

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.

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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.

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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/eh1151.
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).

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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.

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