

itioner provides continuing care, and
ist becomes involved again if disease

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low up in breast cancer. *BMJ* 1995;310:685-6. (18

tigators. Impact of follow-up testing on survival and
ted quality of life in breast cancer patients: a
e randomized controlled trial. *JAMA* 1994;271:

Palli D, Cariddi A, Ciatto S, Pancini P, Distanto V,
ional Research Project on Breast Cancer Follow-up.
diagnostic follow-up after treatment of primary
er: a randomised trial. *JAMA* 1994;271:1593-7.

Yudkin P, Adewuyi-Dalton R, Mant D, Vessey MP.
ized trial of community vs hospital follow-up of
icer. *Consensus conference on follow up of breast
ents. Bari: Special Project Oncologia Femminile
(M), 1994.*

Mant D, Fitzpatrick R, Vessey MP. Specialist and
ictive views on routine follow-up of breast cancer
general practice. *Fam Prac* 1995;12:60-5.

refer specialist follow up

We wish to report the "missing data"—
ients' views—in the debate on routine
a breast cancer.¹ As part of the design
a multicentre study of hospital follow
ollow up based in the community we
ents' views using research methods
the College of Health.² Focus groups
remission were drawn both randomly
ne network of cancer support groups
around Mount Vernon Cancer Centre.³
groups discussed alternatives to the
em of follow up.⁴ The patients' view
he utilitarian approach of clinicians,
differences in the perception of the
outine follow up in the two communi-

nts expressed their anger and distress
discharged to their general practi-
ollow up without having the support
st services of the hospital available in
nity. They challenged the researchers'
patients viewed the hospital—their diag-
specialist physicians, and breast care
heir best defence against a recurrence
er. The hospital was seen as having
r and understanding the magnitude of
e patients' life. Although there were
e hospital system they did not like—the
rushed consultations, and the lack
of care—these were seen as the trade
ling against a relapse. While there is

no evidence that routine follow up improves prog-
nosis or reduces rates of recurrence, this was not
the message they had received.

For patients, an acceptable model of community
based care would include clinics staffed by some-
one with specialised knowledge of cancer—for
example, a breast care nurse—and a fast track
route back to hospital care when this is required;
this would overcome the perceived lack of know-
ledge of their special needs by general practitioners
and provide continuity and a specialised inter-
mediate service. Hospital specialists would also
have a reduced workload, allowing them to concen-
trate their care on those who really need it.

While other models may be proposed, at a time
when cancer services are primed for reorganisation
(precipitated by the Calman report) the views of
the patients should not be ignored. Frequently we
have found that patients, with their wealth of
experiential knowledge, can suggest solutions
when clinicians cannot see the wood for the trees.

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1 Dewar J. Follow up in breast cancer. *BMJ* 1995;310:685-6. (18
March.)

2 College of Health. *Consumer audit guidelines*. London: College of
Health, 1994.

3 Bradburn J, Maher EJ, Young J, Young T. Community based
cancer support groups: an undervalued resource? *Clin Oncol*
1992;4:377-80.

4 Bradburn J, Maher J, Adewuyi-Dalton R, Gunfeld E, Lancaster
T, Mant D. Developing clinical trial protocols; the use of
patient focus groups. *Psycho-oncology* (in press).

Impossible to state which NSAID is safer

EDITOR,—In their article on recent advances in
rheumatology Anthony Bradlow and Joel David
state that ibuprofen is the safest non-steroidal anti-
inflammatory drug when used at conventional
doses.¹ However, they present only the risk of
serious gastrointestinal adverse events and these
for only the seven most commonly prescribed non-
steroidal anti-inflammatory drugs.

Data from the Medicines Control Agency show
that the incidence of hypersensitivity reactions
associated with ibuprofen is similar to that of
gastrointestinal reactions (0.5-1 report per
100 000 prescriptions).² Both ketoprofen and indo-
methacin are less likely to provoke hypersensitivity
reactions. Spanish data collected in a similar
manner show that only 39% of adverse events
associated with non-steroidal anti-inflammatory
drugs were gastrointestinal.³ Gastrointestinal
adverse reactions are considered to depend on the
dose.⁴ It is difficult to assess, from data reported
voluntarily or observational studies, whether the
dose was equivalent between these non-steroidal
anti-inflammatory drugs.

For various reasons, different non-steroidal anti-
inflammatory drugs are used for different indica-
tions. This leads to them being used in different

populations, with variable doses and durations,
which creates further difficulty in interpreting
such data. We therefore conclude that it is not
possible to state with certainty which of the seven
most commonly prescribed non-steroidal anti-
inflammatory drugs is the safest; six of these seven
have similar profiles of adverse events.

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- 1 Bradlow A, David J. Recent advances in rheumatology. *BMJ*
1995;309:637-40. (11 March.)
- 2 Committee on Safety of Medicines, Medicines Control Agency.
Relative safety of oral non-aspirin NSAIDs. *Current Problems*
in Pharmacovigilance 1994;20:9-11.
- 3 Figueras A, Capella D, Castel JM, Laporte JR. Spontaneous
reporting of adverse drug reactions to non-steroidal anti-
inflammatory drugs. *Eur J Clin Pharmacol* 1994;47:297-303.
- 4 Griffin MR, Piper JM, Daugherty JR, Snowden M, Ray WA.
Nonsteroidal anti-inflammatory drug use and increased risk of
peptic ulcer disease in elderly persons. *Ann Intern Med*
1991;114:257-63.

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- 1 Henry JA, Alexander CA.
overdose of antidepressant.
January.)
- 2 Buckley NA, Dawson AL.
toxicity in overdose
antidepressants. *Lancet* 1994;
3 Jick SS, Dean AD, Jick J.
1995;310:215-8. (28 Jan)
- 4 Tanney EL. Mental disorder.
In: Maris RW, Berman
Assessment and prediction
1992:277-320.
- 5 Nordentoft M, Breum L,
Hunding A, Bjaeldager
unnatural causes: a 10 year
to a poisoning treatment
1993;306:1637-41.

Antidepressants and suicide

Study analyses were flawed

EDITOR,—Two recent articles look at use of anti-
depressants and death from suicide. John A Henry
and colleagues have continued previous work and
assessed the relation between death and defined
daily dose.¹ Unfortunately, the defined daily dose
for dothiepin used in the paper (75 mg) should be
150 mg (references quoted by Henry and
colleagues). The correct figure is then 3.08 deaths
per million defined daily doses of dothiepin instead
of 1.54—the second highest figure, after that for
amoxapine. This agrees with a clinical study that
showed that dothiepin has greater toxicity in
overdose than other tricyclic antidepressants.² We
are also concerned about the statistical methods
used by Henry and colleagues. It is unclear how
valid confidence limits are in this context without a
clear definition of x and how the standard error
(not deviation) was calculated. It is inappropriate
to use one tailed tests of significance without a prior
hypothesis, and it is incorrect to use Fisher's exact
test to compare rates.

In the study by Susan S Jick and colleagues we
question the inclusion of flupenthixol, which is
more likely to be used for schizophrenia than
depression and is usually used as a depot prepara-
tion.³ Also, the overall suicide rate of 8.3 per
10 000 person years of antidepressant use seems
remarkably low and is much lower than rates in
affective disorder cited in the literature.⁴ The data
from Henry and colleagues' paper give a death rate
for poisoning with dothiepin alone of 11.25 per
10 000 person years of use.¹ These discrepancies
raise three possibilities. One is that prescribers
were using antidepressants mainly for conditions
other than affective disorder. Another is that
suicide was considerably underestimated in the
cohort. In Henry and colleagues' study only 56% of
the deaths due to poisoning were suicides, the
remainder being undetermined. To ignore these
differences when comparing outcome may obscure
differences in toxicity between antidepressants in
overdose. Thirdly, there was systematic under-
reporting of the antidepressants in the study
compared with the defined daily dose. Obviously,
combinations of all three factors may have
occurred.

Finally, Jick and colleagues comment that their
data are consistent with the proposition that those
who are determined to commit suicide will find a
way that produces the intended outcome. This

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