been used to employ 7700 therapists (26 per primary care trust in England) providing 1.54 million treatment courses of six sessions each a year. This estimate increases to 2.43 million if the therapy is delivered by a graduate mental health worker and falls to 0.51 million if the course of treatment is lengthened to 18 sessions.

Comment

Resources associated with higher levels of NHS antidepressant prescribing in England in 2002 compared with 1991 could have been used to deliver cognitive behaviour therapy to 1.54 million patients, more than a third of adults with depression or mixed anxiety depression.[4] The recent rise in antidepressant prescribing is likely to be due to increased awareness of depression by patients and professionals; reduced side effects associated with newer antidepressants; and the broadening range of indications for which antidepressants are prescribed (for example, panic disorder, seasonal affective disorder, premenstrual syndrome). Despite concern about the dangers of antidepressants,[1] evidence of ineffective and inefficient prescribing,[5] and the effectiveness of alternative treatments,[2] drugs are overwhelmingly the mainstay of treatment for depression in general practice. Increases in the pharmacological treatment of depression have not been matched by the development of psychological services of proved effectiveness, which may reflect the absence of a powerful body, equivalent to the pharmaceutical industry, to promote their development and use.

Although cognitive behaviour therapy is relatively expensive and its population cost effectiveness has not been shown, other cheaper alternatives to both antidepressants and psychotherapy—for example, self help and exercise—may be of equal benefit to patients with mild to moderate depression.[2] Our analysis takes no account of the training costs of psychotherapists but we have also ignored the cumulative cost of drugs incurred in the 11 years. Despite these limitations, the analysis highlights the scale of resources expended in this area and the uncertainty around alternative treatment for particular groups of patients; the results indicate that there is a clear need for further research to establish the most appropriate balance between drugs and non-pharmacological treatments for depression.

What is already known on this topic

The prescribing of antidepressant drugs has risen substantially in the United Kingdom since the early 1990s

Cognitive behaviour therapy is an effective alternative to antidepressant drugs

What this study adds

Opportunity costs indicate that development of psychological therapies is a feasible alternative to antidepressants

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Ethical approval: Not needed.

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National survey of UK emergency endoscopy units

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Upper gastrointestinal bleeding is a common cause of hospital admission and is accompanied by considerable mortality. For patients to survive, the timing of endoscopy can be critical. Clinical scoring systems identify high risk patients who need prompt endoscopy after appropriate resuscitation.[1] Early endoscopic intervention to prevent rebleeding is effective in high risk patients.[2] A recent report indicated that patients are still dying as a consequence of delayed endoscopy,[3] but no data exist on the provision of emergency endoscopy services in the United Kingdom. As part of a national census of endoscopy training units, we examined the extent of out of hours endoscopy provision, including volume of work and resources used.

Participants, methods, and results

We approached endoscopy units registered with the UK Joint Advisory Group. We developed a questionnaire from the British Society of Gastroenterology working party report,[4] and distributed it to lead clinicians in 2002. We sent two reminders to centres that failed to reply. We finished collecting data by August 2002. The number of endoscopy rooms was a surrogate marker for the size of the unit. The response rate was 77% (150 centres).

UK units with emergency endoscopy facilities: consultant numbers, volume of endoscopies, and location and staffing for out of hours endoscopies

No of endoscopy rooms	No of units	Median No of consultants on rota	Mean No of upper gastrointestinal bleeding cases per 100 000 per year (95% confidence interval)	Out of hours endoscopies					
				Location			Nursing staff		
				Theatre	Endoscopy	Ward	Theatre	Endoscopy	Ward
1	11	4	106 (24.1 to 187.8)	4/10	6/10	0	4/10	5/10	1/10
2	66	5	72.9 (55.9 to 90.0)	29/65	31/65	4/65	33/66	28/66	5/66
3	25	4	115 (55.3 to 176.6)	7/24	14/24	2/24	8/23	11/23	2/23
≥4	13	5.5	123 (49.3 to 196.7)	2/13	10/13	1/13	523	5/12	2/12

Overall, 35 of the 150 units that responded (23%) did not provide an emergency out of hours endoscopy service. In the 115 (77%) units that did, this was provided by a median of five consultants and featured junior endoscopists in 47 units, acting independently in 15. Forty one units reported having an ad hoc or goodwill rota rather than a formal on-call arrangement. Out of hours procedures were done in the endoscopy department in 61 units, in theatre in 43 units, and on the ward for the remainder. Trained endoscopy staff helped the endoscopist in 49 units. Theatre staff support was needed in 47 units and ward staff in 15 units. Larger units tended to do the endoscopies in the endoscopy department, but there was no variation in location or staffing for units of smaller sizes (table). A mean of 90.2 (95% confidence interval 72.0 to 108.5) emergency endoscopies per 100 000 population were done each year for upper gastrointestinal bleeding, of which 26.7 were out of hours. Although larger units (including tertiary centres) received more patients with gastrointestinal bleeding and did more out of hours procedures this was not significant.

Comment

Hospitals that admit patients with acute upper gastrointestinal haemorrhage lack emergency endoscopy provision; hospitals need to manage about 100 patients per 100 000 population with acute upper gastrointestinal haemorrhage.[1] Mortality from upper gastrointestinal bleeding remains high at 14%, and this has been attributed to the ageing population.[1] Our survey indicates, however, that in many hospitals patients might be dying because of a lack of an appropriately timed endoscopy, which would identify high risk patients and offer the possibility of endoscopic therapeutic intervention.

Emergency endoscopies in high risk patients were often done in unfamiliar surroundings, with staff not used to dealing with such patients, conflicting with guidance issued by the British Society of Gastroenterology.[4] Mortality in hospitals with a dedicated bleeding unit is almost half the national average,[5] indicating that at least 40% of the deaths associated with gastrointestinal bleeding are preventable. We believe that one reason for this is the failure of many units to ensure that out of hours emergency rotas exist for such patients. Smaller units should consider combining with larger ones to provide cross cover and rectify a shortfall in the service that is essentially manpower related. Physicians and surgeons should work together in this important area so that 24 hour cover can be provided by a hospital equipped to deal with all aspects of serious gastrointestinal haemorrhage.

What is already known on this topic

Risk of death after upper gastrointestinal haemorrhage is related to the rebleeding rate and has not decreased despite modern endoscopic methods of stopping haemorrhage in high risk patients

Endoscopy was done too late in 79% of cases in which the patient died

What this study adds

Half of all hospitals have no emergency on-call rota for patients with acute upper gastrointestinal haemorrhage, and, often, emergency gastroscopy was in unfamiliar surroundings helped by staff unfamiliar with endoscopy

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Endpiece

Overtreatment?

I was languishing, but you, Symmachus, came to me
At once, accompanied by a hundred medical students.
A hundred hands, frozen by the north wind, touched me;
I didn't have a fever, Symmachus, now I do.

Martial, Roman poet

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