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LETTERS

THE PRESCRIPTION OPIOID CRISIS

How to tackle it

SPL

Dhalla and colleagues show that we need to face up to a prescription opioid crisis in chronic pain.[1] Opioid treatment is, however, well established, and we would have welcomed their views on how individual clinicians should treat this group of patients. We offer simple dos and don'ts based on the actions and behaviours we see every week:

(1) Be familiar with national and international guidelines on strong opioids in chronic pain[2]
(2) Develop local polices and protocols to monitor and enforce an agreed best practice for your area
(3) Consider restricting who prescribes long term opioids to experienced clinicians and the number of opioids that are available to be prescribed: familiarity increases safety
(4) Remember that whatever a pharmaceutical representative or colleague tells you no opioid has clearly shown itself superior to another
(5) Do not rush to try a new product simply because it is new and other treatments have failed
(6) Never prescribe a strong opioid in a clinic and discharge the patient at the same appointment: this is bad practice
(7) Do not prescribe more than one opioid to an individual patient—a long acting formulation is preferable
(8) Remember that not all patients will respond to strong opioids. If they don't work stop prescribing them. Don't keep increasing the dose hoping it will work: only the side effects will increase
(9) Set a limit to the maximum dose of opiate that you are prepared to prescribe. Opioids seem to have a limited "ceiling effect" in chronic pain of a 10-30% reduction of pain
(10) Be prepared to reduce the dose in the face of side effects or to stop opioid treatment in patients in whom the side effect to benefit ratio is poor.

Banning a single opiate such as oxycodone would not solve the prescription opioid crisis in the same way that arresting a drug dealer would not solve a drug problem. Oxycodone's pushers may have a lot to answer for but banning the drug would achieve nothing.

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Competing interests: None declared.

1 Dhalla IA, Persaud N, Juurlink DN. Facing up to the prescription opioid crisis. *BMJ* 2011;343:d5142. (23 August.)
2 British Pain Society. The British Pain Society's opioids for persistent pain: good practice. 2010. www.britishpainsociety.org/book_opioid_main.pdf.

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COGNITIVE ASSESSMENT IN ELDERLY

Routine test batteries may not be cost effective

Young and colleagues provide guidance on assessing cognitive impairment in older people, including the use of a battery of tests to establish the underlying cause.[1] The value of such exhaustive test batteries, however, is not well validated.

Brodaty tested consecutive patients attending a memory disorders clinic.[2] No patient had "significant relevant abnormalities" identified. Equivocal abnormalities of low vitamin B12, folate, and thyroid function were each identified once in 13 patients. In no patients did treatment affect the course of cognitive decline. Computed tomography and electroencephalography seemed to have greater yield. Siu also found that, in the absence of evidence of deficiency, the yield of measuring vitamin B12 in patients with a normal full blood count was minimal.[3] VDRL testing was also of minimal value.

Another study found blood counts, thyroid function, calcium, and glucose valuable in assessing patients with dementia.[4] Unselected vitamin B12 testing cost $6426 (£4117; €4752) per diagnosis of vitamin B12 deficiency. Testing only patients with abnormal full blood counts reduced this to $2260.42 without affecting sensitivity. Folate deficiency was seen mainly in patients with abnormal blood counts; those with normal blood counts and low folate did not benefit from treatment. They estimated the cost of using exhaustive test batteries to assess 3 million people at $2.1-3bn, or $450-630 million for more selective testing.

This highlights the need to consider the yield of each test in the patient being assessed. Rates of diagnosis are similar for tailored testing rather than unselected test batteries, but costs are much lower.

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Competing interests: None declared.

1 Young J, Meagher D, MacLullich A. Cognitive assessment of older people. *BMJ* 2011;343:d5042. (7 September.)
2 Brodaty H. Low diagnostic yield in a memory disorders clinic. *Int Psychogeriatr* 1990;2:149-59.
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4 Larson E, Reifler BV, Sumi SM, Canfield CG, Chinn NM. Diagnostic tests in the evaluation of dementia—a prospective study of 200 elderly outpatients. *Arch Intern Med* 1986;146:1917-22.

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FALL ASSESSMENT IN OLDER PEOPLE

Screening for falls may not be cost effective

Raising awareness of fall prevention is important because falls are common, serious, and costly.[1]

However, evidence for systematic screening for fall risk and intervention in people at high risk is limited. Screening and intervention may be clinically effective—a recent randomised controlled trial found a stratum adjusted incidence rate ratio of 0.86 (95% confidence interval 0.73 to 1.01; P=0.08) and 0.73 (0.51 to 1.03; P=0.07) when adjusted for baseline characteristics in favour of a fall prevention programme for community dwelling older people at high risk of falls.[2] It does not seem to be cost effective, however; the same study found an estimated incremental cost effectiveness ratio of £3320 (€3830; $5180) per fall averted.[3]

Such an exercise is unlikely to be affordable on a widespread scale, especially in a cost constrained NHS. Recommendations on screening should be tempered until more robust evidence is available.

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Competing interests: SPC is an active researcher in the field.

1 Close JCT, Lord SR. Fall assessment in older people. *BMJ* 2011;343:d5153. (15 September.)
2 Conroy S, Masud T, Coupland C, Drummond A, Gladman J, Harwood R, et al. A multicentre RCT of a day hospital falls prevention programme for community dwelling older people. *Age Ageing* 2010;39(S1):i33.
3 Irvine L, Conroy SP, Sach T, Gladman JRF, Harwood RH, Kendrick D, et al. Cost-effectiveness of a day hospital falls prevention programme for screened community-dwelling older people at high risk of falls. *Age Ageing* 2010;39:710-6.

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ISLAMIC MEDICAL ASSOCIATION

Some light on Islam and medical practices

Regarding your recent article on the Islamic Medical Association,[1] I would like to shed light on an alternative Islamic viewpoint on the permissibility of vaccines and drugs containing gelatine derived from porcine products.

Islam, unlike many other "organised" religions, has no organised central clergy, with religious edicts and rulings emerging through discourse between qualified religious experts and the laity, who are encouraged to seek their advice and accept rulings on the basis of the strength of the argument proposed by a scholar. It is from this continual discourse that a dynamic religious authority has historically emerged and dealt with the pressing issues of any particular time. Not unlike modern medical practice, orthodoxy emerges from a plurality of opinions presented by scholars, and fortunately for "lay Muslims" such as myself, there is often substantial agreement between scholars.

The Islamic Organisation for Medical Sciences, featuring the most highly qualified Islamic scholars from across the world, concluded in 1995 that gelatine produced from porcine skin, bones, and tendons contained within drugs was "halal" (permissible), on the basis that the porcine products are transformed through the production process, and can no longer be thought of as their original constituent parts. This view has been endorsed and disseminated by the World Health Organization.[2]

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Competing interests: IM is interested in a plurality of viewpoints.

1 Cassidy J. Islamic Medical Association. *BMJ* 2011;343:d5592. (7 September.)
2 WHO. EDB.7/3. 2001. www.immunize.org/concerns/porcine.pdf.

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ZOONOSIS IN VETERINARY PRACTICE

Necrosis from needlestick injury with live porcine vaccine

Actinobacillus pleuropneumoniae causes porcine pleuropneumonia, a highly infectious and commonly lethal disease in pigs.[1] It is present in porcine respiratory tract wherever pig production is industrialised, but it is not considered to be zoonotic.[2] To our knowledge, no cases of infection have been reported in animals other than pigs or in humans, including abattoir and farm workers. Vaccinating pigs against pleuropneumonia is an important aspect of controlling the disease and may be improved by the use of live attenuated vaccines of mutant *A pleuropneumoniae*,[3 4] which are considered safe because the wild type strains are not known to be zoonotic.

Gangrenous necrosis after accidental needlestick infection of thumb with *Actinobacillus pleuropneumoniae* 14 days after inoculation

We report the effects of an accidental needlestick inoculation of *A pleuropneumoniae* by an experienced veterinary surgeon while he was injecting pigs subcutaneously with live mutant vaccine. After an unexpected kick from an animal, he injected around 1 mµL of the vaccine into the back of his right thumb. The pad became swollen within 90 minutes. Treatment at the local hospital with oral amoxicillin was ineffective. After 10 hours the lesion had grown and become dark purple, and he was admitted with moderate to severe pain. After 24 hours he was transferred to a major infectious diseases centre and a bilateral escharotomy performed to relieve pressure and allow drainage. He was treated with intravenous amoxicillin, meropenem, and clindamycin; leeches were also used.

Treatment was effective, but during healing his thumb became necrotic (figure). Plastic surgery was necessary on three occasions to replace the skin and underlying tissues. After 6-7 months the outcome was satisfactory with some loss of feeling in his thumb.

The direct injection of *A pleuropneumoniae* into tissue seems to have caused a compartment syndrome with severe local effect. The potential for human injury when giving these animal vaccines may be greater than has been thought.

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Competing interests: None declared.

Patient consent obtained.

1 Chiers K, De Waele T, Pasmans F, Ducatelle R, Haesebrouck F. Virulence factors of Actinobacillus pleuropneumoniae involved in colonization, persistence and induction of lesions in its porcine host. *Veterinary Research* 2010;41:65-80.
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A FEW FEARS FELT USING FACEBOOK

Is it time for medicine to update its Facebook status?

Facebook focuses on, "Giving people control over their experience so they can express themselves freely while knowing that their information is being shared in the way they intend."[1] This ethos relies on members having the correct perception of how their information is shared, as is shown by the privacy problems experienced by practising doctors.[2]

After several adverse experiences we developed an interest in this area and designed a cross sectional survey to assess the use of Facebook and privacy settings by 42 medical students, 20 foundation trainees, and 20 senior staff (registrars or consultants). We also analysed awareness of current guidelines (university, NHS, and General Medical Council) and perceptions of online exposure.

All students and foundation trainees had Facebook accounts compared with six (30%) senior staff. Of those with accounts, 17 (41%) students had a public "info page" compared with 15 (75%) trainees and three (50%) senior staff. Thirty seven (88%) students reported viewing colleagues acting unprofessionally online compared with 16 (80%) trainees and no senior staff. Thirty two (76%) students, 18 (90%) trainees, and two (33%) senior staff thought that their professional integrity was compromised by using Facebook. Strikingly, only 11 (26%) students, 10 (50%) trainees, and no senior staff were aware of any guidelines specific to Facebook.

Facebook therefore poses a threat to professionalism at all career levels. The generation gap we identified poses the question of whether senior professionals are the best placed to produce informed guidance. Social networking websites are mainly used by younger people, who better understand their importance in modern society. Professionals at all career levels must therefore be involved in producing universally acceptable guidelines.

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Competing interests: None declared.

1 Facebook. Factsheet. 2011. www.facebook.com/press/info.php?factsheet.
2 Fenton CH. A few fears felt using Facebook. *BMJ* 2011;343:d5619. (13 September.)

Cite this as: *BMJ* 2011;343:d6334