

lipidaemia, and blood pressure. In both studies, the cardiovascular risk reduction exceeded 50%.

However, these findings contrast strikingly with epidemiological observations on glycaemia. From observational UKPDS data,⁴ DCCT/EDIC group differences in glycosylated haemoglobin would predict a maximum cardiovascular benefit of 9.6%, and for Steno-2 the predicted benefit is 6.5%.

Both studies involved random assignment to different packages of care, and not just glycaemia. In DCCT,² patients in the intensive therapy group were assigned multiple injection or pump regimens, blood tests four times daily, monthly multidisciplinary clinic visits, and more frequent telephone contact. In Steno-2,³ the conventional treatment group was followed up by general practitioners, whereas the intensive intervention patients were seen every 3 months by a multidisciplinary team at a diabetes centre for advice on physical activity, smoking, and diet.

Gale has pointed out the relevance of the "Hawthorne effect" to clinical trials.⁵ In DCCT/EDIC and Steno-2, intensive interventions by multidisciplinary care teams might have resulted in subtle changes in lifestyle that were more likely than metabolic imprinting to be responsible for the long-term benefit.

I declare that I have no conflict of interest.

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Management of allergic rhinitis

We agree with *The Lancet* that the prevalence of allergic rhinitis has been increasing and that there is a need for more allergy specialists to manage those patients (June 21, p 2057).¹ Given the current shortage, the American College of Allergy, Asthma and Immunology (ACAAI) and the American Academy of Allergy, Asthma and Immunology (AAAAI) recommend better training of primary-care providers to manage milder forms of allergic disorders and to work closely with allergy specialists. However, your Editorial also states that pharmacists should "fill the cavernous hole of allergy knowledge, treatment, and management." We strongly disagree with this statement.

As you mention, the prevalence of allergic rhinitis is increasing. This presents serious cost and quality-of-life issues. Unless a proper diagnosis is made and appropriate environmental control measures are incorporated into a comprehensive management programme, patients are unlikely to achieve optimum control.

A task force of the AAAAI and the ACAAI has just released an updated practice parameter on allergic rhinitis,² keeping specialists current with the latest research to provide the most effective care for those with the disease.

Pharmacists remain an important component of the health-care system, but they should not be encouraged to take on a provider role. Allergy specialists working with primary-care providers remains the best option for provision of optimum care.

We declare that we have no conflict of interest.

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Thromboprophylaxis for patients at high risk of VTE

As Chair of the Guideline Development Group for the current Scottish Intercollegiate Guidelines Network (SIGN) guideline on prophylaxis of venous thromboembolism (VTE),¹ I wish to comment on the letter from Graham Mackenzie and colleagues (June 7, p 1911),² and the reply from Alexander Cohen and colleagues.³

Mackenzie and colleagues report that use of aspirin or compression stockings (but not use of heparin) was associated with lower 1-year mortality after hip fracture than was non-use. I agree that these findings from an observational study might be due to residual confounding, and highlight the need for large randomised controlled trials. I suggest that such trials might usefully include other relevant clinical endpoints (symptomatic non-fatal VTE) and also investigate combinations of these methods (in factorial design).^{1,3}

In their reply, Cohen and colleagues correctly quote the SIGN guideline, which states that, although published evidence from a meta-analysis of all randomised controlled trials in surgical patients suggests that aspirin reduces the risk of fatal pulmonary embolism, aspirin does not reduce total mortality, and is associated with an increased risk of bleeding. However, the section on hip fracture surgery in this guideline¹ noted that, by comparison with its effect on symptomatic deep-vein thrombosis or fatal pulmonary embolism, the excess risk of bleeding is small in those who were not receiving concomitant heparin prophylaxis (for which there is limited evidence for clinical benefit in hip fracture patients).



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