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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1 The Lancet. Allergic rhinitis: common, costly, and neglected. *Lancet* 2008; **371:** 2057.
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Thromboprophylaxis for patients at high risk of VTE


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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 guideline[1] 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).

Cohen and colleagues also contend that "the SIGN guidelines erroneously state that aspirin also reduces cardiovascular events in acute myocardial infarction and ischaemic stroke".[3] The SIGN guidelines are not erroneous: this statement is correct.[4]

I was Chair of the SIGN guideline development group for the SIGN guideline on prophylaxis of venous thromboembolism, and was Chair of SIGN Council, 2002–07.

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1 Scottish Intercollegiate Guidelines Network. Prophylaxis of venous thromboembolism. Edinburgh: SIGN, 2002. http://www.sign.ac.uk/guidelines/fulltext/62/index.html (accessed May 12, 2008).
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Studying medicine with a criminal record

The question as to whether a student with a criminal conviction can study medicine (July 12, p 36)[1] can be answered with a resounding yes. Canada's most famous physician, Sir William Osler, was acceptable to McGill despite a criminal conviction. After a cruel and potentially dangerous prank on the school matron, he and other boys had been charged with assault, probably spent a few nights in jail, and were fined with costs.[2] Thus a student applicant with a criminal record should be assessed with care, but not necessarily banned from admission.

I declare that I have no conflict of interest.

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1 The Lancet. Can a student with a criminal conviction study medicine? *Lancet* 2008; **372:** 88.
2 Bliss M. William Osler: a life in medicine. Toronto: University of Toronto Press, 1999: 36–37.

Department of Error

Mouton R, Finch D, Davies I, Binks A, Zacharowski K. Effect of aprotinin on renal dysfunction in patients undergoing on-pump and off-pump cardiac surgery: a retrospective observational study. Lancet *2008; **371:** 475–82*—In this Article (Feb 9), there were some errors in table 1. The correct version appears below.

	Off-pump study group					On-pump study group				
	Control (n=1532)	Aprotinin (n=125)	P	Tranexamic acid (n=2015)	P	Control (n=485)	Aprotinin (n=1209)	P	Tranexamic acid (n=3740)	P
Men	1249 (82%)	86 (69%)	0·001	1643 (82%)	0·993	360 (74%)	752 (62%)	<0·0001	2754 (74%)	0·781
Angina CCS3 or 4	788 (52%)	76 (61%)	0·046	902 (45%)	<0·0001	181 (37%)	254 (21%)	<0·0001	1336 (36%)	0·493
Dyspnoea MYHA iii or iv	465 (30%)	60 (48%)	<0·0001	577 (29%)	0·269	162 (34%)	573 (47%)	<0·0001	1393 (37%)	0·101
Diabetes mellitus	272 (18%)	33 (26%)	0·017	402 (20%)	0·097	72 (15%)	132 (11%)	0·025	593 (16%)	0·564
Hypertension	976 (64%)	83 (68%)	0·412	1432 (72%)	<0·0001	286 (59%)	597 (50%)	0·001	2214 (59%)	0·952
Pulmonary disease	157 (10%)	20 (16%)	0·047	227 (11%)	0·332	46 (10%)	152 (13%)	0·079	432 (12%)	0·188
Neurological disease	99 (7%)	10 (8%)	0·507	145 (7%)	0·391	30 (6%)	122 (10%)	0·012	327 (9%)	0·061
Carotid bruits	49 (3%)	5 (4%)	0·632	69 (3%)	0·693	11 (2%)	26 (2%)	0·876	85 (2%)	0·995
Preoperative arrhythmia	86 (6%)	10 (8%)	0·275	77 (4%)	0·012	50 (10%)	221 (18%)	<0·0001	415 (11%)	0·619
Unstable angina	93 (6%)	31 (25%)	<0·0001	155 (8%)	0·061	31 (6%)	133 (11%)	0·004	249 (7%)	0·828
Poor LVEF	62 (4%)	13 (11%)	0·001	67 (3%)	0·242	15 (3%)	85 (8%)	0·001	189 (5%)	0·076
Emergency admission	17 (1%)	16 (13%)	<0·0001	18 (1%)	0·519	17 (4%)	149 (12%)	<0·0001	60 (2%)	0·004
Isolated CABG	1474 (96%)	114 (91%)	0·009	1984 (99%)	<0·0001	281 (58%)	159 (13%)	<0·0001	2120 (57%)	0·600
Redo procedure	28 (2%)	27 (22%)	<0·0001	30 (2%)	0·431	20 (4%)	327 (27%)	<0·0001	45 (1%)	<0·0001
Reoperation	69 (5%)	4 (3%)	0·498	43 (2%)	<0·0001	30 (6%)	76 (7%)	0·887	161 (4%)	0·062
Postoperative renal dysfunction	75 (5%)	20 (16%)	<0·0001	115 (6%)	0·287	23 (5%)	139 (12%)	<0·0001	226 (6%)	0·255
In-hospital death	18 (1%)	6 (5%)	0·003	18 (1%)	0·409	5 (1%)	80 (7%)	<0·0001	69 (2%)	0·205
ACE inhibitors given	815 (53%)	86 (69%)	0·001	1293 (64%)	<0·0001	190 (39%)	488 (40%)	0·652	1749 (47%)	0·002
Age at surgery (years)	64·1 (9·6)	65·9 (11·8)	0·048	65·3 (9·1)	<0·0001	63·8 (12·0)	62·8 (16·0)	0·220	65·4 (10·6)	0·004
Weight (kg)	82·8 (14·1)	80·6 (16·2)	0·103	82·9 (14·7)	0·844	80·0 (14·5)	75·9 (16·6)	<0·0001	80·4 (15·2)	0·617
Preoperative creatinine (μmol/L)	109·5 (19·8)	105·8 (23·8)	0·047	106·1 (20·4)	<0·0001	108·7 (20·5)	108·1 (25·2)	0·660	107·5 (20·9)	0·252
Postoperative creatinine (μmol/L)	121·0 (46·2)	142·1 (70·8)	<0·0001	122·0 (54·9)	0·584	123·2 (50·7)	139·1 (74·8)	<0·0001	123·4 (52·9)	0·941
EuroSCORE	3·9 (2·6)	6·8 (3·4)	<0·0001	3·8 (2·7)	0·338	4·9 (3·0)	7·9 (3·3)	<0·0001	4·9 (2·9)	0·874

Table 1: **Characteristics of the off-pump and on-pump study groups**