Drug treatment for Crohn's disease

Sir—In her June 6 feature (p 1710), Dorothy Bonn's[1] quotation "so far no drugs have been shown to effect an improvement that persists after withdrawal of treatment" does not take fully into account our data.[2] The clinical improvement shown in this pilot study of ISIS 2302 extended well beyond the treatment period. In our study, 15 patients received 13 infusions of ISIS 2302 over 26 days, and five patients received placebo. Patients were then followed for an additional 5 months. At the end of the treatment period, seven of the ISIS 2302-treated patients were in remission by Crohn's disease activity index measurements, and at the end of the 180 day trial, five of these seven remitters were still in remission. In addition, significant differences in mean corticosteroid doses were recorded between patients treated with ISIS 2302 and placebo for the entire 5-month follow-up. Mean corticosteroid doses were similar in the treatment groups at baseline. Steroid doses were kept constant during the treatment period, after which time doses in individual patients were adjusted according to blinded clinical judgment.

These data point to the importance of targeting specific inflammatory molecules, especially those far enough down the inflammatory cascade to keep side-effects to a minimum, yet enhance fully activity in terms of efficacy and durability.

Bruce R Yacyshyn

Division of Gastroenterology, Walter Mackenzie Health Sciences Centre, University of Alberta, Edmonton, Canada T6G 2R7

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Mortality among street youth in the UK

Sir—Elise Roy and colleagues (July 4, p 32)[1] report on mortality among street youth in Montreal, Canada. They found standardised mortality ratios (SMRs) among street youth aged 14–25 years (n=10) were almost 12 times that of the general population (11·67/1).

As is the case in North America, while there is some evidence of the morbidity of the homeless in Britain,[2] little is known about their death rates as compared with the general population.

Age (years)	Male rough sleepers in London (1995/96)				Total male population of England and Wales (1995)		
	Rough sleeper deaths	Rough sleepers	Death rate per 1000 people	SMR (95% CI)	Deaths	Population	Death rate per 1000 people
16–29	14	341	41·1	3732 (2038–6263)	5759	5 101 800	1·1
30–44	21	292	71·9	3127 (1935–4780)	12 826	5 682 900	2·3
45–64	32	203	157·6	2074 (1418–2928)	44 460	5 830 200	7·6

Mortality among rough sleepers in London and among the general population

However, a charity for the homeless, Crisis, has published details of deaths among Londoners who were classified as being of no fixed abode on their death certificates,[3] with information on age and sex. From these data it is possible to calculate SMRs for male rough sleepers in London. The number of rough sleepers is taken from the 1991 Census.[4]

There are undoubtedly many difficulties with the reliability of these data; it is impossible to calculate with great accuracy death rates for this indeterminate and mobile population. The results in the table are, however, the first to be calculated for a UK sample, and suggest that the death rates of male rough sleepers aged 16–29 years are almost 40 times those of the general population. For all men aged 16–64 years, this number is about 25 times greater (SMR=2587).

Although it is not surprising that rough sleepers have higher death rates than the general housed population, the magnitude of the difference noted here is startling. In the light of the fact that homelessness seems to be becoming a permanent feature of society, this high rate is cause for grave concern.

**Mary Shaw, Danny Dorling*

School of Geographical Sciences, University of Bristol, Bristol BS8 1SS, UK

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Measuring quality in the NHS

Sir—Paul Shekelle and Martin Roland (July 18, p 163)[1] imply that in the US, quality is an integrated part of health care, based on clinical data, whereas in the UK, administrative data do not support improvement of clinical performance. This difference is due to slow development: "what physicians in the UK are facing now resembles what US physicians faced 30 years ago". They are also critical to administrative data as a measure of quality. We feel that they simplify matters and that the two approaches cover different features. These differences are context-specific (eg, care as commodity *vs* part of the welfare system) rather than because of time or development.

Integrated clinical and administrative data are used in Sweden, where health care is similar to the UK, based on taxes, rationing, central priorities, and equality, irrespective of insurance and income. Regional and local authorities have responsibility for all kinds of health care, in a similar way to managed care. Statistics from private providers are available, since they are the basis for reimbursement. The legal basis is to supply citizens with "good care", and all providers are by law obliged to do systematic quality assurance.

Quality development in Sweden is based on local total quality management or similar principles, medical audit, and use of nationwide databases developed by cooperation between hospitals, counties, and the National Board of Health and Welfare (NBHW), a governmental agency. An administrative dataset is common to many countries, including lists such as the hospital discharge registry, indicating local differences in practice and use of care, the cancer registry, and the cause of death registry. The other dataset is clinical and includes 40 (1998) registries on specific procedures or diseases such as surgery for hip replacement, coronary-artery bypass grafting and percutaneous transluminal coronary angiography, cataract surgery, renal replacement therapy or diabetes.[2] By statistical procedures, updated standards of indications, use, and performance are developed. Primary data are available to participating hospitals as bench-markers, on an aggregate level available to counties, the NBHW, and the public. These databases of comparable numbers are powerful tools for long-term systematic quality development in health care. Similar development is currently happening in other Scandinavian countries.

The definition of quality in health care varies with the perspective. Access to care, the balance between suppliers, and efficient use of resources based on the correct implementation of medical