phase 1 to phase 2 in rehoused and not rehoused groups, including the interaction effect (the difference in the intervention group minus that in the control group) with an appropriate confidence interval. Although for the other outcomes considered, these analyses lead to similar conclusions to the naive approach of interpreting significant as real and non-significant as null, this would not generally be the case, and should not be regarded as an adequate basis for inference.

In similar vein, the authors argue that in the rehoused group there was a significant change in damp in respondents aged over 50 ($p = 0.04$) but not in those aged 50 or under ($p = 0.08$). The difference between these two $p$ values is small and could well be entirely attributable to the fact that the majority of the sample, 59 per cent, fell in the over-50 group. Had the authors chosen to dichotomize age at 60, say, they might well have concluded that the effect of intervention was confined to the lower age group. The correct approach here is to examine whether there is evidence for an interaction between group (intervention or control) and the explanatory factor of interest, here age.

The above deficiencies point to the need for us in public health, as a highly numerate discipline, to seek to maintain an exemplary standard in peer-reviewing and reporting research findings.

References


Yours faithfully

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DOI: 10.1093/pubmed/fdg093

Contact tracing and population screening for tuberculosis – who should be assessed?

Sirs,

We have read the paper on this subject by Underwood *et al.* with great interest and were particularly interested in their outcome data from screening new entrants to the United Kingdom. Such screening is recommended as part of the national programme for control and prevention of TB, but few data are available on the effectiveness of screening programmes and Underwood *et al.* have shown no cases of TB diagnosed in 322 new entrants screened and only 10 (3.1 per cent) were given chemoprophylaxis.

In 1999 in Croydon we set up a holistic clinic for new entrants, where as well as TB screening, the wider needs of new entrants could be met. Refugee Health Visitors gave advice on benefits,
finding schools, housing issues and registration with general practitioners (GPs) and dentists. However, the outcome data for the results of TB screening over nearly 4 years shown in the Table are disappointing and show that one case of TB was diagnosed per 951 entrants screened. The three patients diagnosed with TB were non-infectious.

During this same period 110 symptomatic new entrants presented with TB, none of whom had attended the New Entrant Screening Clinic. They presented through accident and emergency departments, referred by their GPs, or more recently some have been referred direct from the Croydon Walk-In Centre direct to the Chest Clinic TB nurses.

Our experience has shown that new entrant screening does not succeed in targeting those with symptoms and suggests that the emphasis should therefore be placed on early diagnosis rather than screening. This must include easy and rapid access to primary care, or to nurse-led walk-in centres for those new entrants unable to register with a GP. In addition, TB services should develop close links with the agencies involved in the management of new entrants to allow rapid, direct referral to TB nurses experienced in the assessment of symptomatic new entrants.

We therefore agree with Underwood et al. that the benefits of extended contact tracing are likely to far outweigh those of new entrant screening as practised at present in parts of London. Moreover, at present, there is no convincing evidence base for population screening for tuberculosis in London and this needs to be addressed in future guidelines and in the expected National Plan for Tuberculosis. Research currently being undertaken into new entrant screening supported by the Department of Health may increase the evidence base for this controversial intervention, but it should be recognized that at present in London there is an urgent need to better target those new entrants who are already showing symptoms.

References

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DOI: 10.1093/pubmed/fdg098

Contact tracing and population screening for tuberculosis — who should be assessed?

Sirs,

We agree with Underwood et al.’s conclusions that it may be of more benefit to trace and treat contacts of tuberculosis (TB) cases, rather than screening all new entrants to the United Kingdom from high-prevalence countries.

We reviewed the literature to estimate the likely benefits of screening new entrants to the United Kingdom, as recommended in national guidance, and estimated that between 30 and 50 cases of TB would be prevented or detected early by screening a hypothetical population of 10000 new entrants (Table). This estimate assumes an ‘ideal world’ where all new migrants eligible for screening were identified, attended for screening, completed screening tests and adhered to recommended treatment and preventive measures.

TB is an important, long-term public health problem globally. Good TB control, with or without screening, requires services adequately resourced to ensure identification of infectious cases and their contacts, and treatment completion. Like any screening programme, TB screening has the potential to do harm. The main public health risk is increased multi-drug resistance from incomplete treatment.

Under ideal conditions, screening of new entrants from high-prevalence countries for TB may have only modest benefits. In practice, identifying and screening new entrants for TB has significant practical and resource implications. Many existing UK programmes report difficulties in implementing new entrant screening as recommended in national guidance, and high levels of non-attendance. It may be of more public health benefit to concentrate