SIR, I read with interest the report by Thompson et al. [1] examining the long-term use of NSAIDs in primary care. Generally, the number of patients hospitalized due to peptic ulcer disease has decreased, but the number of hospitalizations due to bleeding or perforation has increased especially in older women, probably due to increased NSAID consumption. The same applies to mortality [2]. It is possible that the elderly are more sensitive to NSAIDs, because bleeding occurs seven times more frequently in them than in younger users of NSAIDs [3]. The risk of upper gastrointestinal bleeding in elderly patients is significantly higher with acute use of NSAIDs compared with chronic use.

One of the problems is the under-representation of the oldest people in most trials. On average, the age of the group of elderly people in research studies is no greater than 60 yr. The oldest group is usually from one cohort [4, 5]. This is especially important regarding investigations of the use and side-effects of NSAIDs [6].

Key messages

- The problem of the gastrointestinal adverse effects associated with the use of NSAIDs cannot be solved in the absence of information about the age of the population being treated.

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Letters to the Editor

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Under-representation of the oldest people in NSAID therapy trials

SIR, We read with interest Nixon and Courtney’s survey [1] about copying correspondence to patients. In our survey we asked patients their views using three open-ended questions rather than using a structured questionnaire. First, we asked what patients liked about receiving the letter that was written about them and sent to their GP; second, we asked what they did not like about receiving these letters; third, we asked what they would like changed about these letters. We also left space for other comments and asked patients to bear in mind that the letter was a communication between doctors. The choice of our questions was based on a study of patient satisfaction that we have used in surveys of our out-patient practice [2]. We surveyed 61 new patients and 141 follow-up patients seen in one consultant’s clinic. Fourteen (23%) new patients and 79 (56%) follow-up patients responded. Responses were classified, independently, by two researchers and the classification later agreed by consensus.

All but one follow-up patient felt that copy letters were a good idea. The dissenting patient wanted letters written directly to them and did not want their GP to be kept informed. Reasons given for appreciating this practice are shown in Table 1.

There were fewer responses to the question about dislikes (overall 65 patients, 70%). A majority (72%) felt nothing needed to be changed but two patients were concerned that this practice imposed a burden on the NHS. Overall five patients (5%) did not want sensitive information included and 5% had difficulty with medical terminology. Two follow-up patients had difficulty in accepting the reality of diagnoses listed in the letter. One comment in each of the following categories was received: inaccuracies in medical history; delayed receipt of letter; regret that other departments did not supply letters; and, did not wish GP to receive this information. In describing how letters could be improved patients referred to voiced dislikes; for example, recommending correction of errors or removing medical terminology. Others requested that results of investigations be added (four patients). One individual even expressed a concern that the content of letters was being edited for patients’ consumption. In the space for other comments four patients expressed their gratitude. One each requested that: the letter be sent in large print; the letter be translated into other languages; and, the letter contain more information.

Our survey clearly indicates that most patients value copies of correspondence sent to their GP. Many use the letter to reflect on issues discussed in the consultation and seem to be empowered in terms of feeling involved, understanding the disease process and understanding the health professional’s perspective. These are key aspects of care in chronic disease. It was disappointing to note that a small proportion of new patients responded, particularly as the first letter about a patient is an opportunity to touch on their key concerns. However, it is possible that in many cases the episode was incomplete and depended on results of investigations, perhaps inhibiting a response to our survey. We also did not pursue non-respondents with a second mailing.

Despite our best efforts, including the use of a structured out-patient letter that has sections for diagnosis, past medical history, medication and a section describing the consultation, many patients, including regular attenders, do not know important items of medical information, such as diagnosis. Also, despite a national mandate that patients receive a copy of their