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Clinical coding of long COVID in English primary care: a federated analysis of 58 million patient records *in situ* using OpenSAFELY

Our paper in the *BJGP*¹ on diagnostic coding of long COVID described wide variation in use of the codes, and dramatically lower rates of use of the diagnostic coding when compared with long COVID as measured in self-reported survey data. As COVID is an unprecedented and evolving situation, we are providing updated analyses for key findings. A report on long COVID diagnostic code usage can be found on the OpenSAFELY reports website (reports.opensafely.org).²

As of this letter, data are current to 5 September 2021, providing 19 weeks' additional follow-up time from the original paper. During this period, 33 827 additional people had a code for long COVID recorded, making 57 100 people in total. The rate at which new diagnoses are being recorded remains largely unchanged. The overall prevalence of coded long COVID diagnosis in the total population is now 99.6 per 100 000, compared with 40.1 per 100 000 in the original paper, due solely to greater follow-up time. As before, prevalence of coding in EMIS practices (126.0) remains higher than in TPP practices (63.1); however, this gap is diminishing over time, with a rate ratio of 2.0 now, and 2.6 at 19 weeks previously.

As we discussed in our article, it is critical for research and planning of services that GPs are able to appropriately code cases of long COVID. We will continue to update this report regularly to inform clinical coding of long COVID. Readers are encouraged to view the full updated report to see trends at the time of reading.²

Alex J Walker,
Epidemiologist, The DataLab, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.
Email: alex.walker@phc.ox.ac.uk

Brian MacKenna,
Honorary Clinical Researcher, The DataLab, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

Ben Goldacre,
Director, The DataLab, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

(On behalf of all OpenSAFELY study authors.)

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DOI: <https://doi.org/10.3399/bjgp21X717449>

Interpretation of ethnicity-specific data: increased risk versus increased utilisation

It was with great pleasure we read the article by Robson *et al* titled 'NHS Health Checks: an observational study of equity and outcomes 2009–2017'.¹ We would like to offer additional contributions regarding explanations for the findings and differences between ethnic groups. It is difficult to ascertain whether ethnic disparities in incidence of disease between attendees and non-attendees are due to underlying higher risk of disease in these groups or the result of the NHS Health Check. It is well established that Black and South Asian patients have increased risk of hypertension and diabetes compared with White patients, and that ethnicity-

specific body mass index (BMI) cutoffs should be utilised. It would be important to understand the risk of incident disease in attendees versus non-attendees within each ethnic group.

Interestingly, in a recent 2021 *Lancet* article, study authors found that adjusted incidence of type 2 diabetes occurred at far lower BMI in South Asians (BMI of 23.9) and Black Caribbeans (BMI of 26.0) compared with White patients with BMI of 30.0.² Additionally, at comparable BMIs, Bangladeshis had the highest risk of type 2 diabetes, followed by Pakistanis and Indians. This is in line with the ethnic differences in NHS Health Check attendance rates, potentially offering an explanation for South Asians' high attendance rates.

Lastly, Eastwood *et al*, in a June 2021 article assessing UK ethnic differences in statin initiation, found that time to initiation of statins was longest for South Asians, followed by Black patients.³ They also found that South Asians and Black patients were significantly less likely to initiate statins compared with European patients.³ This disparity in the overall primary care setting may overestimate the ethnic differences seen in attendees versus non-attendees. Overall, we believe the authors of this paper make a strong case regarding the low uptake and effectiveness of the NHS Health Checks and that more targeted, culturally sensitive cost-effective approaches should be considered. Further studies should keep in mind the different comorbid risk factors as well as changing national guidelines and ethnicity-specific guidance that may influence findings.

Alizah Ali,
MD Student Researcher, Morehouse School of Medicine, Atlanta, Georgia.
Email: aiali@msm.edu

Fariha Hameed,
MD Student Researcher, McGovern Medical School, Houston, Texas.

Bharath Nagaraj,
MD Student Researcher, Rutgers New Jersey Medical School, Newark, New Jersey; North American Disease Intervention, New Brunswick, New Jersey.