

surgery in hypertensive patients, but rather to assess whether introducing beta-blockade immediately prior to surgery and continuing it for 30 days reduced the risk of cardiac events in patients at risk of, or with, coronary artery disease, vascular disease, previous stroke, etc. In POISE, about 60% of patients had a history of hypertension, but there are no data on the quality of blood pressure control or the presence or absence of elevated blood pressure at the time of surgery. Hypertension did not figure among the predictors of adverse outcome, and no data suggest that beta-blockade did more harm than good specifically in hypertensive patients.

We are concerned that your editorial may lead some readers to conclude erroneously that patients on beta-blockers may be particularly at risk and that beta-blockers should be stopped. Beta-blockers are no longer first-line treatment for hypertension, yet, in those receiving them for indications such as coronary artery disease or tachyarrhythmias, cessation prior to surgery could be harmful. Indeed, maintaining beta-blocker treatment receives a Class I recommendation in the recent ACC/AHA/ASA and ESC/ESA guidelines.^{3,4}

We think this needs to be clarified as misinterpretation of your editorial may result in the unnecessary and potentially harmful discontinuation of beta-blocker therapy.

Pierre Foex,

Emeritus Nuffield Professor of Anaesthetics, Nuffield Division of Anaesthetics, University of Oxford.
E-mail: pierre.foex@nda.ox.ac.uk

John Sear,

Professor of Anaesthetics, Nuffield Division of Anaesthetics, University of Oxford.

REFERENCES

- McCormack T, Carlisle J, Anderson S, Hartle A. Preoperative blood pressure measurement: what should GPs be doing? *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X684865. <http://bjgp.org/content/66/646/230>.
- Devereaux PJ, Yang H, Yusuf S, et al. Effects of extended-release metoprolol succinate in patients undergoing non-cardiac surgery (POISE trial): a randomised controlled trial. *Lancet* 2008; **371(9627)**: 1839–1847.
- Fleisher LA, Fleischmann KE, Auerbach AD, et al. 2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery: a report of the American College of Cardiology/American Heart Association Task Force on practice guidelines. *J Am Coll Cardiol* 2014; **64(22)**: e77–e137.
- Kristensen SD, Knuuti J, Saraste A, et al. 2014 ESC/ESA guidelines on non-cardiac surgery:

cardiovascular assessment and management: the Joint Task Force on non-cardiac surgery: cardiovascular assessment and management of the European Society of Cardiology (ESC) and the European Society of Anaesthesiology (ESA). *Eur Heart J* 2014; **35(35)**: 2383–2431.

DOI: 10.3399/bjgp16X687253

Encouraging medical students to pursue general practice

There are, I am sure, a number of GPs who are still enthusiastic about the job (including those, like me, who are part-time GPs as part of a 'portfolio career') who do not have the time or opportunity to act as GP tutors to medical students or F2 doctors but who would value the opportunity to share our enthusiasm.¹ Perhaps access to registrar half-day training sessions or undergraduate events would provide a forum for this? Or even an evening event?

Dorothy Anne King,

Salaried GP and GP Endoscopist, Fountains Medical Practice and Countess of Chester Hospital, Chester.
E-mail: dorothy.king@nhs.net

REFERENCE

- White GE, Cole OT. Encouraging medical students to pursue general practice. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X686245. <http://bjgp.org/content/66/649/404.2>.

DOI: 10.3399/bjgp16X687265

Incidence of cow's milk protein allergy

This was a really useful article and will clear up a lot of the confusion between these conditions.¹ However, I think it is also useful to note that, although the incidence of cow's milk protein allergy (CMPA) in formula-fed babies is around 5–7%, in breastfed babies it is 0.5–1%. That's not to say this is a stick we can use to beat bottlefeeding mothers with, but when a breastfed baby presents with symptoms that may be due to CMPA, we should be slower to assume that this is the

case, and certainly should not rush to advise mothers to restrict their diets excessively.

Jan Sambrook,

Salaried GP, Slaithwaite Health Centre, Huddersfield, West Yorkshire.
E-mail: jan@hmmn.org

REFERENCE

- Walsh J, Meyer R, Shah N, et al. Differentiating milk allergy (IgE and non-IgE mediated) from lactose intolerance: understanding the underlying mechanisms and presentations. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X686521. <http://bjgp.org/content/66/649/e609>.

DOI: 10.3399/bjgp16X687277

Barriers to advance care planning in primary care

One of the main themes to emerge from Mitchell and colleagues' qualitative data analysis is the importance of advance care planning (ACP) in identifying early palliative care needs and recognising the end of life.¹ Other benefits of ACP include less aggressive medical care, improved quality of life near death, assisting families to prepare for a loved one's death, resolving family conflict, and coping with bereavement.² Patients however may not wish to engage in discussions about future care as it involves them thinking about a deterioration in their condition and some GPs may be unwilling to initiate ACP discussions as they feel discussing prognosis with patients will cause undue distress and destroy hope.³

ACP has the potential to promote patient autonomy and shared decision making,⁴ but without a significant change in patients' perception and GP attitudes it is unlikely to be more widely adopted.

Ian Jack Hamilton,

Researcher, Institute of Health and Wellbeing, University of Glasgow.
E-mail: ijhamilton@doctors.org.uk

REFERENCES

- Mitchell S, Loew J, Millington-Sanders C, Dale J. Providing end-of-life care in general practice: findings of a national GP questionnaire survey. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X686113. <http://bjgp.org/content/66/650/e647>.
- Mullick A, Martin J, Sallnow L. An introduction to advance care planning in practice. *BMJ* 2013; **347**: f6064.

- Barnes K, Jones L, Tookman A, King M. Acceptability of an advance care planning schedule: a focus group study. *Palliat Med* 2007; **21**(1): 23–28.
- Boyd K, Mason B, Kendall M, *et al*. Advance care planning for cancer patients in primary care: a feasibility study. *Br J Gen Pract* 2010; DOI: 10.3399/bjgp10X544032. <http://bjgp.org/content/60/581/e449>.

DOI: 10.3399/bjgp16X687289

Alerts in electronic medical records in primary care to promote colorectal cancer screening

We agree with Gommans *et al* that the main evaluation of effectiveness should rely on intention-to-treat analysis.¹ Accordingly, the results in the discussion section of the article are those derived from this analysis. In our opinion, the lack of statistical significance may have been influenced by the fact that a non-negligible percentage of individuals did not visit their primary care centre during the study period, as well as the low response rate from professionals. In contrast with Gommans *et al*'s statement, the present study was intentionally designed following a pragmatic approach. Indeed, if a centre agreed to participate in the study, all their primary care professionals were involved regardless of their particular intention, thus avoiding the inclusion of highly-motivated professionals only, and evaluating the intervention in daily practice conditions.

We do believe that electronic reminders can play a great role in promoting colorectal cancer screening, but we need to advance into qualitative and technological issues favouring its use by health professionals. For that reason, we were interested in emphasising the statistically significant results observed in the per-protocol analysis, that is, individuals attending in primary care, although we are aware of the weak effect found.

We are convinced that primary care is an ideal setting to develop preventive care measures and to enhance the uptake rates of population-based screening programmes. In such a scenario, synergies among all professionals involved — although complex — are critical to achieve these final goals.

Carolina Guiriguat,
Primary Care Physician, University of

Barcelona, University Institute in Primary Care Research Jordi Gol, Spain.
E-mail: cguiriguat.bnm.ics@gencat.cat

Antonio Castells,
Gastroenterology Specialist and Medical Director, Hospital Clinic, University of Barcelona, Spain.

REFERENCE

- Gommans Y, Razenberg M, van den Driest J. Letter: alerts in electronic medical records in primary care to promote a colorectal cancer screening programme. *Br J Gen Pract* 2016; <http://bjgp.org/content/66/648/e483/tab-e-letters#alerts-in-electronic-medical-records-in-primary-care-to-promote-a-colorectal-cancer-screening-programme>.

DOI: 10.3399/bjgp16X687301

Prediction rules and POC D-dimer testing as a way to prevent diagnostic delay of fatal pulmonary embolism

Pulmonary embolus (PE) is one of the most common cardiovascular diseases. In the UK, 47 594 cases were reported in the 1-year period between 2013 and 2014.^{1,2} The symptoms of PE may be relatively mild, and therefore can be easily missed.³

The GP is exposed to a wide spectrum of symptoms and signs, and most patients with suggestive symptoms of a PE do not have the disease.⁴ Chest pain has a low regression coefficient (0.64) compared with sudden onset of dyspnoea (1.29) in the structured clinical model derived by the PISA-PED Group.⁵ This means, that the symptom of chest pain is not as significant as dyspnoea or fever of ≥ 38 degrees, which is negatively correlated (−1.17). A patient with chest pain might have a higher diagnosis of a PE because chest pain might lead to an urgent admission under the impression of an underlying myocardial infarction rather than an underlying PE.

Clinical assessment alone is insufficient to diagnose or rule out PE. In order to diagnose an underlying PE one can use clinical prediction rules, which establish the pretest probability and predicted risk for a PE. One can use the Wells rules, which have been validated in the primary care setting and give the best performance in terms of lower

failure rates.⁶ The Wells rules can be used together with a point of care (POC) D-dimer test to exclude safely a PE on the basis of a Wells score of ≤ 4 and a negative D-dimer test result.⁷

Clinical prediction rules are easy to use and maintain their accuracy when used by less experienced clinicians, comparing well with the clinical gestalt of an experienced physician. One should be aware that using exclusively Wells criteria without D-dimer testing might miss PE, as we might not be aware of undiagnosed underlying risk factors (for example, cancer), which makes a PE much more likely. In some hospital trusts, clinical prediction rules and clinical gestalt are used to authorise D-dimer tests during a case discussion with the GP involved in the patient care. This can lead to a PE slipping through the net. There is still family grief over sudden death caused by undiagnosed PEs, and one would hope that this will be less common with implementing Wells criteria with a POC D-dimer test.⁸

Bernard Klemenz,
GP Principal, Southsea Medical Centre, Southsea.
E-mail: BernardK@doctors.org.uk

REFERENCES

- Walen S, Damoiseaux RAMJ, Uil SM, van den Berg JWK. Diagnostic delay of pulmonary embolism in primary and secondary care: a retrospective cohort study. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685201. <http://bjgp.org/content/66/647/e444>.
- Hospital episode statistics, admitted patient care, England — 2013–14. 2015. www.hscic.gov.uk/catalogue/PUB16719 [accessed 8 Sep 2016].
- Schiff GD, Hasan O, Kim S, *et al*. Diagnostic error in medicine: analysis of 583 physician-reported errors. *Arch Intern Med* 2009; **169**(20): 1881–1887.
- PIOPED Investigators. Value of the ventilation/perfusion scan in acute pulmonary embolism: results of the Prospective Investigation of Pulmonary Embolism Diagnosis (PIOPED). *JAMA* 1990; **263**(20): 2753–2759.
- Miniati M, Monti S, Bottai M. A structured clinical model for predicting the probability of pulmonary embolism. *Am J Med* 2003; **114**(3): 173–179.
- Hendriksen T, Geersing GT, Lucassen WA, *et al*. Diagnostic prediction models for suspected pulmonary embolism: systematic review and independent external validation in primary care. *BMJ* 2015; **351**: h4438.
- Geersing GJ, Erkens PM, Lucassen WA, *et al*. Safe exclusion of pulmonary embolism using the Wells rule and qualitative D-dimer testing in primary care: prospective cohort study. *BMJ* 2012; **345**: e6564.
- Havant family's grief over sudden death of super-fit Lisa. *Portsmouth News* 2016; www.portsmouth.co.uk/news/health/havant-family-s-grief-over-sudden-death-of-super-fit-lisa-1-7368199 [accessed 8 Sep 2016].

DOI: 10.3399/bjgp16X687517