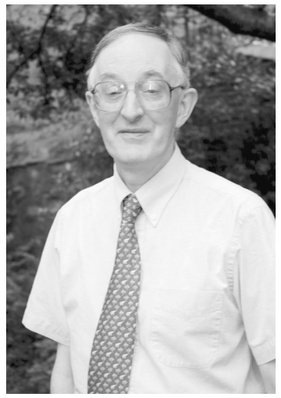
Staff profile



Adrian Grant

Adrian joined the Unit in April 1994 as Unit director and as such has had overarching responsibility for all Unit activities since then. He has led the Unit successfully through three Unit Reviews and his leadership has been acclaimed at each of these. Once it became clear that the Unit's value had been endorsed at the latest review with extension of the core grant for a further five years, Adrian accepted an offer of a 50% secondment to join the new English National Institute for Health Research (NIHR) as Director of its Programme Grants for Applied Research Programme. He will remain in Aberdeen based with Professor James N'Dow in the Academic Urology Unit, and will devote the other 50% of his time to continuation of his Cochrane work (as co-ordinating editor of the Cochrane Incontinence Group and now with greater involvement as the Collaboration's Co-Chair); and collaboration with the Unit in specific trials and its reviewing work for NICE. In addition, he is currently vice-chair of the Health Technology Programme's Clinical Trials Board, and vice-chair of RAE sub-panel 7: health services research. The quality of his work while at the Unit was recognised during 2006 by his election as Fellow of the Royal Society of Edinburgh.

Recent publications

Brazzelli M, McKenzie L, Fielding S, Fraser C, Clarkson J, Kilonzo M, Waugh N. Systematic review of the effectiveness and cost effectiveness of Healozone for the treatment of occlusal pit/fisssure caries and root caries. *Health Technol Assess* 2006;10(16):1-96.

Grimshaw J, Eccles M, Thomas RE, MacLennan GS, Ramsay C, Fraser C, Vale L. Evidence (and its limitations) of the effectiveness guideline dissemination and implementation strategies 1966-1998. *J Gen Intern Med* 2006;21:S14-S20.

Improved Clinical Effectiveness through Behavioural Research Group (ICEBeRG), [Francis J]. Designing theoretically-infirmed implementation interventions. *Implement Sci* 2006;1:4 (23 February 2006). Available from: URL:http://www.implementationscience.com/content/1/1/4

Keating JF, Grant A, Masson A, Scott NW, Forbes J, Scottish Orthopaedic Trial Network. Randomised comparison of reduction and fixation, bipolar hemiarthroplasty and total hip replacement: treatment of displaced intracapsular hip fracture in healthy older patients. *J Bone Joint Surg Br* 2006;88:149-260.

McDonald A, Knight R, Campbell MK, Entwistle VA, Cook JA, Grant A, Wilson PD. What influences recruitment to randomised controlled trials? A review of trials funded by two UK funding agencies. *Trials* 2006;7:9 (7 April 2006). Available from: URL:http://www.trialsjournal.com/content/7/1/9

Thomas RE, Croal BL, Ramsay CR, Eccles MP, Grimshaw JM. Effect of enhanced feedback and brief educational reminder messages on laboratory test requesting in primary care: a cluster randomised trial. *Lancet* 2006;367(9527):1990-6.

Torrance N, Mollison J, Wordsworth S, Gray J, Miedzybrodzka ZH, Haites NE, Grant A, Campbell MK, Watson MS, Clarke A, Wilson B. Genetic nurse counsellors can be acceptable and cost-effective alternative to clinical geneticists for breast cancer risk genetic counselling. Evidence from two parallel randomised controlled equivalnce trials. *Br J Cancer* 2006;95(4): 435-44.

Treweek S, McCormack K, Abalos E, Campbell MK, Ramsay C, Zwarenstein M, PRACTiHC Collaboration. The Trial Protocol Tool: The TRACTiHC software tool that supported the writing of protocols for pragmatic randomised controlled trials. *J Clin Epidemiol* 2006;59:1127-33.

Staff news

HSRU Staff photo, August 2006

We welcome Susan Wong (Clinical Research Fellow), Jude Frankau (PhD Student), Mari Imamura (Systematic Reviewer) and Margaret MacNeill (Data-Co-ordinator/Secretary) to the Unit.
Anne Milne, Anne Langston and Silvia Anton have recently left and we wish them well in their new appointments.

UNIVERSITY OF ABERDEEN

Editorial team: Cynthia Fraser and Kathleen McIntosh.
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This newsletter is produced twice yearly by:
The Health Services Research Unit, University of Aberdeen, Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD.
Telephone: 01224 553909. Fax: 01224 554580. Email: c.fraser@abdn.ac.uk. WWW: http://www.abdn.ac.uk/hsru/

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Health Services Research Unit

Newsletter
Winter 2006/07

Core contract extended to 2013 – after successful quinquennial review

2006 was marked by a rigorous review of the Unit by the Chief Scientist Office of the Scottish Executive Health Department, which core funds the Unit. The review was a two-stage process. In May, the strategic value of a health services research unit to Scotland and the extent to which the current Unit meets this need was considered; in October, there was a review of the scientific quality of the Unit's work and its future plans. The Unit was highly acclaimed at both stages and as a consequence, core funding has been extended to 2013, with another review scheduled for 2011.

The scientific review involved a two-day visit to Aberdeen by a team chosen by the Chief Scientist Office, including independent experts. To quote from the review report: "The review team was extremely impressed with the quality of the work carried out by the Unit. The Unit was (judged) one of the very best performing Units in the UK." The broad thrust of the future plans within the current two large programmes, Health Care Assessment and Delivery of Care was endorsed, with helpful recommendations on specific aspects.

Change at helm – Adrian Grant steps down as director after 12 years

After leading the Unit through his third successful CSO Review, Adrian Grant is stepping down as the Unit's director at the end of 2006. Adrian came to the Unit in 1994 as successor to the Unit's first director, Ian Russell. Notable achievements have been: the expansion of the Unit to around 50 people principally through competitive grant income; the broadening of the Unit's multidisciplinarity, with strength in both quantitative and qualitative methods; the establishment of a formal trials facility – the Centre for Healthcare Randomised Trials; formation of the largest systematic review group in Scotland; and capacity development through the nurturing of a very able cohort of younger researchers. In fact, Adrian will be succeeded by one of these, Marion Campbell, the Unit's current deputy director. Marion and her plans for the next stage of the Unit will be featured in a subsequent newsletter.

The Health Services Research Unit has moved

In August, HSRU relocated to the new Health Sciences Building at Foresterhill. The building brings together leading researchers from a range of life sciences and health-related disciplines.

Contents

Results of a systematic review of the clinical and cost-effectiveness of laparoscopic surgery for colorectal cancer inform revised guidance by NICE

Surgery is the main treatment for colorectal cancer and is currently almost always performed as an open surgical procedure. Guidance from the National Institute for Health and Clinical Excellence (NICE) in 2000 stated that, "open surgery is the preferred procedure. Laparoscopic surgery should only be undertaken as part of a randomised controlled trial (RCT)." New evidence on both short and long term outcomes of surgery has since become available.

In our recently published review, we identified 20 studies (19 RCTs and one individual patient data meta-analysis) comparing laparoscopic with open surgery. Laparoscopic surgery was associated with a quicker recovery and there was no evidence of a difference in mortality or disease-free survival up to three years following surgery. However, operation times were longer and a significant number of procedures initiated laparoscopically were converted to open surgery.

Laparoscopic surgery was estimated to be £250 to £300 more costly to the NHS than open surgery. Although little data were available to estimate quality adjusted life years (QALY), it is plausible that the earlier recovery following laparoscopic surgery would provide sufficient extra QALYs to give a cost-effective incremental cost per QALY.

Wider use of laparoscopic surgery would lead to an increased requirement for training. Given the small number of surgeons currently providing laparoscopic colorectal surgery, it may take some time before the provision of laparoscopic surgery can be increased.

In 2006, on the basis of evidence available (including this review), NICE changed its guidance and recommended that laparoscopic surgery is an acceptable method of surgery for colorectal cancer in the UK.

For further information, contact Luke Vale
(E-mail: l.vale@abdn.ac.uk Telephone: 01224 551127).

Reference

Murray A, Lourenco T, de Verteuil R, Hernandez R, Fraser C, McKinley A, Krukowski Z, Vale L, Grant A. Clinical effectiveness and cost-effectiveness of laparoscopic surgery for colorectal cancer: systematic reviews and economic evaluation. *Health Technol Assess* 2006;10(45).

First Cochrane umbrella review features work done by the Unit

A new development within The Cochrane Collaboration is 'umbrella reviews', in which evidence from multiple Cochrane reviews is compiled into one accessible and user-friendly document. The hope is that umbrella reviews will provide a quick overview of Cochrane reviews relevant to a particular clinical decision. The first of these appeared in a new derivative product of The Cochrane Collaboration, Evidence-based Child Health. It was gratifying that this was on childhood nocturnal enuresis (bedwetting) based on seven reviews led by a member of the Unit, Charis Glazener, and published in The Cochrane Library through the Cochrane Incontinence Group, whose editorial base is within the Unit. Based on these seven reviews it appears that enuresis alarms are the most effective method for securing sustained benefit. Drugs such as Desmopressin are effective and may be particularly useful when children and parents want a short-term benefit such as during a 'sleep-over', but their effects do not seem to persist after stopping treatment. There was little evidence about other approaches to management. This suite of reviews is widely quoted and was previously also the basis for an Effective Healthcare Bulletin.

For further information, contact Charis Glazener
(E-mail: c.glazener@abdn.ac.uk Telephone: 01224 553732)

References

Russell K, Kiddoo D. The Cochrane Library and nocturnal enuresis: an umbrella review. *Evid-Based Child Health* 2006;1:5-8.

NHS Centre for Reviews and Dissemination, [Glazener CMA], [Grant AM], [Wallace SA]. Treating nocturnal enuresis in children. *Eff Health Care Bull* 2003;8(2):1-8.

ProLong: PROlapse and Incontinence: LONGterm research – follow-up survey commences

The long-term consequences of childbirth on urinary and faecal incontinence, prolapse and sexual dysfunction (collectively known as pelvic floor dysfunction) are poorly understood and under-researched. It is generally realised that having a baby can have long-lasting effects on women's health, although very few studies have examined all the relevant symptoms in detail or how often they might occur. These problems can affect a woman's quality of life eventually leading to the need for treatment such as physiotherapy, drugs or surgery.

WellBeing of Women, the only UK charity dedicated to funding research and raising awareness of all aspects of reproductive health, has funded Charis Glazener, within the Unit, and colleagues in Birmingham (England) and Dunedin (New Zealand) to research the effect of childbirth on women's health.

The researchers intend to follow up over 8,000 women who were first recruited in 1993-1994, three months after they gave birth and who were surveyed again six years later. The second survey found that around 40% of women had urinary incontinence after giving birth, 10% had faecal incontinence and 20% showed possible early signs of vaginal prolapse.

Now, 12 years on, this follow-up survey will explore further the natural history of their pelvic floor function and relate it to childbirth and other factors (particularly caesarean section and forceps delivery) in order to unravel the causes of long-term problems and to see how often they occur.

For further information, contact Charis Glazener
(E-mail: c.glazener@abdn.ac.uk Telephone: 01224 553732)

Systematic review of the safety and efficacy of electrosurgery for tonsillectomy helps to clarify concerns regarding subsequent haemorrhage rates

In March 2004, the interim report of the England and Northern Ireland National Prospective Tonsillectomy Audit (NPTA) noted an overall haemorrhage rate three times higher for bipolar diathermy than traditional 'cold steel' tonsillectomy. This systematic review was commissioned through the UK Interventional Procedures Programme of the National Institute for Health and Clinical Excellence (NICE) as a result of the concerns raised by the NPTA interim report.

Fifty studies involving over 11,000 people were included, plus three population-based registry reports involving over 43,000 people and covering England and Northern Ireland, Scotland and Wales. In the meta-analysis models, compared with cold steel dissection with ties/packs haemostasis (reference technique):

- Monopolar and bipolar diathermy dissection and haemostasis, coblation, and cold steel dissection with monopolar or bipolar diathermy haemostasis were all associated with statistically significant higher odds of secondary haemorrhage.
- Bipolar diathermy dissection and haemostasis was associated with a statistically significant lower odds ratio (OR) of primary haemorrhage (OR 0.1, 95% credible interval (CrI) 0.03 to 0.5), including primary haemorrhage requiring return to theatre (OR 0.002, 95% CrI <0.001 to 0.3).
- Coblation was associated with statistically significant higher odds of secondary haemorrhage requiring return to theatre (OR 33.8, 95% CrI 1.2 to 5676.0).

The review was considered by NICE's Interventional Procedures Advisory Committee (IPAC) when it met in June 2005. Subsequent NICE guidance on the use of electrosurgery for tonsillectomy, issued in December 2005, stated that:

- Current evidence on the safety and efficacy of electrosurgery (diathermy and coblation) appeared adequate to support the use of these techniques.
- Surgeons should avoid excessive use of diathermy.
- Clinicians wishing to use coblation should be specifically trained.
- Surgeons should ensure that patients or their parents/carers understand the risk of haemorrhage after tonsillectomy using these techniques.

Meta-analysis models, all secondary haemorrhage

Categories	OR (adjusted for study design)	95% CrI
Cold steel dissection with ties/packs haemostasis	Reference technique	
Monopolar diathermy dissection and haemostasis	4.1	1.1 to 14.7
Bipolar diathermy dissection and haemostasis	2.9	1.1 to 8.0
Coblation dissection and haemostasis	3.8	1.3 to 12.1
Cold steel dissection with monopolar diathermy haemostasis	4.8	1.6 to 15.9
Cold steel dissection with bipolar diathermy haemostasis	9.2	3.1 to 30.5
Cold steel dissection with diathermy or ties + diathermy haemostasis	1.2	0.5 to 3.5

For further information, contact Graham Mowatt (E-mail: g.mowatt@abdn.ac.uk Telephone: 01224 552494)

Reference

Mowatt G, Cook JA, Fraser C, McKerrow WS, Burr J.
Systematic review of the safety of electrosurgery for tonsillectomy.
Clin Otolaryngol 2006;31:95-102.

PRaCTICaL: A Pragmatic Randomised, Controlled Trial of Intensive Care post-discharge review clinics in improving Longer-term outcomes from critical illness

A recent episode of the BBC programme, Watchdog, highlighted some of the medical and social consequences of care in an Intensive Care Unit (ICU) because of critical illness. Besides the implications for patients, these problems represent a continuing financial burden for the NHS. Despite a lack of evidence, over 40 hospitals across the UK have developed intensive care post-discharge review clinics in an attempt to improve outcomes after ICU discharge.

The PRaCTICaL study is a multi-centre randomised controlled study looking at whether ICU follow up clinics can improve physical and psychological health after intensive care discharge. Eligible patients will be randomised to one of two intervention groups after ICU discharge but prior to hospital discharge: Group 1 - patients will attend an ICU post-discharge review clinic 2-3 months and 9 months after hospital discharge or; Group 2 - standard care group where patients will have no intensive care post-discharge follow-up after hospital discharge.

The study is led by Brian Cuthbertson, within the Unit with co-investigators in Aberdeen, Dundee, Perth and Reading. Recruitment began in early November and 30 patients joined the study in the first month. Recruitment will continue until August 2007 with trial follow-up until summer 2008.

This study is funded by the Chief Scientist Office of the Scottish Executive Health Department.

For futher information, contact Brian Cuthbertson
(E-mail: b.h.cuthbertson@abdn.ac.uk Telephone: 01224 552730)