Recent publications


Newsletters

Winter 2006/07

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

Core contract extended to 2013 – after successful quinquennial review

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.

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Recent publications


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 versus 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.

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 cold steel 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 were both 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 0.02, 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 767.6).

The study 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.

## 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 alarmers 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 presumably also the basis for an Effective Healthcare Bulletin.

**Reference**

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

**References**


**Meta-analysis models, all secondary haemorrhage**

- Cold steel dissection with ties/packs haemostasis
- Monopolar diathermy dissection and haemostasis
- Bipolar diathermy dissection and haemostasis
- Coblation dissection and haemostasis
- Monopolar diathermy dissection with monopolar diathermy haemostasis
- Cold steel dissection with bipolar diathermy haemostasis
- Cold steel dissection with diathermy or ties + haemostomy haemostasis

- Cold steel dissection with diathermy or ties + haemostomy haemostasis

**OR (adjusted for study design)**

- Cold steel dissection with ties/packs haemostasis
- Monopolar diathermy dissection and haemostasis
- Bipolar diathermy dissection and haemostasis
- Coblation dissection and haemostasis
- Monopolar diathermy dissection with monopolar diathermy haemostasis
- Cold steel dissection with bipolar diathermy haemostasis
- Cold steel dissection with diathermy or ties + haemostomy haemostasis

**Reference technique**

- Cold steel dissection with ties/packs haemostasis
- Monopolar diathermy dissection and haemostasis
- Bipolar diathermy dissection and haemostasis
- Coblation dissection and haemostasis
- Monopolar diathermy dissection with monopolar diathermy haemostasis
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- Cold steel dissection with diathermy or ties + haemostomy haemostasis

**95% CrI**

- 1.1 to 14.7
- 1.1 to 8.0
- 1.3 to 12.1
- 1.6 to 15.9
- 3.1 to 30.5
- 0.5 to 3.5

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


## 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 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)

## PrAACtical: 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 PrAACtical 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, with 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 further information, contact Brian Cuthbertson (E-mail: b.h.cuthbertson@abdn.ac.uk Telephone: 01224 552720)