This is a published version of a paper published in *BMJ*.

Citation for the published paper:
"Coeliac disease: Decision tool needs to be developed for children."
*BMJ*, 334(7599): 864

Access to the published version may require subscription.

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-16315

http://umu.diva-portal.org
not reflect BMA policy, and the BMA needs to clarify this with some urgency, look to its accountability, and return to evidence based practice.

Michael D Goodyear assistant professor, Department of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada B3H 2Y9 mgoodyear@dal.ca

Competing interests: None declared.

2 Day M. BMA public health doctor is accused of stigmatising sex workers. BMJ 2007;334:767. (14 April.)
5 BMA. Sexually transmitted infections: an update from the board of science. January 2007. [www.bma.org.uk](http://www.bma.org.uk/content/stiupdate05)

INTENSIVE CARE

Help for patients and relatives

The DIPEx (Directory of Individual Patient Experiences) Research Group at the University of Oxford publishes a website of patients’ experiences of health and illness. There is a module on intensive care [www.dipex.org/intensivecare](http://www.dipex.org/intensivecare) where you can read and watch interviews with patients of all ages talking about their experiences.

Lisa E Hinton graduated student Department of Primary Care, University of Oxford, Oxford OX3 7LF lisahinton@dpiphc.cox.ac.uk

Competing interests: None declared.


COPD

Drug management of COPD

In the second step of prescribing for long term management of chronic obstructive pulmonary disease, McVor and Little recommend the addition of a long acting β₂ agonist (LABA) to a short acting β₂ agonist as needed, supplemented by stepwise addition of regular short or long acting anticholinergic inhalers. I agree with this, and it is supported by evidence; tiotropium has advantages over a LABA. The National Institute for Health and Clinical Excellence (NICE) also recommends adding a LABA in its COPD guideline (No12, 2004). At that time there was no evidence to show whether this was a useful combination, but now evidence shows the addition of a LABA to tiotropium has no additional benefit over tiotropium alone, so this is not really a suitable option.

The authors’ next step is to add an inhaled corticosteroid or a combination of inhaled corticosteroid and a LABA as a single inhaler. If an inhaled corticosteroid is to be used in COPD then it should be in line with the NICE guideline. Evidence that a combination inhaler such as Seretide (fluticasone propionate and salmeterol) produces clinically important benefit over and above the separate components is lacking.

If a patient on regular tiotropium and, as needed, a short acting β₂ agonist requires additional drug treatment then I suggest that the two options are to add an inhaled corticosteroid (as per NICE guidance) or add an oral mucolytic. To assess the effectiveness of drug therapy I suggest using five recommended questions (similar to using three questions in asthma).

Peter D Burni special pharmacist adviser for public health, Derbyshire County Primary Care Trust, Chesterfield S41 7TP. peterburnill@derbyshirecountypct.nhs.uk

Competing interests: None declared.

1 McVor A, Little P. Chronic obstructive pulmonary disease. BMJ 2007;334:796. (14 April.)

COELIAC DISEASE

Decision tool needs to be developed for children

The decision tool for coeliac disease developed by Hopper et al is restricted to adults. However, coeliac disease often presents in childhood with different symptoms and signs. It may therefore be inappropriate to use the clinical characteristics suggested by Hopper et al when dividing children into high and low risk groups with respect to coeliac disease.

The second part of the clinical decision tool of Hopper et al is testing with tissue transglutaminase autoantibodies. Also here clinicians need to consider the implications of age. In a recent review by Rostom et al, the pooled sensitivity of human tissue transglutaminase IgA autoantibodies was lower in children (95.7%) than in adults (98.1%); more false negative cases can therefore be expected.

The clinical decision tool proposed by Hopper et al should be adapted for children, and thereafter tested prospectively in an unselected population.

Jonas F Ludvigsson consultant paediatrician Department of Paediatrics, Örebro University Hospital, 701 85 Örebro, Sweden jonasludvigsson@yahoo.com

Anneli Ivarsson epidemiologist, Department of Public Health and Clinical Medicine, Umeå University, Sweden

Competing interests: None declared.


SHIFT WORK

The view from Denmark

As a junior doctor I worked all the different work rotas imaginable, both full time and flexibly, for seven years—and in three countries (the United Kingdom, Malaysia, and Denmark). Now I work full time in Denmark but just 37 hours a week, maybe 40 on a bad week, and this includes on-call hours.

How does the Danish public health system function with such reduced doctors’ working hours? Perhaps it is because Denmark has more doctors (they are still looking for more), and doctors are more efficient at time keeping during an average working day. The department I work in performs over 200 cleft cases and 150 free breast flaps in a year, plus all the skin cancer cases and burns injuries. These figures are similar to those of London teaching hospitals.

The downside? The training takes longer, but who cares if you can still have a good social and family life as well as enjoy your work? And there is no special treatment for women either; both parents are entitled to a shared maternity or paternity leave of up to nine months.

Sharya Khalid Erikson clinical fellow, plastic surgery Rigs Hosspitalanlæg, 2100, Copenhagen, Denmark

Competing interests: None declared.