



## Letter to the Editor

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#### Recruiting to a photo-ageing study in community pharmacy: reflections of a recruiter.

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##### Corresponding Author:

Oksana Burford,  
Lecturer/PhD candidate,  
School of Pharmacy,  
Curtin University,  
GPO Box U1987  
Perth WA 6845  
Email: O.Burford@curtin.edu.au

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Dear Editor,

Community pharmacies are frequented by people of all ages, at all times of the day. This makes the pharmacist a very accessible healthcare professional who is at the frontline for people seeking formal and informal health advice. (1, 2)

One of these public health issues is smoking, which is still considered to be a significant health challenge.(3) There is, therefore, considerable interest in ways in which pharmacists can be proactive in their health care counselling and play a role in smoking intervention. To date, there are a number of smoking cessation interventions, but few target young people.

A pilot RCT (randomised controlled trial) was conducted in community pharmacies in Western Australia by a pharmacist-researcher, to determine if a pharmacist could deliver a 'personalised' smoking cessation intervention to young adult smokers aged 18-30 years.

The research method involved recruiting participants who were waiting for their pharmacist to dispense their prescription or who were purchasing a product. The pharmacist-researcher had to be proactive in the initial approach to potential recruits; to seek the person's attention; to assess their response and to be sensitive to cues that the person made to gauge whether further questions could be asked about their smoking status. When recruiting, it was as an advantage for the pharmacist-researcher to display a badge with their name and academic logo attached, as all potential participants were observed to take note of this

detail in determining the credentials of the person recruiting to the study. Good communication skills were also essential in assisting the process. Out of 83 possible recruits, 50 people consented to participate in the research with 33 people declining to be recruited stating reasons such as: "sorry, don't have time"; "don't want to participate"; "can't be bothered".

Once participants had been recruited to the research, the 3-month follow-up telephone calls also proved challenging. Although all participants readily stated their phone contact details (the overwhelming number of contact details ascribed a mobile phone number rather than a landline number), many were unwilling or unable to take calls. It was often necessary to call at least three times, on different days and at different times, to endeavour to make contact; 32% of participants had their mobiles set to message mode (a way of screening calls?) and did not respond to messages. Additionally, another 8% of mobile phone numbers appeared to be disconnected so no follow up contact was possible. This amounted to a 40% attrition rate.

Therefore, lessons for further research recruitment are as follows:

- A name badge is essential.
- Communication skills and an observant, sensitive attitude are also imperative.
- A short questionnaire form (A4 page back & front being the maximum length) is preferable to a long document – clients are far more willing to participate when they are presented with the survey on a single page.
- Obtaining, whenever possible, additional contact details apart from a mobile number for follow-up phone calls. (E.g. home or work phone number)
- Establishing, at the initial interview, the best times for contacting the recruit for any future follow-up calls.

Sincerely,

Oksana Burford  
Lecturer / PhD candidate,  
School of Pharmacy, Curtin University



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## Headache: The influence of contemporary lifestyles and its prevalence in the urban scenario.

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### Corresponding Author:

Anmol Ulhas Naik,  
Medical Student (Intern),  
Rajiv Gandhi Medical College,  
Thane, Maharashtra,  
INDIA.  
Email: [anmolnaik@hotmail.com](mailto:anmolnaik@hotmail.com)

Dear Editor,

Headache may be a benign phenomenon without any ascertainable cause, or the secondary manifestation of an underlying local/systemic pathology. It is among the most common disorders of the nervous system and causes substantial levels of disability.<sup>[1]</sup> No other symptom probably has such long differential diagnosis as headache. Headache is believed to be among the commonest complaints for sickness absenteeism amongst children and adults, resulting in loss of productivity.

The International Headache Society (IHS) released the latest classification of headache disorders in 2004.<sup>[2]</sup> It includes an exhaustive list of headache disorders with their characteristics/diagnostic criteria. It is often impractical for a physician to arrive at a precise diagnosis in all cases where patients present with headache as chief complaint. This is especially true in case of primary headaches. We believe that in such a scenario, local epidemiology may play a vital role in the management of this often underestimated disorder. Hence, we conducted a preliminary study that could report

the patient profile in cases of headache and identify factors responsible for such a profile in our institute.

A single-observer study was conducted at Chhatrapati Shivaji Maharaj Hospital, Thane over a period of 3 months after prior approval from the Institutional Clinical Ethics Committee. After obtaining informed consent, 209 randomly sampled voluntary participants aged  $\geq 18$  years, residing in the community of Thane and Kalwa were distributed a pre-tested and validated questionnaire consisting of open-ended and closed questions. Participants were explained the purpose of study before obtaining consent. The questionnaire had to be self-administered by the patient. Any individual having a previously documented history of psychiatric illness was excluded from the study. The data generated was analyzed using appropriate statistical tests. Statistical significance was determined at 95% confidence intervals [ $p < 0.05$ ].

### Results

Out of 209 respondents, 178 (85%) agreed to have had an episode of headache at least once in the preceding year. A summary of the study findings is illustrated in Table 1. Of the 178 individuals who complained of headache, 92 (52%) were men and the rest 86 (48%) were women. The prevalence of headache among men was significantly higher [ $p < 0.05$ ]. The highest prevalence was found in the age category of 18-27 years (30%;  $n=53$ ), though prevalence had no significant association with age. Though highest prevalence was found among the graduates (38%;  $n=67$ ), it had no significant association with education levels. In terms of average number of work hours, the proportion of people who worked for more than 12 hours and experienced headache was significantly higher than those categories whose work-hour routine was  $\leq 12$  hours [ $p < 0.05$ ]. Individuals whose nature of work was primarily restricted to indoor activities experienced headache significantly greater than other categories [ $p < 0.05$ ]. There was no association of prevalence of headache across different income groups.

Regarding personal habits and preferences, there was no significant association between smoking habits and prevalence of headache in our study, though the number of smokers who experienced headache was higher than non-smokers. There was no significant difference between the prevalence of headache in those who consumed alcohol regularly (at least  $\geq 100$ ml  $\approx$  1 glass per week) and those who did not. As illustrated in Table 1, tea-drinkers were divided into two categories and there



was no significant difference in prevalence of headache between the categories.

As illustrated in Figure 1, a major proportion of individuals (44%) experienced at least one episode of headache on a fortnightly basis. In a majority of individuals (62%), headache lasted for hours - Figure 2. 29% of the individuals reported experiencing varied phenomena that could be included under 'aura'. 63% of the individuals resorted to over-the-counter (OTC) medications while only 37% consulted a physician in the past year. The most commonly used drug for relief was paracetamol (62%). Among those who sought medical advice, 43% had undergone radiological procedures at least once in the past year.

The study thus brought out a clear picture of the socio-epidemiological characteristics of headache in the study sample. Some of the demographic parameters and contemporary lifestyles viz., gender, nature of work, average number of work-hours, appear to have a significant bearing on the prevalence pattern of headache. These findings highlight the need for social aspects to be taken into account while managing the patient. However, before extrapolating the results of this study to general population, limitations of small sample size and lack of standardized definitions for parameters need to be considered. Large-scale studies need to be taken up in this regard in the future.

Sincerely,

Anmol Ulhas Naik<sup>1</sup>, S Kartikeyan<sup>2</sup>

<sup>1</sup> Medical student (Intern), Rajiv Gandhi Medical College, Thane, Maharashtra, INDIA.

<sup>2</sup> Professor and Head, Department of Preventive and Social Medicine, Rajiv Gandhi Medical College and Chhatrapati Shivaji Maharaj Hospital, Thane, Maharashtra, INDIA.

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**Table 1: Prevalence of headache with respect to socio-demographic parameters**

Parameter	Headache + <sup>#</sup>	Headache - <sup>#</sup>
1. Overall	178	31
2. Gender		
- Males	92	9
- Females	86	22
3. Age		
- 18-27	53	7
- 28-37	46	6
- 38-47	32	7
- 48-57	36	6
- 58-67	11	5
4. Education levels		
- Illiterate	11	5
- Primary	22	4
- Secondary	31	7
- Junior college	20	3
- Graduate	61	7
- Post-graduate and above	33	5
5. Hours of work (average)		
- <6	35	7
- 6 to 12	137	19
- >12	6	5
6. Nature of work		
- Indoor	95	6
- Outdoor/Field work	62	16
- Indoor + Outdoor	21	9
7. Monthly income* (in Rupees)		
- =19575	6	3
- 9788-19574	10	2
- 7323-9787	31	4
- 4894-7322	29	6
- 2936-4893	36	5
- 980-2935	41	7
- =979	25	4
8. Smoking habit		
- Smokers	97	13
- Non-smokers	81	18
9. Alcohol consumption		
- Regular consumer <sup>†</sup>	56	9
- Non-consumer	122	22
10. Tea consumption		
- >5cups per day	147	25
- <5 cups per day	31	6

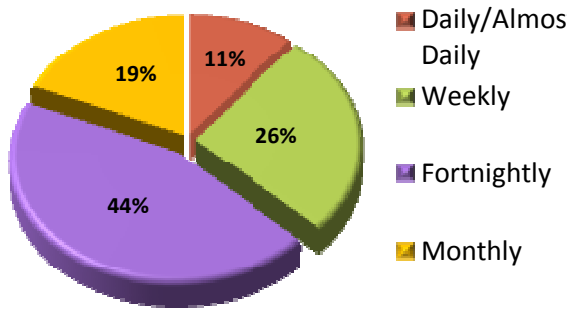
<sup>#</sup>[Headache +] = At least one episode of headache in the past year; [Headache -] = No complaint of headache in the past year

\*Income groups formed according to modified Kuppuswamy scale<sup>[3]</sup>

<sup>†</sup>Those who consumed ≥ 100ml ≈ 1 glass per week



**Figure 1: Frequency of headache among the study sample**



**Figure 2: Duration of headache among the study sample**

