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## Thirty-minute compared to standardised office blood pressure measurement in general practice

We read with interest the study by Scherpier-de Haan *et al* regarding the use of the 30-minute blood pressure measurement in dealing with the 'white coat effect' and the accompanying editorial by Wallace and Fahey.<sup>1,2</sup> Both highlighted the importance of having an office-based alternative to ambulatory blood pressure monitoring (ABPM). This is most topical as practices react to the 2011 National Institute for Health and Clinical Excellence (NICE) unequivocal recommendation that 'ABPM should be implemented for the routine

diagnosis of hypertension in primary care'.<sup>3</sup>

In the RAMBLER II study, we prospectively examined the use of ABPM in 114 Irish general practices over a 1-year period between 1 April 2009 and 31 March 2010. All practices used the dabl® ABPM expert online software system ([www.dabl.ie/en/prod\\_abpm.aspx](http://www.dabl.ie/en/prod_abpm.aspx)), which provides online transmission of ABPM data for instantaneous reporting and storage of data. There were 13 303 ABPM recordings from 11 537 individual patients (47.9% female, average age 57.9 [standard deviation {SD} 14.6] years) with an average of 102 (SD 83, median 84) ABPM recordings per practice per year. With most practices having only one device, this suggests that many devices are being used close to capacity even before the revised NICE recommendation was made.

In 6224 (53.8%) ABPMs, the recommended minimum of 14 daytime and seven night-time measurements were obtained. In 8475 (73.2%) ABPMs, at least 13 daytime and six night-time measurements were obtained. The reasons for this shortfall need to be further examined. Having the recommended number of readings had a small but significant impact on both white coat and diastolic averages but not on systolic averages (data available from authors).

Mean systolic blood pressure (SBP) was 139.4 mmHg (SD 14.7 mmHg) and 121.5 mmHg (6.8 mmHg) for day and night respectively; mean diastolic blood pressure (DBP) was 80.8 mmHg (SD 11.1 mmHg) and 67.1 mmHg (10.7 mmHg) for day and night respectively. Mean blood pressure in the first hour of the ABPM (white coat window) was 158.8 mmHg (SD 21.7 mmHg) and 95.1 mmHg (SD 17.1 mmHg) for SBP and DBP respectively. These figures emphasise the real impact of the 'white coat effect' in routine practice.

This study emphasises the heavy current workload of ABPM devices, the importance of ensuring that the recommended minima of readings are obtained, and the importance of the 'white coat effect' in routine practice.

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## Tips for GP trainees working in general medicine

We write to congratulate the authors on writing an excellent piece of work that GP trainees on general medical rotations should find very helpful.<sup>1</sup>

Although the article provides good advice on commonly encountered medical problems, we would like to highlight issues relating to pleural problems (point 20: 'Never let the sun go down on an emptyema').

Pleural intervention (including thoracocentesis and drain insertion) is associated with a range of potential complications, and each procedure should be performed by competent (or supervised) medical staff. These procedures are best avoided out of hours. We recommend that in most situations you can 'let the sun set' and defer the intervention until the next day.

1. The authors suggest that everyone with pneumonia-associated pleural effusion needs a pleural tap. Diagnostic pleural tap should be guided by clinical need. Up to 40% of pneumonias have associated para-pneumonic effusion (the most common cause of exudative pleural effusion in young patients)<sup>2</sup> and the vast majority will settle with antibiotic treatment. Pleural tap should be considered in the context of persistent sepsis despite antibiotics.