

P1-326 100 YEARS OF SUICIDE IN BRIGHTON AND HOVE, ENGLAND

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Introduction Compared with the suicide rates in England (12.0/100 000 males, 3.7/100 000 females), Brighton and Hove (B&H) (population=250 000) has the 3rd highest rate in males (18.9/100 000) and the highest rate in females (10.2/100 000). We investigated long-term trends in suicide by age, sex, and method in B&H from 1901 to 2008.

Methods Age-standardised suicide rates (ASR) were calculated from 1901 to 2008. Information on suicides was obtained from the Reports of the Medical Officers/Directors of Public Health for B&H and the Office of National Statistics.

Results Suicide rates in B&H were consistently higher than the rates in England for most of the 20th Century. The male:female ratio fluctuated from 3:1 in the 1920s to 1:1 in 1960s to 2:1 in 2000s. The ASR (per 100 000) in males fluctuated from 31.2 in the 1920s to 16.3 in 1960s to 27.0 in 2000s, and from 11.0 in the 1920s to 16.5 in 1960s to 11.6 in 2000s in females. Coal gas inhalation was the most common method in both sexes (22% males, 41% females) in the 1920s. This was replaced by self-poisoning in 1960s (39% males, 57% females). In the 2000s, hanging became more common in males (37%), whereas self-poisoning remained the most common method in females (45%).

Conclusion The epidemiology of suicide in B&H has varied over the past 100 years. However, in contrast with the national decline in suicide rates, B&H rates have consistently remained high. These findings are discussed in light of information obtained from the local Public Health Reports/suicide audit.

P1-327 EVIDENCE SUPPORTING THE USE OF REDUCED DOSE SCHEDULES FOR PNEUMOCOCCAL CONJUGATE VACCINES: SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction Pneumococcal conjugate vaccines (PCVs) are designed to protect against *Streptococcus pneumoniae* disease. The first PCV (7-valent) was licensed based on clinical efficacy of 3 primary doses in infancy and a booster ("3p+1"). Many countries have since introduced reduced dose schedules; in 2010, 19 countries were using 2p+1 and 21 were using 3p+1 schedules. Evidence supporting the use of the 2p+1 schedule was examined in a systematic review.

Methods We searched 12 databases up to March 2010. We included randomised controlled trials (RCT) and case-control studies comparing 2p+1 to 3p+0 or 3p+1 schedules. Data on clinical outcomes, nasopharyngeal carriage and seropositivity (ELISA antibody concentration >0.35 µg/ml for all studies and serotypes) or geometric mean concentrations (GMC) were analysed.

Results There were no RCTs reporting clinical or carriage outcomes for direct comparisons between 2p+1 and 3p+0 or 3p+1 schedules. Percentages seropositive, or GMC following 2p+1 and 3p+1 schedules (3 RCTs) were similar for most serotypes, except 6B and 23F, where 3p+1 schedules were consistently favoured. GMC (1 RCT) at 13 months were substantially higher in the 2p+1 than the 3p+0 group. Differences were smaller 6 months later.

Conclusion Clinical and carriage data are absent for direct comparisons (RCTs) between 2p+1 and 3p+0 or 3p+1 schedules. Evidence supporting a 2p+1 schedule is based on limited RCT data about

immunogenicity (where the correlation with protection against clinical disease is not well defined), non-randomised comparisons, or indirect comparisons of post-introduction surveillance data.

P1-328 COMPARISON OF PREVENTIVE PRACTICES AMONG WOMEN IN SÃO PAULO/BRAZIL

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The aim of this study was to compare estimates of Pap smear screening and mammogram obtained from household survey and a telephone survey in São Paulo/Brazil in the year 2008, according to sociodemographic characteristics, and to dimension the observed differences from those estimates. The study used data from the ISA-Capital 2008 Survey, conducted in São Paulo city, by Faculty of Public Health of the University of São Paulo with support from the Municipal Health Department, and VIGITEL (São Paulo), a telephone survey conducted by the Brazilian Ministry of Health towards Surveillance of Risk and Protection Factors for Chronic non-transmissible Diseases. Estimates of Pap smear and mammogram in women, as well as its realisation in the year prior to the interview were compared according to type of survey (household/telephone) by Poisson regression adjusted for age and education. There were no statistically significant differences between the estimates obtained by VIGITEL and ISA-Capital for the prevalence of mammogram in the year prior to the interview. However, estimates for the global estimates of the Pap smear at least once in life and in the last year and mammogram at least once in life, there has been observed statistically significant differences, with higher prevalence among those interviewed by telephone. It shows a tendency to overestimate the prevalence of mammography and Pap smear in the telephone survey data indicating a necessity for new studies that also contribute to a better understanding of the differences observed using different types of surveys.

P1-329 SOCIOECONOMIC INEQUALITIES IN CANCER RISK BY SITE, AGE, AND SEX IN SCOTLAND, 2000–2007

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Some cancers are associated with socioeconomic inequality (SEI); this study quantified the extent and differences by cancer type, age and sex. We reviewed 216 315 incident cancers (excluding non melanoma skin cancer) from 2000 to 2007 classified into 27 anatomical groups. Further analyses were performed by morphology or sub site. Deprivation was measured using the Scottish Index of Multiple Deprivation and SEI using the slope index of inequality and the relative index of inequality (RII). Analyses were partitioned by five-year age group and sex. For both sexes, incidence was positively associated with deprivation for lung, head and neck, stomach, oesophagus, bladder, liver, pancreas and negatively associated with deprivation for cutaneous melanoma. Prostate, rectum (male), cervical and breast (female) cancers also show inequalities; only prostate and breast cancers are negatively associated with deprivation. Female RII (0.36) was lower than male RII (0.53). For males, SEI is pronounced at ages 45–74 years, peaking at 60–64 years