14.2 mmHg with a white lab coat, and 5.7 mmHg without a white lab coat (P<0.001). The difference between the average reading of the systolic

blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the cardiovascular technician was 2.8 mmHg with a white lab coat, and –1.8 mmHg without a white lab coat (P<0.001). This suggests that blood pressure recordings are most erroneous when done by a physician, than by a nurse, and most closely match the gold standard of ABPM when done by a cardiovascular technician, and that wearing a white lab coat also exaggerates the effects of the white coat syndrome. Both the study I performed and the study in your journal demonstrate that when doctors measure blood pressure, the readings may be more erroneous than if measured by a nurse, a cardiovascular technician, or ABPM. Perhaps clinics should have blood pressure measured by allied healthcare professionals not wearing a white coat to reduce the risk of erroneous readings.

Arjun K Pandey,

Grade 9 Student, Waterloo Collegiate Institute, Ontario, Canada.
E-mail: arjunpandeywaterloo@gmail.com

REFERENCE

1. Clark CE, Horvath IA, Taylor RS, Campbell JL. Doctors record higher blood pressures than nurses: systematic review and meta-analysis. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X677851.

DOI: 10.3399/bjgp14X680041

The effect of clinical inertia on the management of blood pressure

We read with interest the study by Sheppard *et al* regarding missed opportunities in the prevention of cardiovascular disease in primary care.[1] Recently-published ESH/ESC hypertension guidelines (2013) state that patients whose blood pressure fails to fall by at least 15/15 mmHg overnight (so-called 'non-dippers') should be diagnosed with hypertension.[2] According to the guidelines:

'... night-time blood pressure is a stronger [risk] *predictor* [of clinical cardiovascular outcomes] *than daytime blood pressure'.*[2]

NICE hypertension guidelines 2011 make no reference to identifying or treating 'non-dippers'.[3]

We reviewed the use of ambulatory blood pressure monitoring (ABPM) in one Irish practice over a 3-year period from 1 January 2010 to 17 December 2012 and identified cases where treatment plans differed from the recommendations of the NICE guidelines 2011. We re-interpreted the data using 2013 ESH/ESC guidelines to include 'non-dippers' and compared the results with those obtained using NICE guidelines to highlight the implications of the 2013 guidelines on clinical practice.

Two hundred and forty-seven ABPMs from 202 patients (57.9% female, average age 62.5 years [standard deviation {SD} 15.6]) were included in the review. Of these, 59.5% (n = 147) of the recordings were abnormal according to the NICE guidelines. Of the abnormal recordings, 45.6% (n = 67) resulted in no change in patient management. When we re-interpreted the data using 2013 ESH/ESC guidelines, the number of abnormal recordings increased to 73.7% (n = 182).

Sheppard *et al* identified a number of possible explanations for differences between patient treatment plans and guideline recommendations, including GP judgement, polypharmacy issues and individual patient preferences. We propose an additional explanation: the incidence of clinical inertia, for example, reluctance to change the treatment regimen of the patient compliant with their antihypertensive medication(s) who on follow-up have a mildly abnormal ABPM.

Those opting to replace 2011 NICE guidelines with 2013 ESH/ESC guidelines will see an increase in the number of patients diagnosed with hypertension, given the inclusion of 'non-dippers' as outlined above, with increased workload as a consequence. Despite this, clinicians should attempt to minimise clinical inertia in the management of hypertension, given the positive benefits optimal treatment may have on the efficacy of vascular screening programmes and, ultimately, on patient outcomes.

John Maher,

Letterkenny General Hospital, Co Donegal, Ireland.
E-mail: drjohnmaher@gmail.com

Mel Bates and Patricia Carmody,

Fairview Family Practice, Dublin, Ireland.

REFERENCES

1. Sheppard JP, Fletcher K, McManus RJ, *et al*. Missed opportunities in prevention of cardiovascular disease in primary care: a cross-sectional study. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X676447.
2. Mancia G, Fagard R, Narkiewicz K, *et al*. 2013 ESH/ESC Guidelines for the management of arterial hypertension: The Task Force for the management of arterial hypertension of the European Society of Hypertension (ESH) and of the European Society of Cardiology (ESC). *Eur Heart J* 2013; DOI: 10.1093/eurheart/eht151.
3. National Institute for Health and Care Excellence. *The clinical management of primary hypertension in adults*. London: NICE, 2011. http://guidance.nice.org.uk/CG127/Guidance (accessed 5 May 2014).

DOI: 10.3399/bjgp14X680053

Correction

In the September 2013 *BJGP*, the article by Scheel BI, *et al*. Cancer suspicion in general practice: the role of symptoms and patient characteristics, and their association with subsequent cancer. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X671614 , the authors reported 263 patients with cancer, 106 of whom presented warning signs of cancer (WSC). Further detailed analysis of follow-up data about the diagnostic procedure has revealed that two patients without any WSC recording had established, progressive cancer instead of a new cancer or a new recurrence of cancer, and they were thus protocol deviant. Therefore the correct number of patients with cancer is 261. Also, one patient with lymphoma turned out to be a new case of cancer instead of the recurrent case as reported in the follow-up questionnaire. As the three patients in question had no WSC and therefore no recording of cancer suspicion, there are no changes in the conclusions of the study. The online version has been corrected.

DOI: 10.3399/bjgp14X680065