Letters

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Use of renal transplants from living donors

Practice is essential to alleviate shortage of organs

EDITOR—Nicholson and Bradley call for an increase in the donation of organs from living donors.[1] I have held this view for several years.[2] The negative attitudes of the directors of transplant programmes are one of the main causes of the low rate of living donation in Britain.

I have suggested a donor charter to ensure that positive attitudes to living donation prevail in a transplant programme.[3] It would include a call for familiarisation with the advantages of living donation, including its ethical acceptability and better results. It would also provide the potential recipient and his or her family with understandable information, which should include the risks involved, the experience of previous successful living donors, and the fact that living donation would enable pre-emptive transplantation before dialysis.

In a recent review colleagues and I have provided evidence based justification for living renal donation and discussed the ethical issues involved.[2] We must remember that in much of the developing world most kidney transplants are from living donors[4]; appreciable damage from hyperperfusion does not occur in the remaining kidney when the donor is healthy[2]; and donors themselves benefit by expressing altruism in what is perhaps the most meaningful way possible—by an increase in their self esteem—and by early treatment should they be found to have any undiagnosed medical conditions during the screening process.

Fear that living donation will lead to commercialisation is unnecessary. And there is no reason to exclude unrelated living donors other than spouses: it is now quite common to see good friends with enduring bonds of friendship donating to each other in the United States. In Germany a transplant surgeon has even donated anonymously to a needy recipient on the waiting list.[2] In spousal situations the potential for coercion can be overcome by professional psychological evaluation, as has been developed in the Munich model.[2]

Eventually tissue engineering or even xenotransplantation may solve the problem of organ shortage,[5] but until then the one realistic method of alleviating suffering, reducing costs, and enabling altruism is to increase living donation. Cadaveric donation will not be adequate even if the highest donation rates (those in Spain) are reproduced elsewhere, especially for countries such as Egypt and the United States, which have high rates of end stage renal failure.

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Surgical techniques should be fully evaluated

EDITOR—The editorial by Nicholson and Bradley on renal transplantation from living donors rightly pointed out that the United Kingdom has a lower rate of transplantations which use kidneys from living donors than the United States or Norway.[1] The recent report by the Royal College of Surgeons on organ transplantation in the United Kingdom recommended that steps should be taken to increase the use of kidneys from living donors in the United Kingdom to offset the shortage of cadaveric kidneys as well as to improve outcome.[2] In the United Kingdom in 1998, 38% more transplantations were performed using organs from living donors than in 1997. However, there is still some way to go if a level similar to that of the United States or Scandinavia (25-30%) is to be achieved.

Nicholson and Bradley identify the risks associated with donor nephrectomy and state that much of the morbidity that occurs after open nephrectomy is related to the wound. For this reason they believe that the use of laparoscopically assisted donor nephrectomy needs to be examined in the light of the experience of, for example, the Johns Hopkins Hospital in Baltimore, Maryland. However, there have been no randomised prospective trials of this procedure, which takes longer than open nephrectomy. Furthermore, all of the non-randomised comparisons have been of open nephrectomy performed through a loin incision, with or without removal of a rib. If an anterior transverse, transperitoneal approach to the donor kidney is used, as is our practice, the operation usually takes less than two hours, the morbidity from the wound is minimal, and patients generally go home on the fifth day after surgery.

Laparoscopically assisted donor nephrectomy is not without problems, and there is still a need for a randomised prospective trial to compare laparoscopically assisted donor nephrectomy with open nephrectomy using the anterior approach.

We would also reiterate the need for prospective follow up of living donors over a long period, not only to observe outcome but especially to evaluate the risk, if any, resulting from modest degrees of hypertension or occasional haematuria in the donor before surgery. Steps have been taken by the kidney advisory group of the United Kingdom Transplant Support Service Authority to establish such a registry for the United Kingdom.

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Call to needle times after acute myocardial infarction

Paramedics in Derbyshire can admit direct to coronary care unit when they diagnose myocardial infarction

EDITOR—Edhouse et al have shown that in an urban area such as Sheffield the optimum method of hastening thrombolytic treatment for acute myocardial infarction is for patients to dial 999 and be brought to the casualty department and for the thrombolytic treatment to be given there.[1] This reduced the door to needle time to a median of 41.5 minutes.

In North Derbyshire, a mix of urban and rural areas adjacent to Sheffield, we have a system of direct admission to the Chesterfield and North Derbyshire Royal Hospital coronary care unit by paramedics (bypassing the accident and emergency department) when the paramedics diagnose an acute myocardial infarction from a 12 lead electrocardiogram obtained at the patient's home.[2] In the 21 months since the system was introduced in May 1997 I have collected data on all admissions to the coronary care unit.

The unit has received 889 patients with myocardial infarction, of whom 159 have been delivered directly by paramedics. Altogether 495 of the patients have received thrombolytic treatment, including 131 of those delivered by the paramedics. The mean (median) times from arrival in hospital to thrombolysis (door to needle times) were 89 (107) minutes for all patients with acute myocardial infarction yet only 42 (43) minutes for those delivered by paramedics. Altogether 171 patients given thrombolysis who were admitted to the coronary care unit direct from the accident and emergency department had mean door to needle times of 80 (76) minutes.

At present we do not give thrombolysis in the accident and emergency department, although this policy is under review. The door to needle time that we achieve with our paramedic direct admission service is similar to the Sheffield model of thrombolysis in the accident and emergency department. This model should also be considered as a means of delivering thrombolysis more quickly than traditional methods of admission to hospital. If thrombolysis starts to be given in the accident and emergency department in Chesterfield we will have to compare this service with the existing paramedic service and determine if the model proposed by Edhouse et al is even quicker.

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GPs are encouraged to rely on ambulance service

EDITOR—I was interested to see that the letters criticising the paper by Rawles et al on call to needle times after acute myocardial infarction were written by trust employees.[1 2] As a general practitioner practising immediate care and offering domiciliary thrombolysis I wonder whether they have a genuine wish to improve patient care, or are they influenced by a powerful conflict of interest?[3]

As Edhouse et al and Ahmad et al confirm,[1] in an emergency most patients make a 999 call for an ambulance in the belief that an ambulance offers the quickest route to hospital care and therefore the best outcome. This need not be the case. As Rawles et al show, at least in the case of acute myocardial infarction, general practitioners can offer an improved clinical outcome but only if they are adequately equipped, readily available, and mobilised in time.[2]

Few general practitioners currently offer domiciliary thrombolysis or indeed any other emergency medical care. Most receive financial inducements to delegate out of hours care to the cooperative deputising services. Unfortunately, this means that in many cases a doctor cannot be provided in time to influence the clinical outcome when one is genuinely needed. Delays in visiting of more than an hour are now common, so it is no surprise to learn that the corporatist NHS hierarchy, in the form of the Sandwell NHS Trust, encourages acutely ill patients to bypass their general practitioner and dial 999 instead.[1]

Although official ambulance response times in Suffolk often exceed 30 minutes and the trust is under investigation by the region for its poor performance, local general practitioners are encouraged to rely on the ambulance service in all acute cases rather than provide a comprehensive service themselves. On one occasion the ambulance trust initially refused to contact me for a patient in pulseless ventricular tachycardia after its receipt of a 999 call, although I had been asked for by name and was readily available. In fact, I arrived well before the ambulance and initiated treatment and the patient survived. In a more recent but identical case I was called belatedly, only to confirm death.

The provision of quality medical care by general practitioners is greatly hampered by unreasonable patient demand and trust corporate philosophy. In consequence there has been a reduction in general practitioners' involvement and an increase in the use of the ambulance service and accident and emergency departments. I have yet to be convinced, however, that patients receive better treatment in consequence.

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New standard of 60 minutes has been proposed but may be too rigorous

EDITOR—Since our paper was published[1] and the responses to it were written,[2] a new standard call to needle time of 60 minutes has been proposed.[3] This supersedes the 90 minute standard set by the British Heart Foundation.

In relation to these standards the table shows up to date call to needle times from the Grampian audit, comparing prehospital thrombolysis by general practitioners in rural areas with scoop and run in the city and suburbs of Aberdeen and in rural areas 25 km or more from Aberdeen. In the scoop and run cases, patients taken to hospital after a 999 call were given thrombolytic treatment either in the accident and emergency department or in the coronary care unit to which they were directly admitted. No doctor to doctor referrals occurred in these cases, so these times are about the shortest that are achievable with this approach.

Audit of call to needle times after acute myocardial infarction in Grampian in relation to proposed standard of ⩽60 minutes[3] and British Heart Foundation's standard of ⩽90 minutes

	Prehospital thrombolysis	Scoop and run	
		Urban	Rural
Median call to needle time (min)	45	62	90
Proportion (%) in whom call to needle time was:			
⩽60 min	156/211 (74)	40/84 (48)	1/13 (8)
⩽90 min	198/211 (94)	70/84 (83)	8/13 (62)

These results suggest that the rigorous 60 minute call to needle standard is unlikely to be achieved in most cases unless thrombolysis is initiated in the community before patients are transported to hospital.

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Emerging tobacco hazards in China

Is assumption of no association between smoking and other causes of death valid?

EDITOR—Liu et al used the term "proportional mortality study" to describe their method of comparing the smoking habits of 0.7 million adults who died of neoplastic, respiratory, or vascular causes with those of a reference group of 0.2 million who died of other causes in China.[1] The term can be confusing as it is used only for proportional mortality ratio analysis in standard epidemiology textbooks.[2] We suggest that the study can be more easily understood if it is described as a case-control mortality study.

An important assumption in such analyses is that the other causes of death should be unrelated to the exposure "not only in the sense of causation but also in terms of 'self-selection' for the exposure and the diagnosis and certification of the underlying cause of death."[3] Liu et al validated this assumption by showing that the smoking rates of the male and female reference groups were only slightly higher than those of the surviving spouses of the people who had died. However, they did not elaborate whether this similarity was true for each city or rural area in China, and, if it was not, why.

Could this similarity be a feature of populations in which the tobacco epidemic is at an early stage? The authors' assumption may not be valid in other studies (such as our Hong Kong study[4]) or future studies that use a similar design. One potential confounding factor is social class, which is often associated with both smoking and mortality, and it may lead to an association between smoking and other causes of death. Studies elsewhere have observed some association between smoking and other causes of death (for example, in the American Cancer Society's cohort the mean annual mortality from other medical causes was 39/100 000 men

in never smokers and 81/100 000 in current smokers)[5]; choosing such other causes as referents would underestimate the risks from smoking.

It is fairly easy to define a priori which are the other causes of death for smokers as relations between smoking and many diseases are known, but it is difficult to define them when other risk factors (such as alcohol consumption) are studied in relation to mortality. Information on smoking (and confounders and other risk factors) in another control group randomly selected from the surviving population should be collected for validation; if the results do not support the assumption, classical case-control analysis comparing the dead and the living is necessary.

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Double standards apply with importation of tobacco into developing countries

Editor—Smoking is a scourge that, although universal in distribution, ravages the economies of developing countries both directly and indirectly. As a non-medical person, I acknowledge with admiration the moral and economic purpose behind studies such as those by Liu et al and Niu et al.[1 2] I wonder, however, about the lack of speculation in the papers, let alone recommendations, on the possible measures that governments, health bodies, and non-governmental associations should undertake to combat what is obviously a healthcare disaster. Given the press coverage that high impact papers such as these attract and that the *BMJ*'s readership extends to the non-medical world, Lopez in particular missed the opportunity to put this right in his editorial.[3]

In the electronic responses to these studies Pletten attempts to rectify this.[4] But his triumphalism—that China should learn from the United States' experience of dealing with tobacco—displays the ignorance that individuals with his views have of the enormous contribution made by the United States to the importation of tobacco into developing countries. More sensitive people in the Western world would find disturbing the fact that cigarette packets intended for sale in the West bear health warnings such as "cigarette smoking kills" and "cigarette smoking causes cancer" whereas those intended for sale in the developing world bear warnings diluted of impact, such as "cigarette smoking may be injurious to health" and "cigarette smoking may damage your health"—both in English and in the language used locally. The ethics, or lack thereof, of the parties concerned is obvious.

Medical researchers are often in a powerful position when it comes to influencing healthcare decisions and should use this for the public good. Now that these papers have proved the obvious, perhaps we should do something about it.

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UK authors' reply

Editor—Three different types of study have led to virtually identical conclusions about smoking and death in China[1 2]:

(1) A case-control study in which the smoking habits of one million people who had died were compared with those of 300 000 who had not[1]

(2) A prospective study of 250 000 adults, 10 000 of whom had died[2];

(3) What we chose to call a proportional mortality study, in which the smoking habits of 700 000 adults who had died of neoplastic, respiratory, or vascular disease were compared with those of a reference group of 200 000 adults who had died of other causes.[1]

To avoid confusion between the second and third of these, we are reluctant to adopt Lam's suggestion of calling the third a case-control mortality study, but the choice of terminology is not very important. What chiefly matters is the results: already there are almost a million deaths a year from smoking in China, and eventually there will be two or three million a year. These facts were not appropriately widely accepted until these studies were done, and their wide acceptance may well be achieved more rapidly if (despite Lhatoo's concerns) the findings are presented without any strong recommendations other than that they should be widely known. Both papers are available in translation in the February 1999 Chinese language edition of the *BMJ*.

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I don't want to be invited to invest in the tobacco trade

Editor—The British Heart Foundation was criticised by the *Independent on Sunday* last year for using pension funds that invested in tobacco companies.[1] A spokesperson for the BMA commented that charities promoting health should, as a matter of principle, avoid investment in tobacco companies and that "charities campaigning against tobacco should certainly not invest in tobacco stock."[1] However, the *BMJ* and the BMA (through its financial services subsidiary) could be criticised on similar grounds as both promote saving and pension funds investing in tobacco stocks. Last year the *BMJ* carried a full page advertisement for the Royal National Pension Fund for Nurses promoting "an outstanding investment opportunity."[2] I would have hoped that saving and pension funds designed for health professionals would avoid tobacco investment, but the Royal National Pension Fund for Nurses was unable to provide reassurance on this when I wrote to it. As the *Independent on Sunday* has shown, pension and savings funds, unless specifically screened, commonly invest in tobacco stocks because they are profitable.[1]

BMA Services also continues to promote funds that have no screening to exclude tobacco investment. Indeed, when I wrote to the company about this it replied that "many doctors require consistent growth in preference to investing ethically." At a time when pension and savings funds that offer both consistent growth and tobacco-free investment do exist, I find it disturbing to receive promotional literature tucked in my *BMJ* inviting me to invest in the tobacco trade.

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Women must be given fully informed information about cervical screening

Editor—The General Medical Council has now produced clear ethical guidelines with respect to getting informed consent from patients undergoing any medical procedure, including screening tests.[1 2] This would include cervical screening.

The guidelines are quite specific in stating that a doctor or other party should explain the purpose of screening; the likelihood of positive and negative findings, including false negative and false positive results; uncertainties and risks of screening; important medical, social, or financial consequences of screening; and follow up plans, including counselling and support services. Several other, more general, points may also apply to screening, such as

conflicts of interest due to financial benefits, the withholding of information necessary for decision making, and allowing patients sufficient time to reflect before and after they make a decision.

Leaflets given to patients and general practitioners about the cervical screening programme have been criticised for being misleading and not fully disclosing all the information required for women to make an informed decision about having this screening test.[3] In particular there is the problem of false negative and false positive smears, which occur in all laboratories but are rarely made known to smear takers or women; the psychological problems after an abnormal smear; and the morbidity that may follow colposcopy and treatment for cervical intraepithelial neoplasia.

It is sometimes argued that the benefits to society of reducing the incidence of cervical cancer outweigh the rights of individual women to have this information in case it upsets them and they decide to refuse screening.[4] Again the General Medical Council's guidance is clear on this point, and such information should not be withheld on this basis. Some doctors—including me—believe that the NHS cervical screening programme should be more open and honest about the limitations and uncertainties of screening for cervical intraepithelial neoplasia and cervical cancer.[3 4] It is therefore gratifying that this is, by implication, the view of the General Medical Council.

Perhaps now we can expect the NHS cervical screening programme to produce fully informative and honest literature for women and to ensure that this information is made available to the smear takers, who are clearly under an ethical obligation to provide it. The case for fully informed written consent before women have a smear test now seems stronger than ever.

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Cancer patients should be offered semen cryopreservation

Editor—Møller and Skakkebæk have confirmed the association between male subfertility and subsequent testicular cancer.[1] We and others have shown that men with malignant disease, and especially with testicular cancer, have reduced sperm quality at the time of diagnosis of their illness.[2–4] Further deterioration occurs due to the damaging effect of chemotoxic agents on spermatogenesis, which may be temporary or permanent.[5] However, most men have sufficient suitable sperm for freezing before starting chemotherapy.

Survival of young men with cancer has improved in recent years. Progress in assisted reproductive techniques, and especially in micromanipulation and intracytoplasmic sperm injection, can secure the fertility potential of these men. Men with cancer, particularly those who have not completed their family yet, must have the opportunity to freeze semen samples for future use. Our results indicated that their probability of fathering their own genetic children is quite high.[2] Moreover, patients' knowledge that their fertility potential is secured would help in the emotional battle against the cancer.

We wish to increase the awareness of general practitioners, oncologists, haematologists, and patients to the new opportunities opened to them in recent years. Our impression, after running a successful sperm cryopreservation programme for the past nine years, is that only a minority of eligible patients are offered sperm cryopreservation. We call on medical teams treating male cancer patients to refer them for semen cryopreservation in tertiary assisted conception centres before starting chemotherapy. These centres have the facilities and experience for cryopreservation and can offer appropriate assisted reproductive treatments.

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Few patients with prostate cancer are willing to be randomised to treatment

Editor—No one would deny the need for controlled prospective trials to determine best management in serious conditions such as prostate cancer. But to adopt a nihilistic approach towards available treatments because such data do not exist is to turn back the clock of progress. Proponents of evidence based medicine may claim that there is no evidence that radical prostatectomy is the treatment of choice for early prostate cancer, but there is no evidence that it is not.

Willis's suggestion that patients should "only have access to a treatment by agreeing to abide by the protocol, which would include randomisation," is arrogant, and insulting to patients and doctors.[1] Men with a life expectancy of 10-25 years who develop prostate cancer will not allow themselves to be randomised to a "watchful waiting group" (waiting for what?—disease progression? metastases?), as the early ending of the MRC PRO6 trial showed.

Stepping Hill Urology and the uro-oncologists at the Christie Hospital have for 12 months been conducting a prospective controlled trial to compare radical prostatectomy with radical radiotherapy. Currently 20 patients have been entered and three more are being processed. If funding is forthcoming the study will be opened to the North West region's urologists and others. All patients are fully counselled by a urologist, a radiation oncologist, and a specialist nurse, then offered randomisation. Of the first 20 patients, only one agreed to be randomised, the other 19 making their own informed decision between the two treatments.

Patients want to make up their own minds regarding their future, and they deserve to have full information about and access to all available treatments. A study comparing surgery and radiotherapy is still possible, but it is unlikely ever to be a randomised study.

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Trial of prophylactic mastectomy is needed

Editor—I agree with Fentiman that all cases of prophylactic mastectomy should be centrally registered, but his proposals should go further to maximise the potential information from this group of women.[1] The proposals should include compulsory testing of all women undergoing the operation for known mutations of the BRCA1 and BRCA2 genes; a central archive should be established for storing part of the mastectomy specimen, and a chemopreventive trial should be considered.

The first measure is crucial to allow research into the correlation between the BRCA1 or BRCA2 gene concerned, the nature of the mutation, and its position along the gene with the risk of breast cancer after mastectomy. This is important given that currently there are over 200 mutations for BRCA1,[2] that different BRCA1 and BRCA2 mutations are associated with different risk of cancer,[3] and that the penetrance of BRCA1 and BRCA2 genes may vary.[4] This information may allow surgeons in the future to give an indication of the risk of breast cancer after mastectomy based on BRCA status and allow risk stratification.

Hartmann et al recently showed in a retrospective study that prophylactic mastectomy reduced the incidence of breast cancer in women at high risk on the basis of their family history. However, they did not test the women for mutations of the BRCA1 or BRAC2 gene and so were unable to assess the benefit of mastectomy for this risk factor.

A tissue bank would allow the prevalence of any new BRCA mutation to be investigated, and this could subsequently be linked to the risk of breast cancer after mastectomy. The library would also be useful for any future research into new genes that may have a role in the pathogenesis of familial breast cancer.

In the light of ongoing chemopreventive trials, consideration should also be given to establishing an international trial comparing mastectomy alone, mastectomy and chemoprevention with tamoxifen, and tamoxifen alone, given that some women may wish to avoid mastectomy. Hopefully, this trial would show the optimum preventive strategy. Furthermore, if the nature of the BRCA mutation was known the trial might allow the various prophylactic measures to be tailored on the basis of the mutation.

As with tamoxifen, the role of mastectomy in the prevention of breast cancer needs to be evaluated: all women may not benefit equally, and some may be spared the need for surgery and its inherent risks.

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Article on Colombia should have been more objective

Editor—We Colombians must cope with clichés about drugs, violence, and underdevelopment. Although we have enormous problems, Veeken's article on Colombia lacks objectivity and fairness. It is based on prejudices arising from personal experiences, which he extends to the whole country. The *BMJ* should adopt a scientific approach to articles on health in Colombia instead of publishing subjective generalisations.

According to a 1997 United Nations report, Colombia's human development index (which measures personal income, life expectancy, health, and educational standards) ranks 51st among the indices of the 175 developed and underdeveloped nations.[2] Colombia's index (0.848) is well above the average for developing countries and close to the average for industrialised ones (0.907). Life expectancy increased to 70.1 years in 1994 from 56.6 years in the 1960s. Infant mortality fell to 26/1000 live births in 1994 from 99/1000 in the 1960s. The fertility rate has fallen to 2.1 children per mother in 1994 from 4.1 in the 1970s.

By the mid-1990s, 81% of the population had access to healthcare services. Safe water and sanitation were accessible to 85% of the population. Public expenditure on health was 1.8% of gross domestic product in 1990, compared with 0.4% in the 1960s. In 1988-94 the population per doctor was 1650 versus the average of 1064 for countries with a high human development index.[2]

We have eliminated almost all diseases preventable through vaccination. Dr Manuel Elkin Patarroyo's work on a malaria vaccine is worthy of mention. Furthermore, the Colombian authorities are engaged in important work to protect the environment. There has been universal acknowledgement of our efforts to conserve our forests and biodiversity—crucial to developing existing and future medicines for mankind.

A supposedly scientific view of the drugs issue does not bear much weight without an equally rigorous consideration of consumption and without recognition of the shared responsibility of producers and consumers. It is untrue that half of our economy depends on cocaine. Such a simplistic generalisation is contradicted by serious economic studies and is untenable since it fails to take into account Colombian exports, such as petroleum, coal, coffee, and flowers.

The distorted statements contained in this article are a lesser concern than their futility. If Veeken went to Colombia under the auspices of Médecins Sans Frontières to help our country it is clear that he wasted his time there.

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1 Veeken H. Colombia: winner takes all. BMJ 1998;317:1649-50. (12 December.)
2 Presidency of the Republic of Colombia. *Economic guide, 1997-1998*. Bogota: Arte Editorial, 1997.

Behaviour described in scenario in paper would be unethical

Editor—The third scenario in Zwitter et al's article on attitudes towards unsolicited medical intervention describes a doctor undertaking research on blood samples without the consent of the people who submitted the samples.[1] This behaviour would clearly be unethical and ought not to be approved by any research ethics committee. One of the reasons for this, of course, is to avoid the discovery of important adverse prognostic factors in an individual's blood sample without that person knowing that the testing was taking place.

It is unfortunate that this was not acknowledged in the discussion section of the article. It may underlie the significant differences reported between respondents from different countries in relation to this scenario, which were substantially greater than for the other two.

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1 Zwitter M, Nilstun T, Knudsen LE, Zakotnik B, Klocker J, Bremberg S, et al. Professional and public attitudes towards unsolicited medical intervention. *BMJ* 1999;318:251-3. (23 January.)

Teaching patients with bipolar disorder to identify early symptoms of relapse

When were outcomes separated?

Editor—The decision to analyse the relapses for mania and depression separately in Perry et al's trial in patients with bipolar disorder is crucial.[1] The reported power analysis was calculated for the overall (mania and depression) relapse rate, but no result is shown relating to the overall relapse rate. This raises the possibility that the decision to split the outcomes was taken later.

The authors explain why the decision was taken: they considered that the experimental and control treatments differed qualitatively for mania and depression. But did the data in the study influence the decision to split the outcomes? If separate analysis of the two outcomes was specified in advance in the study protocol the authors' conclusions are justified. If it was not then the distinction between the different effects on manic and depressive relapse rates becomes an interesting observation that merits further study. Could the timing of the separation of the outcomes be made clearer?

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1 Perry A, Tarrier N, Morriss R, McCarthy E, Limb K. Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. *BMJ* 1999;318:149-53. (16 January.)

Authors' reply

Editor—The decision to split the outcomes into manic and depressive relapses rather than total relapses was taken after our six month pilot work was completed[1] before the main trial reported in the *BMJ*. Our pilot work confirmed previous retrospective recall studies suggesting that the manic and depressive prodromes were qualitatively different in terms of symptoms.[2] Before this we were uncertain how much manic and depressive prodromes overlapped because some common prodromal symptoms such as irritability and steep disturbance preceded full relapse.[2]

We carried out our reported power calculation based on total relapse to obtain funding for both the pilot work and the main trial. No previous treatment study using this technique had been performed, so the power calculation was only a rough guide.

We hope that further studies of our intervention and similar interventions that use cognitive-behavioural therapy techniques in bipolar disorder will be carried out. Until they are we cannot be confident that the intervention is effective or generalisable, or precisely estimate its effect size.

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1 Perry A, Tarrier N, Morriss R. Identification of prodromal signs and symptoms and early intervention in manic depressive psychosis: a case example. *Behav Cognit Psychother* 1995;23:399-409.
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Recognition of depression and anxiety in primary care

Patients' attributional style is important factor

EDITOR—Kessler et al found that doctors detected psychiatric illness in less than half of patients scoring highly on the general health questionnaire (85% of patients with a normalising attributional style and 38% with a psychologising style were not detected).[1] These data are in accordance with the work that we did in four Spanish primary care centres. Using the general health questionnaire-28 in the first part of the study and a SCAN interview[2 3] in the second, we found similar figures of non-recognition of psychiatric illness[4] and the same relevance of somatisation to lower rates of recognition of mental illness by general practitioners.[5]

In her commentary on the paper Heath doubts that scoring highly on the general health questionnaire could be equated with having a treatable disorder. We agree with her that the general health questionnaire is a screening questionnaire, not a diagnostic tool, and that doctors should not talk of depression and anxiety just because patients scored highly on the questionnaire. But Kessler et al's findings are relevant. Questionnaires such as the general health questionnaire provide an approximation of the rate of well defined psychiatric illness in primary care. The diagnosis and treatment of psychiatric illness by general practitioners are usually based on a suspicion about mental illness rather than on diagnostic criteria according to current nosology.

In an attempt to analyse this issue we repeated the analysis of our data only for those with a definite affective or anxiety disorder. In our published study we collected data on patterns of symptom presentation ("attributional style"—physical, psychologising, and mixed symptoms). Among the (unweighted) 72 patients with these diagnoses as defined in the international classification of diseases, 10th revision (18 depression, 12 dysthymia, 2 cyclothymia, 3 panic disorder, 31 generalised anxiety disorder, 2 obsessive-compulsive disorder, 4 phobic anxiety), only 11 (23%) of the 47 with somatising attributions were recognised by their general practitioner as having affective or anxiety disorder. Equivalent figures were 93% (14/15) of the psychologising attributions group and 90% (9/10) of the "mixed" group.

We also performed a logistic regression, with recognition of psychiatric caseness by the general practitioner as a dependent variable; symptom attribution and marital status were included as significant variables influencing recognition by the general practitioner. Patients with psychologising and mixed style attributions were more likely to be detected by general practitioners (table), as were married and previously married patients. Thus our results support the relevance of attributional style in patients with well defined depressive and anxiety disorders, for whom effective treatments exist.

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Variables included in logistic regression with dependent variable "general practitioner's recognition of mental illness" for 72 patients with diagnosis of depression or anxiety disorder according to ICD-10 (international classification of diseases, 10th revision)

Variable	B coefficient (SE)	Wald statistic	df	P value	*r*	Significance of log likelihood ratio*	Odds ratio
Marital status	1.77 (0.90)	3.82	1	0.05	0.13	0.02	5.9
Symptom attribution:							
Somatising		17.99	2	0	0.37	0	—
Psychologising	1.39 (0.80)	2.99	1	0.08	0.10	—	4.0
"Mixed style"	1.10 (0.83)	1.76	1	0.18	0.00	—	3.0
Constant	–0.09 (0.80)	0.01	1	0.90	—	—	—

*For the model if variable is removed from the model.
Fifty nine of the patients were correctly classified in the model.

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General health questionnaire alone is not sufficient for making psychiatric diagnosis

EDITOR—In their study on depression and anxiety in primary care Kessler et al aimed at examining reasons why depression fails to be detected in general practice.[1] Several fundamental methodological flaws in the study, however, mean that their conclusions are irrelevant.

The authors incorrectly use the general health questionnaire as a diagnostic instrument when in fact it can only indicate caseness. A further structured psychiatric interview is always necessary to make a psychiatric diagnosis. This error accounts for the 52% of patients considered by the researchers to have measurable depression and anxiety.

The general health questionnaire used is able to screen only for psychological disorder in general. The larger 30-item general health questionnaire, when it has been examined by factor analysis, has been found to contain three other factors in addition to anxiety and depression—difficulty in coping, feelings of incompetence, and social dysfunction.[2] With the authors' methodology, readers remain ignorant of the actual number of patients with a diagnosis of depression and anxiety. As a result, to compare the authors' rate against attributional style is flawed.

This study seems to be suggesting that all of life's major problems should be labelled as depression or anxiety. Heath's analysis in her commentary on the paper is pertinent when she refers to "the medicalisation of human distress."[1] This indeed is a contemporaneous trend, which some would have us believe has no end point. As she rightly indicates, however, "normalisers" could be seen as showing a healthy cognitive attributional style in which normal feelings are not medicalised or psychologised. By avoiding such medicalisation the individual is likely to adapt to life's difficulties instead of receiving inappropriate drug treatment or psychotherapy.

The study's hypothesis therefore remains untested. This is disappointing in view of the importance of the subject matter. The detection of depression and anxiety and depression will be aided by the use of screening instruments but only if they are used within their natural limits.

Personally we think that most general practitioners do a difficult job well. Any improvement in detection is likely to come about from research into closer liaison of general practitioners with their psychiatric colleagues. Certainly it will not happen if attempts are made to undermine psychiatric skills with inappropriately used screening instruments.

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2 Huppert FA, Watters DE, Day NE, Elliott BJ. The factor structure of the general health questionnaire (GHQ30): a reliability study on 6317 community residents. *Br J Psychiatry* 1989;155:178-85.

Authors' words foster stigmatisation of commercial sex workers in India

Editor—The Indian component of the HIV/AIDS pandemic has recently gained international attention because of the alarming rate at which it is taking hold in this populous part of the world. What makes the case of HIV/AIDS in a country like India especially difficult is that it is caught in a complex web of sociocultural mores that can act as serious deterrents to control and prevention of disease.

One critical component of this complex web is stigmatisation, not only of individuals who are HIV positive but also of commercial sex workers and others whose high risk behaviour makes them vulnerable to infection. Allowing or encouraging such stigmatisation negates some of the fundamental strategies for controlling disease. For example, holding sex workers responsible for the spread of the epidemic prevents us from gaining their trust and cooperation, which are prerequisites to implementing strategies that empower sex workers to instigate safer sex among clients.

As a group of concerned medical and public health professionals, we were deeply disturbed to find such stigmatising views appearing in the article by Rao at al in the *BMJ*.[1] The authors refer to lorry drivers as being "easy prey for commercial sex workers." This choice of words denounces sex workers as the pernicious culprits who hunt down "unsuspecting" lorry drivers. Not only does this misrepresent the dynamics of the general interaction between sex workers and their clients, but it also fosters the stigmatisation that we are struggling to abolish.

It is imperative that representatives of the medical and health professions realise that the words we choose become driving forces for change and can be critical in creating an environment that does not tolerate stigmatisation of risk groups for any disease. An important place to start would be to ensure that there is no tolerance of articles containing such discriminatory language, least of all in our leading medical journals.

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1 Rao KS, Pilli RD, Rao AS, Chalarn PS. Sexual lifestyle of long distance lorry drivers in India: a questionnaire survey. *BMJ* 1999;318:162-3. (16 January.)

Careers article on psychotherapy was not balanced

Editor—Key and Dare's article on psychotherapy failed to do justice either to an emerging medical speciality or to the broader profession of psychotherapy.[1] Instead, it was an account of the relation between the conservative psychoanalytical training and the medical profession. It might more accurately have been entitled "doctors training as psychoanalysts in greater London."

The most politically telling factor was the omission of reference to the UK Council for Psychotherapy, or its register of psychotherapists, which lists 4500 practitioners from a variety of backgrounds including cognitive behaviour.[2] Instead, the authors present the smaller British Confederation of Psychotherapist's register as "the" register of psychotherapists without indicating that it is maintained by one of two parties to a bitter political split. The British Confederation of Psychotherapy registers members of a few select psychoanalytical organisations and is opposed to a unified profession. Given the bitterness of the disagreement the omission cannot be a simple oversight but an attempt to establish the legitimacy of one body rather than another in the minds of readers.

The piece almost disregards an important and developing specialty within medicine. Stewart-Brown recently and eloquently described some of the areas medical psychotherapists (as well as liaison psychiatrists) address.[3] Medical psychotherapy also provides for those with severe personality dysfunction, who present disordered help seeking behaviour to all specialties.

There is now a broad specialist registrar training, embracing several methods of therapy, with relevance to all branches of medicine, both primary and secondary. Psychotherapy services have been established which attend to the needs of communities.[4] These work creatively with limited resources to address the long neglected emotional contributions to both physical and psychiatric illness and offer achievable treatment approaches for the many rather than highly intensive experiences for the few.

It is a pity that this broader perspective was lost in Key and Dare's article. Psychotherapy is indeed a rich and rewarding speciality for doctors, but its modern, service based context was not done justice by them.

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1 Key A, Dare C. Psychotherapy [career focus]. *BMJ* 1999;316:2-3. (http://classified.bmj.com/careerfocus/7177cf.htm)
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Vulvodynia is important cause of vulval pain

Editor—Although Butcher's review of female sexual problems discusses the causes of superficial vulval pain,[1] it omits to mention vulvodynia—in our experience an important cause of vulval pain and superficial dyspareunia.[2 3] The International Society for the Study of Vulvar Disease defines vulvodynia as chronic vulvar discomfort, especially that characterised by the patient's complaint of burning, stinging, irritation, or rawness.[4]

Dysaesthetic vulvodynia is thought to be an abnormal pain syndrome analogous to trigeminal neuralgia and postherpetic neuralgia.[5] Physical examination gives essentially normal results, with no evidence of vestibulitis. The most successful treatment is low dose amitryptiline, starting at 10 mg daily and increasing to a maximum of 75 mg daily in conjunction with 5% lignocaine gel.[5]

Patients with superficial vulval pain should be assessed in a specialist vulval clinic, as vulvodynia is otherwise often not recognised.

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1 Butcher J. Female sexual problems II: sexual pain and fears. *BMJ* 1999;318:110-2. (9 January.)
2 Harrington CI. Vulvodynia. *Dermatol in Pract* 1990;June/July:18-21.
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Medical examiners employed by health authorities should audit death certificates

Editor—Horner may be right that there is an impending crisis in recruiting medical referees to crematoria, but I disagree with his assertion that abandoning the present system would be hazardous.[1] Presumably

the hazard is failing to detect a homicide, but the Brodrick committee concluded in 1971 that "secret homicide has not been a significant danger at any time in the past 50 years."[2]

After 10 years' experience as the medical referee to a large crematorium I have no confidence that I could detect a secret homicide from the certificates B and C, despite considerable efforts to ensure that the forms are completed fully. I do not see my role as undertaking medical audit, nor do I consider that the forms give enough information for standards of medical care to be assessed. I strongly support the Brodrick committee's recommendations that an improved death certificate would be adequate to allow either cremation or burial, subject to the existing requirements to report certain deaths to the coroner.

Roughly £32 million is spent each year in England and Wales on medical fees for cremation certificates and coroners' post-mortem examinations. This sum should be used more effectively, and a different system might well contribute to clinical governance as well as monitoring hazards and providing adequate mortality statistics. I would favour the establishment of medical examiners employed by a health authority to monitor and audit death certificates and to provide advice to coroners, health authorities, and other relevant organisations. A team of examiners should comprise clinicians and pathologists and could provide a service over a wide area. The team would also be better qualified to interpret medical information for coroners than the present coroners' staff, who are usually police officers.

Various relevant authorities investigate road traffic, industrial, and aviation accidents etc; the role of coroners in the small proportion of fatal events seems open to question. The present historical arrangements need changing from a legally based system to one in which monitoring health and health services takes a higher priority.

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1 Horner S. Crisis in cremation. *BMJ* 1998;317:485-6.
2 Home Office. *Report of the committee on death certification and coroners.* London: HMSO, 1971. (Cmnd 4810.)

Advice to authors

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Trauma related shin splints

Shin splints are symptoms, not a diagnosis

EDITOR—Macleod et al's comment that bone scans were abnormal if stress fractures or shin splints were present[1] is inaccurate. Shin splints are a clinical feature (posteromedial tibial pain and tenderness) rather than a diagnosis.

Isotope bone scanning forms part of the investigation of tibial pain. The three commonest causes of such pain are stress fracture; periostitis near the origin of the flexor digitorum longus or soleus, or both; and chronic exertional compartment syndrome. These give rise to different findings on isotope bone scanning: localised increased uptake (stress fracture), linear streaking over the posteromedial tibia (periostitis), and essentially normal findings (chronic exertional compartment syndrome).

Clinical assessment is essential for differentiating between these three conditions, and isotope bone scanning undoubtedly plays a part in this assessment. Taking the findings of such scanning in isolation, however, is flawed.

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1 Macleod MA, Houston AS, Sanders L, Anagnostopoulos C. Incidence of trauma related stress fractures and shin splints in male and female army recruits: retrospective case study. *BMJ* 1999;318:29. (2 January.)

Author's reply

EDITOR—In common with most imaging specialists, we tend to use Holder and Michael's findings to define shin splints. They found localised abnormal uptake in the middle and distal thirds of the posteromedial aspect of the tibial cortex in nine of 10 patients being investigated for shin splints.[1] This appearance in bone scintigrams has been confirmed by others[2–4] and has led to the term shin splints being used as a synonym for and definitive indication of periostitis, with bone involvement being a precursor of stress fractures.

Ashford may well be right in a narrow sense, but the term shin splints is now used, along with a plethora of synonyms, signs, and symptoms,[5] to describe intermittent pain in the lower extremities associated with a specific scintigraphic appearance.

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1 Holder LE, Michael RH. The specific scintigraphic pattern of 'shin splints' in the lower leg. *J Nucl Med* 1984;25:865-9.
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All GPs have problems when they first start in practice

EDITOR—Easterbrooke, a locum general practitioner, finds it almost impossible to complete a modern consultation in the short time allocated.[1] I sympathise and have written him this letter.

Dear Jonathan,

I completely understand your view. When I first started general practice 10 years ago my average consultation time was 14 minutes. I overran, always missed my coffee breaks, and found it difficult to understand how the other partners coped. Ten years on it is very different. I have discovered that it is neither possible nor useful to try to cover everything in one consultation. In addition, I have several hours' knowledge under my belt for almost all my patients and now know that Mr Jones gets backache when his teenage son comes home; that Mrs Franks does not want me to get her headaches better but just to acknowledge what an awful life she has; and that when Mrs Bloggs says she's a little worried about one of the twins you drop everything and go.

I have found that I have help and support from the rest of the team. The health visitor can sort out the feeding problem that I'm probably not really qualified to advise on; our practice nurse is far better at knowing what travel immunisations are needed for Tibet; and our receptionist is like a terrier when it comes to finding results. I don't overrun much now. I discuss with the patients how many consultations we will need to sort out their six problems. I might examine them in one consultation and see them for another to explain what irritable bowel is. I only see patients with controlled hypertension once a year, and our nurses see more and more patients for me.

You will have a difficult time when you first join a practice. You need to get to understand your patients' language, their worries and background. You will want to alter their drug treatment from old fashioned frusemide to an angiotensin converting enzyme inhibitor; you might want to challenge some diagnoses; and you will certainly want to stop all that prescribing of non-steroidal anti-inflammatory drugs. A whole cohort of patients will come out of the woodwork hoping that you will at last have the answer for their pruritus ani, migraine, and annoying wind.

Give yourself breaks every hour, talk about difficult patients to the partners (they will have been in the same boat), don't compromise your medicine, but at the same time don't practise it quite so hard.

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1 Easterbrooke J. The emperor has no clothes on. *BMJ* 1999;318:173. (13 February.)