the pre-eminent approach in the field and deserves a mention.

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ERRATUM

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Please note the authors of the letter 'NHS research governance procedures' were Peter Selby, director and John Sitzia, acting chief operating officer from the National Institute for Health Research Clinical Research Network. The title of the next letter should not have the title 'National Institute for Health Research Clinical research Network'

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

A survey of new to follow-up ratios in rheumatology outpatients departments

Practice Based Commissioning (PBC) and Payment by Results (PBR) have introduced perverse incentives for clinicians to work in ways that are not always in the best interests of the patient. PBC may lead to patients who would benefit from a specialist opinion not being referred on cost-saving grounds, or being referred to alternative providers (including private companies) who lack the training and expertise of established specialty multidisciplinary teams. PBR increases income by focusing on new, rather than follow-up, patients (higher tariff earnings for the former compared with the latter) with up to a 13% increase in income if the consultant sees predominantly new patients.[1,2] This has led to some colleagues being asked to lower new to follow-up ratios or having to work to fixed ratios which are usually lower (n = more new, less follow-ups) than those currently being achieved by the unit. Other pressures on new to follow-up ratios include the 18-week pathway and the perception that many follow-up visits are unnecessary and tie up clinical time.

The British Society for Rheumatology (BSR) clinical affairs committee was contacted by a number of colleagues expressing concern about new to follow-up ratios being imposed upon. In order to determine the size of the problem, and whether any recommendations could emerge from this, the committee embarked on a survey to collect data on new to follow-up ratios and whether colleagues had been pressurised to reduce these figures in favour of new patients.

The survey was sent to all consultant rheumatologists both electronically and by post in October 2007 with a reminder sent out in January 2008. It included a diary function in which rheumatologists recorded their clinics and how many new and follow-up patients were seen in each. Only 96 responses were received from a possible 545. The median number of years that consultant respondents had been in post was 10 years (range 0.5–29). The median population served per unit was 330,000 (range 110,000–1,000,000). In total, 93% knew their new to follow-up ratio, which was a median of 3.6:1 (range 1–8). Of respondents, 79.6% were pure rheumatologists without a commitment to another discipline. The median number of consultant-led clinics was four (range 2–7).

The survey asked about annual figures of new and follow-up patients and a new to follow-up ratio (3.3:1) was calculated based on these figures. The reported ratio and the calculated ratio were then compared using linear regression. There was a wide variation with only 30% of the variance in the reported ratio being explained by the calculated ratio. Figure 1 shows that for some colleagues there was a large discrepancy between the new to follow-up ratio that they had reported for their unit and the number calculated for the ratio based on the number of new and follow-up patients listed in the diary. Part of this discrepancy could have been accounted for by differences in practice, and by interpretation of what constituted a follow-up (for example disease-modifying antirheumatic drug (DMARD) monitoring was counted as a follow-up appointment in 24.7% of responses).

Of the respondents, 34.5% had been asked to work to a set new to follow-up ratio. This was a median of 3.1 (range 1.3–4). In total, 17.5% of respondents reported that their unit or hospital would incur a financial penalty if they did not reduce their ratios. These data were presented at the Standards Audit and Guidelines Working Group meeting held at the BSR annual general meeting (AGM) in Liverpool. The data sparked a debate over two main points:

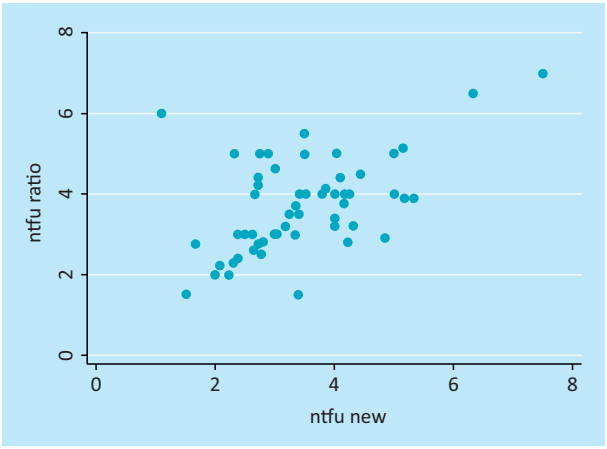

Fig 1. Correlation between actual calculated new to follow-up (ntfu) ratios and those submitted by the respondents.

1 Case-mixes varied markedly between individual units and teams. The type of service was different in different parts of the country, with some having a large soft tissue, neck and back workload, with others providing a service purely for inflammatory arthritis and connective tissue diseases.
2 Nursing input into the new to follow-up ratios varied from unit to unit. Some units provided a DMARD monitoring service with the support of their commissioners, while others moved this activity out into primary care.

The survey and presentation at the AGM uncovered the complexity and controversy of this area. To produce one-size-fits-all BSR-endorsed recommendations on new to follow-up ratios was seen to be counter-productive. The BSR could undertake work in individual diseases or conditions and produce recommendation on appropriate new to follow-up ratios for rheumatoid arthritis (RA), for example. This would involve a considerable amount of work and is still almost certainly controversial. A better approach is to give broad recommendations as per National Institute for Health and Clinical Excellence (NICE) guidelines, patients should have a minimum of specialist unit-led review, even if their disease is quiescent and stable.[3] The following further advice is also recommended:

1 Data are vital, if you can demonstrate that your follow-ups need following up then the argument that your practice is inappropriately reviewing patients can be dismantled
2 Call up your allies. Local GPs may not be aware of the impact of the workload of you discharging inflammatory arthritis back to them, and may be reluctant to take the additional workload and responsibility on.
3 Individual patients and representative groups (eg The Association of Residential Managing Agents, the National Rheumatoid Arthritis Society and Arthritis Care) may feel that their choice which is so much part of the government agenda, including the Next Stage Review[4] is being undermined by being discharged back to primary care.

This exercise has raised more problems than solutions, and the debate at the BSR AGM highlighted the controversies and complexities in this area and recommendations on new to follow-up ratios are still a long way off.

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3 National Institute for Health and Clinical Excellence. *Rheumatoid arthritis: the management of rheumatoid arthritis in adults.* London: NICE, 2009.
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The impact of obesity on cancers of the gastrointestinal tract

Introduction

The current obesity juggernaught affecting the developed world appears unstoppable and has serious implications on the health of the population. The consequences to cardiovascular disease are well appreciated, but the potential links with cancers of the gastrointestinal (GI) tract are less well known. This short review documents the biological mechanisms on how obesity may lead to cancer, the supportive epidemiological data and the potential impact the increased number of cancers will have on general practitioners, hospital doctors and public health physicians.

Biological mechanisms for the effects of obesity

There are several plausible biological mechanisms for how obesity may promote carcinogenesis including: hyperinsulinaemia, hormonal changes, increased inflammation and local physical factors. These may influence several pathophysiological processes including tumour initiation and progression. One of the more developed hypotheses suggests that increased insulin and insulin-like growth factor 1 (IGF-1) levels in overweight and obese individuals promote carcinogenesis.[1] Chronic hyperinsulinaemia is common in obese subjects and bioavailable IGF-1 is also elevated. IGF-1 is a potent mitogen and prevents cell death (anti-apoptotic effect) leading to increased cellular proliferation and