GUIDELINES

Longer term management of self harm: summary of NICE guidance

Tim Kendall,[1 2 3] Clare Taylor,[1] Henna Bhatti,[1] Melissa Chan,[1] Navneet Kapur,[4 5] On behalf of the Guideline Development Group

[1]National Collaborating Centre for Mental Health, Royal College of Psychiatrists, London E1 8AA, UK
[2]University College London (Clinical, Educational and Health Psychology), London WC1E 7HB
[3]Sheffield Health and Social Care NHS Foundation Trust, Sheffield S10 3TH, UK
[4]Centre for Suicide Prevention, Centre for Mental Health and Risk, University of Manchester, Manchester M13 9PL, UK
[5]Manchester Mental Health and Social Care Trust, Manchester M21 9UN, UK
Correspondence to: Professor T Kendall, National Collaborating Centre for Mental Health tim2.kendall@virgin.net

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This is one of a series of *BMJ* summaries of new guidelines based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

Further information about the guidance, a list of members of the Guideline Development Group, and the supporting evidence statements are in the full version on bmj.com.

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- Diagnosis and management of colorectal cancer (*BMJ* 2011;343:d6751)
- Hyperglycaemia in acute coronary syndromes (*BMJ* 2011;343:d6646)
- Recognising and diagnosing autism in children and young people (*BMJ* 2011;343:d6360)
- Antenatal care for twin and triplet pregnancies (*BMJ* 2011;343:d5714)

Self harm is common but its prevalence may be underestimated because many studies rely on self report. In a study of 17 countries an average of 2.7% of adults reported self harm.[1] A survey in the United Kingdom of 15-16 year olds estimated that more than 10% of girls and 3% of boys had self harmed in the previous year.[2] Self harm and psychiatric disorder are strongly associated.[3 4] Importantly, once a person has self harmed, the likelihood that he or she will die by suicide increases 50 to 100 times,[5 6] with 1 in 15 dying by suicide within nine years of the index episode.[7] The UK suicide rate is 17.5 for males and 5.2 for females per 100 000 population,[8] which is nearly 10 times the homicide rate. Understanding and helping people who self harm is therefore likely to be an important part of an effective suicide prevention strategy.

This article summarises the most recent recommendations from the National Institute for Health and Clinical Excellence (NICE) on the longer term management of self harm.[9] This guideline is intended to complement the earlier NICE guideline on the short term management of self harm (treatment within the first 48 hours after an episode of self harm).[10]

Recommendations

NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group's experience and opinion of what constitutes good practice. Evidence levels for the recommendations are in the full version of this article on bmj.com.

General principles of care

- When working with people who self harm:
  - Aim to develop a trusting, supportive, and engaging relationship
  - Be aware of stigma and discrimination sometimes associated with self harm and be non-judgmental
  - Ensure that people are fully involved in decision making about their treatment and care
  - Aim to foster people's autonomy and independence whenever possible
  - Maintain continuity of therapeutic relationships whenever possible
  - Ensure that information about self harm is communicated sensitively to other team members.

Psychosocial assessment in community mental health services and other specialist mental health settings

- Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self harm, and initiate a therapeutic relationship.
- Assessment of needs should include:
  - Skills, strengths, assets, and coping strategies
  - Mental and physical health problems or disorders
  - Social circumstances and problems
  - Psychosocial and occupational functioning, and vulnerabilities
  - Recent and current life difficulties, including personal and financial problems
  - The need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
  - The needs of any dependent children.
- When assessing children and young people who self harm, follow the same principles as for adults (above), but also include a full assessment of their family, social situation, and child protection issues. [*Based on the experience and opinion of the GDG*]
- When assessing the risk of repetition of self harm or risk of suicide, identify and agree with the person the specific risks for them, taking into account:
  - Methods and frequency of current and past self harm
  - Current and past suicidal intent
  - Depressive symptoms and their relationship to self harm
  - Any psychiatric illness and its relationship to self harm
  - The personal and social context and any other factors preceding self harm, such as specific unpleasant affective states or emotions and changes in relationships
  - Specific risk factors and protective factors (social, psychological, pharmacological, and motivational) that may increase or decrease the risks associated with self harm
  - Coping strategies that the person has used either to successfully limit or avert self harm or to contain the impact of personal, social, or other factors preceding episodes of self harm
  - Important relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
  - Immediate and longer term risks.
- Do not use risk assessment tools and scales to predict future suicide or repetition of self harm because the modest predictive value of those currently available makes them of limited usefulness in clinical practice.

Care plans

- Discuss, agree, and document the aims of longer term treatment in the care plan with the person who self harms. These aims may be to:

  - Prevent escalation of self harm
  - Reduce harm arising from self harm or reduce or stop self harm
  - Reduce or stop other risk related behaviour
  - Improve social or occupational functioning, quality of life or any associated mental health conditions.
- Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than one year.
- Care plans should be multidisciplinary and developed collaboratively with the person who self harms and his or her family, carers, or significant others. Care plans should:
  - Identify realistic and optimistic long term goals, including education, employment, and occupation
  - Identify short term treatment goals (linked to the long term goals) and steps to achieve them
  - Identify the roles and responsibilities of any team members and the person who self harms
  - Include a jointly prepared risk management plan
  - Be shared with the person's general practitioner.

Risk management plans

- A risk management plan should be a clearly identifiable part of the care plan and should:
  - Outline how to deal with each of the long term and more immediate risks identified in the risk assessment
  - Outline how to deal with the specific factors (psychological, pharmacological, social, and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self harm and/or the risk of suicide
  - Include a crisis plan outlining self management strategies and how to access services during a crisis when self management strategies fail
  - Ensure that the risk management plan is consistent with the long term treatment strategy.
- Inform the person of the limits of confidentiality and that information in the plan may be shared with other professionals.

Interventions for self harm

- Consider offering three to 12 sessions of a psychological intervention that is specifically structured for people who self harm with the aim of reducing self harm. The intervention should be tailored to individual need and could include cognitive behavioural, psychodynamic, or problem solving elements. Therapists should be trained and supervised in the therapy they are offering and be able to work collaboratively with the person to identify the problems causing distress or leading to self harm.
- Do not offer drug treatment as a specific intervention to reduce self harm.

Treating associated mental health conditions

- Provide psychological, pharmacological, and psychosocial interventions for any conditions associated with self harm—for example, the following conditions covered by published NICE guidance:
  - Alcohol use disorders[11]
  - Depression[12]
  - Schizophrenia[13]
  - Borderline personality disorder[14]
  - Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52)[15 16]
  - Bipolar disorder.[17]

Overcoming barriers

Services for people who self harm vary considerably.[18] In some, liaison psychiatrists provide a comprehensive treatment programme and train other healthcare professionals. Others may be limited to an emergency department and community mental health teams with no self harm training. Possible reasons for poor services include limited resources, lack of an evidence base for treatments, and the unpopularity of this group of service users among some clinical staff.[19] People who self harm often report negative responses from staff in mental health services; primary and secondary physical healthcare; and particularly in emergency departments. This may be linked to professionals' lack of understanding of self harming behaviour.[20] A poor healthcare experience may prevent people from seeking help if they self harm in the future.[21]

Young people who self harm often come to the attention of school teachers and young people's health advisers. Although these staff often receive training in how to deal with disclosures about self harm from young people, this aspect of work causes concern among staff, who often request further training from local healthcare professionals.

This guideline is intended to increase awareness and knowledge of self harm among frontline staff and service providers and lessen stigma, thereby reducing important barriers that prevent service users from receiving appropriate care. Although the evidence base is limited, the guideline will help inform better longer term management for people who self harm, enable increased access to psychological treatment, and reduce the harm that services can sometimes inflict, in terms of both inappropriate prescribing (see the "Further information" box in the full version of this article on bmj.com) and the discrimination and stigmatisation of people who self harm.

As a major factor in completed suicide, self harm can no longer be regarded as a marginal or shameful behaviour in people using mental health and other healthcare services.

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PRACTICE POINTER

Persistent vaginitis

Gayle Fischer,[1] Jennifer Bradford[2]

[1]University of Sydney, Sydney Medical School, PO Box 4028, Royal North Shore Hospital, LPO, St Leonard's, New South Wales, Australia
[2]University of Western Sydney, Campbelltown, Australia
Correspondence to: G Fischer
gayle.fischer@sydney.edu.au

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Persistent vaginitis can be a challenging problem in general practice. We review the steps to accurate diagnosis and effective treatment

A 36 year old woman visits her general practitioner complaining of a six month history of vaginal soreness, itch, discharge, dyspareunia, and painful postcoital vulval swelling. Her symptoms are worse premenstrually and improve during menstruation. She reports that she has had recurrent "thrush" since her mid-20s, precipitated by courses of antibiotics, and has successfully self medicated with intravaginal miconazole. These episodes have gradually become more frequent, and recently her symptoms failed to resolve with over the counter antifungals. Although she had been known to have positive swabs for *Candida albicans* in the past, recent swabs and vaginal microscopy had been persistently negative. She is healthy and does not have diabetes, and her only medication is the oral contraceptive pill with 30 µg oestrogen. A trial of pill cessation did not improve her problem. She is very embarrassed about this problem and, when asked, she volunteers that she is worried that she may have somehow contracted genital herpes or cancer. Examination shows a confluent, oedematous vulvovaginitis extending to the labia majora, with associated fissuring; erythema of the perineum; and erythema of the vagina.

In this article we explore the features of persistent vaginitis and suggest recommendations for managing the condition.

Methods

We assessed previous publications on persistent vaginitis, including several from our group. We conducted a literature search using Medline and PubMed databases up to August 2011. We found few systematic reviews and randomised controlled trials and cohort studies on persistent vaginitis; however, we also selected several well conducted and convincingly reported case series and narrative reviews by respected authors. Our suggestions in this article are based on these publications and on our own clinical experience in a large dermatogynaecology practice.

What is persistent vaginitis?

Vaginitis is inflammation of the vaginal epithelium evidenced by erythema, discharge, or other changes, such as erosions (loss of epithelium). Infection is the most common cause, but there are less common, non-infective causes (box). Vaginitis may occur in isolation or be associated with a dermatosis of the mucosal surface of the labia minora, the vulva, and/or perianal skin. Persistent vaginitis occurs when this symptomatic inflammation either recurs after, or is resistant to, initial treatment. Many of

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- Managing Parkinson's disease during surgery (*BMJ* 2010;341:c5718)

Differential diagnosis of chronic vulvovaginitis

Common
- Recurrent vulvovaginal candidiasis: defined as four attacks a year[1]; however, some patients' candidiasis is more indicative of a chronic continuous process[2 3]
- Recurrent bacterial vaginosis
- Contact dermatitis (allergic and irritant contact): caused by intravaginal pessaries and creams (usually obvious on history[4])

Uncommon
- Desquamative inflammatory vaginitis: an uncommon, non-infective, painful vaginitis of unknown cause characterised by shiny erythematous patches and/or petechiae[3 5]
- Intravaginal foreign body (eg, retained tampon): a cause of persistent vaginitis with a heavy discharge
- Chronic fixed drug eruption: an erosive vulvovaginitis most often associated with non-steroidal anti-inflammatory drugs and statins
- Type 1 hypersensitivity reactions: itch, burning, swelling, and even anaphylaxis can result from exposure to latex condoms and seminal fluid[6]

Rare
- Mucosal lichen planus: a skin disease that often involves the oral as well as the vaginal mucosa with very painful erosions that may eventually lead to scarring[7 8]
- Oestrogen hypersensitivity vulvovaginitis: a cyclical vulvitis with a presentation closely similar to that of recurrent candidiasis but not causally associated with candida[9]

Very rare
- Crohn's disease: a cause of vulvovaginitis[10]
- Immunobullous disease: erosive vaginal involvement without generalised skin disease may occur, particularly in cicatricial pemphigoid[11 12]
- Graft versus host disease: a vulvovaginitis indistinguishable from lichen planus[13]

the causes of persistent vaginitis are rare and may not be familiar to the general practitioner (box).

Most presentations of vaginitis in general practice are acute—that is, of sudden onset and short duration. Most vaginitis is the result of acute candidiasis or bacterial vaginosis, diagnosable by vaginal swab, microscopy, culture, and pH level and treatable with a prompt short course of antifungal or antibiotic medication.[1 14] In practice these patients are often treated empirically. In this article we will not cover the sexually transmitted causes of vaginitis as they are not a cause of persistent symptoms.

Persistent vaginitis is less common than acute vaginitis and is often perplexing for the clinician. For the patient, it can be the cause of enormous misery, anxiety, sexual guilt, and even relationship breakdown. There are three patterns: recurring attacks, chronic unremitting symptoms, or symptoms that are chronic but worsen at certain times of the menstrual cycle. The main differentiating feature between acute and chronic disease is duration of symptoms and rapid recurrence after treatment. A systematic review has shown that, taken individually, symptoms, signs, and tests are poor predictors of the cause of vaginitis.[15]

History taking in persistent vaginitis

Symptom	Observed changes	Onset	Course	Medications
Itch	Discharge	Sudden	Duration	Prescribed
Soreness	Swelling	Insidious	Recurrent	Over the counter
Burning	Fissuring	Precipitating events	Continuous	Complementary
Dyspareunia	Ulcers, erosions; shrinking and scarring		Cyclical (premenstrual)	

Does the complaint of persistent vaginitis indicate disease?

A patient presenting with persistent, symptomatic vaginitis is highly likely to have a defined cause.[16] The exception is the patient who presents with culture negative heavy, non-offensive discharge in the absence of other symptoms and signs. This is a normal variant.

The differential diagnosis of persistent vulvovaginitis is not long (box). The list is based on our published observations[17] and shows relative prevalence in our own tertiary practice, although no published studies record prevalence in general practice.

In most patients, chronic persistent vulvovaginitis is not a sign of systemic illness or infection. Of all of the conditions listed in the box, only recurrent candidiasis and bacterial vaginosis are causally related to specific micro-organisms. With the exceptions of lichen planus, immunobullous disease, and Crohn's disease (which have defined histopathology), none are diagnosable by biopsy and a previous study has shown that biopsy is not reliable for lichen planus.[8]

The causes of these conditions differ greatly, and an accurate diagnosis is therefore essential for rational management.

History

A detailed and specific history is essential for making a diagnosis (table) Historical triggers can be critical for a correct diagnosis, especially for contact dermatitis,[4] type 1 hypersensitivity reactions,[6] and fixed drug eruptions.[18] Vaginal surgery may trigger desquamative inflammatory vaginitis,[17] and both candidiasis and desquamative inflammatory vaginitis can be exacerbated by antibiotic use and contraceptive pills with high oestrogen content.[1 17] Events that exacerbate symptoms are also useful to know about—for example, the tendency of candidiasis to worsen in the premenstrual phase of the menstrual cycle.[1]

Examination

Several diagnoses may also affect the external genital skin (for example, candidiasis (fig 1), fixed drug eruption (fig 2), lichen planus (fig 3), Crohn's disease (fig 4), or precipitate reactive external dermatosis (fig 5)). Any vaginitis may trigger genital psoriasis as a result of the Koebner phenomenon in predisposed individuals.[16]

Examination of female genital skin is very difficult because of the great variation in texture and colour and because the clinical signs of dermatosis may be far more subtle in this area than on other parts of the skin.

External examination

- First inspect the labia minora and majora for erythema, oedema, and scale, and note whether erythema is accentuated in the sulcus between them, which may indicate candidiasis. Loss of the labia

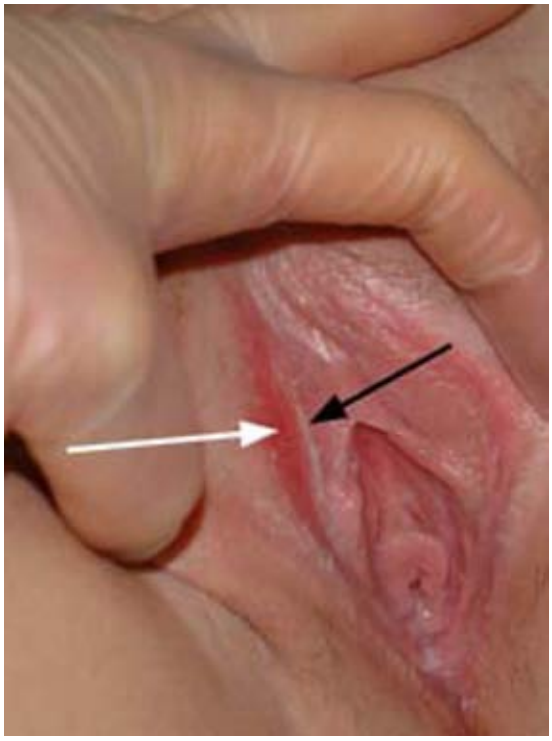

Fig 1 | Vulvovaginal candidiasis with non-erosive vaginitis, discharge (black arrow) and extension to the vulval and perineal skin with accentuation in the sulcus between the labia major and minora (white arrow)

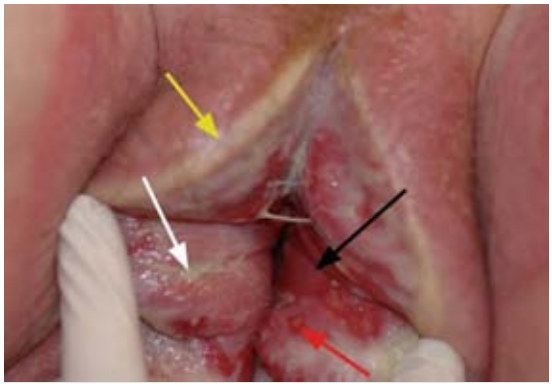

Fig 2 | Chronic fixed drug eruption showing complete loss of vaginal epithelium (black arrow), erosions (red arrow), and extension on to the vulva. The white arrow indicates the peeling vaginal epithelium, and the yellow arrow points to a build-up of desquamated epithelium at tips of labia majora

minora and introital fusion may be associated with lichen planus. This is also seen in lichen sclerosus, but the latter does not involve the vagina.

- Look for fissures on the introitus, perineum, or perianal skin; these are common in candidiasis.[16]
- Inspect the mucosal surface of the introitus: look for confluent erythema or the petechial lesions typical of desquamative inflammatory vulvovaginitis.[17]
- Look for erosions that might indicate a fixed drug eruption, erosive lichen planus, or immunobullous disease.[5 7 11 12 18 19] It is rare to see intact blisters as they rapidly erode in this location; nonetheless, they should be sought.
- Perform a general skin and, particularly, oral examination to look for other signs of lichen planus, such as a reticulate white eruption on the buccal mucosa.

Speculum examination (if possible)

- Note if the inflammation is confluent or patchy: patchy inflammation (especially with petechiae) is typical of desquamative inflammatory vaginitis (fig 6) or lichen planus.
- Note the type of discharge: recurrent candidiasis may not produce the "cheesy" discharge so typical of its acute counterpart. A green discharge may indicate desquamative inflammatory vaginitis. A heavy purulent discharge is seen in lichen planus.
- Look carefully for erosions, ulcers, adhesions, or scarring, which indicate lichen planus or immunobullous disease.
- Ensure there are no intravaginal foreign bodies such as a retained tampon.[20]

Investigations and further management

Always do a vaginal swab for microscopy and culture to exclude candidiasis and bacterial vaginosis, especially if this has not been done recently. However, if the history and clinical examination are consistent with candidiasis (see case scenario), a negative swab result should not preclude a trial of antifungal medication. Although vaginal microscopy at the point of care may be useful, it is often non-specific and requires equipment, time, and a level of skill that is not available in general practice.[1] We do not usually recommend biopsy in a general practice setting. There are no other reliable and valid tests for recurrent or chronic vaginitis, and sometimes the only option is a treatment trial.[17]

If candidiasis and bacterial vaginosis have been excluded, it is usually possible, after the history and examination, to make a short list of likely diagnoses.

Contact dermatitis and type 1 hypersensitivity are confirmed by resolution of the vaginitis after cessation of the offending substance. If the patient has erosive vaginitis and is taking a drug that has been implicated in vulval

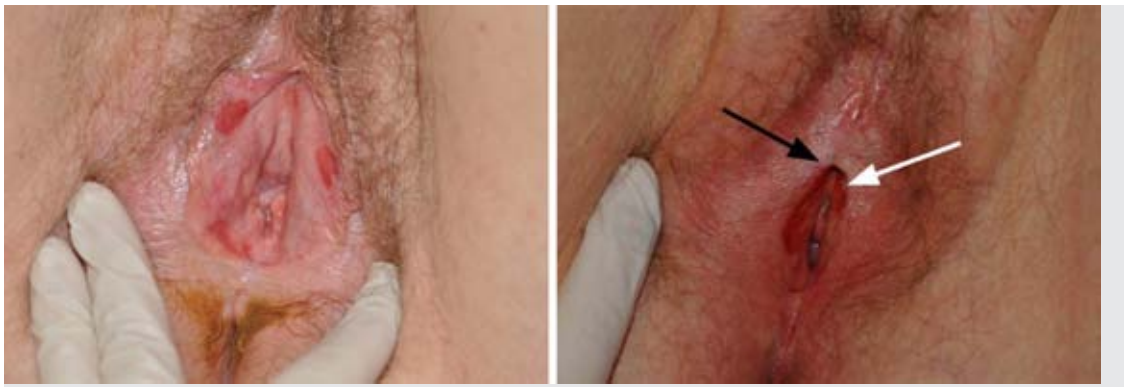

Fig 3 | Left: Erosions in lichen planus. Right: End stage lichen planus with severe scarring (black arrow) and vaginal erosion (white arrow)

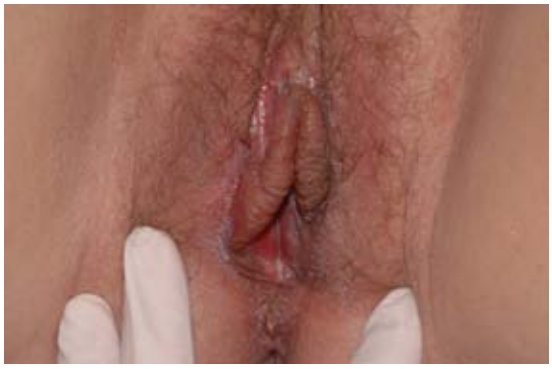

Fig 4 | Crohn's disease of the vulva showing intense oedema of the labia minora and erosion of the introital epithelium and sulcus between the labia minora and majora. The vagina is obscured by labial oedema

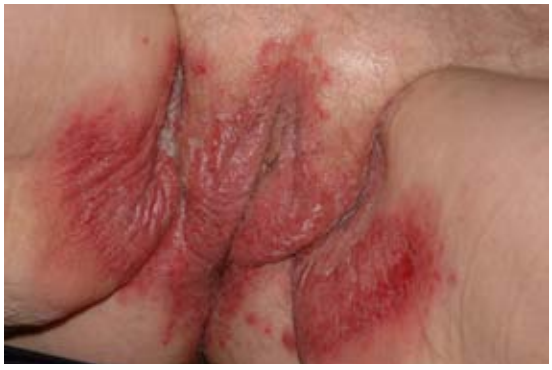

Fig 5 | Acute contact dermatitis from topical antifungal medication showing extension to the vulva with intense oedema, erythema, and erosion

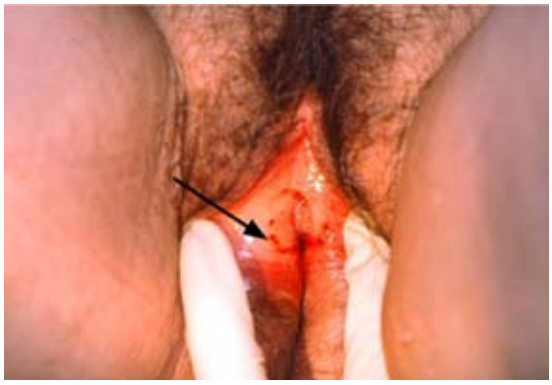

Fig 6 | Desquamative inflammatory vaginitis: characteristic petechial eruption (arrow)

fixed drug eruption, the next step is to stop the drug(s). A rapid improvement will occur within two weeks.[18 19] Rechallenge will confirm the diagnosis in one or two days.

A non-erosive vaginitis extending only to the labia minora, particularly if patchy or petechial, may indicate desquamative inflammatory vaginitis.[5 17] This is a clinical diagnosis confirmed by exclusion of other causes and by an adequate response to treatment .[5] A two to four week trial of intravaginal clindamycin 2% cream with 1% hydrocortisone used externally will give an adequate clinical response.[17]

If erosive vaginitis has not responded to stopping an offending drug or if the patient is not taking any drugs (including over the counter drugs such as paracetamol[19]) that are suspected of triggering the condition, then consider lichen planus or immunobullous disease and refer the patient to a specialist for biopsy, which may require immunofluorescent testing. Indeed, we recommend specialist referral for any perplexing vaginitis case: these women must receive timely and effective help to prevent even more distress.

LEARNING POINTS

A drug history, including over the counter medications, is essential to check for a chronic fixed drug eruption. Ask about use of intravaginal pessaries and creams as allergic or irritant contact dermatitis is often a cause of persistent vaginitis

Always do a vaginal swab to check for common causes, *Candida albicans*, and bacterial vaginosis; however, a negative swab result does not rule out recurrent or chronic candidiasis.

Confluent erythema or petechiae may indicate desquamative inflammatory vulvovaginitis (a non-infective, painful vaginitis of unknown cause)

Referral for specialist review and biopsy may be useful if an erosive vaginitis, unresponsive to cessation of possible allergens, is present or there is a lack of response to empiric treatment

No other reliable and valid diagnostic tests are available for many causes of chronic vaginitis, and treatment trials may sometimes be the only option—for example, if chronic candidiasis and desquamative inflammatory vaginitis are suspected

At specialist review a vulval biopsy from the edge of the erosion is indicated to rule out lichen planus. Note that this is specific but not sensitive.[8] A negative biopsy result in the presence of a strong suspicion of lichen planus warrants a trial with a potent topical corticosteroid or a short course of oral prednisone at a dose of 0.25 mg/kg a day. A good response is usually seen within four to six weeks.[21]

Outcome

This patient's recent negative results for swabs and vaginal microscopy might have been the result of her ongoing self medication with antifungal agents. Recurrent candidiasis was provisionally diagnosed, and she was prescribed a trial of oral fluconazole 50 mg a day.[16] In any chronic vulvovaginitis, advice on environmental modification—for example, avoidance of soaps, irritating topical treatment (such as antifungal creams), sanitary towels, and panty liners—and use of loose, cotton underwear will aid treatment response. She gradually became asymptomatic over the next three months. This patient is at high risk of recurrence. A randomised placebo controlled trial has shown that relapse can be prevented by weekly treatment with fluconazole, and she was subsequently prescribed fluconazole 150 mg weekly for the next six months.[22] She was warned about the potential risks of fluconazole in pregnancy and was advised to maintain effective contraception. She was given strong reassurance about the benign, non-transmissible nature of her condition.

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Corrections and clarifications

Acute altitude illnesses

The authors of this clinical review, Chris Imray and colleagues, have alerted us to an error in their article (*BMJ* 2011;343:d4943, print publication 20-27 August, pp 411-7). In figure 3 the dosage for nifedipine should be "30 mg sustained release twice daily" as stated in the main text (not "6 hourly" as we published, and which the authors had taken from their source for their adapted figure).

Target practice: choosing target conditions for test accuracy studies that are relevant to clinical practice

When redrawing the figure for this Research Methods & Reporting article by S J Lord and colleagues (*BMJ* 2011;343:d4684, print publication 10 September, pp 523-6), we misplaced the words "no action," "monitor," and "treat" on the x axis. These decisions are based on clinical factors and so should have been placed in the body of the figure. For the corrected figure see bmj.com (www.bmj.com/content/343/bmj.d6155.full).

Minerva

The affiliation given for the authors of a Minerva picture item (*BMJ* 2011;343:d5920, print publication 24 September, p 646) is incorrect; it applies only to one of the authors (Seleena Farook), and it is her current work address. The affiliation, correct for all authors at the time the picture was taken, should have read: Salford Royal NHS Foundation Trust & University Teaching Hospital, Salford M6 8HD.

Comparing bivalent and quadrivalent HPV vaccines

In the third paragraph from the end in this editorial by René H M Verheijen (*BMJ* 2011;343:d5720, print publication 1 October, pp 647-8) the author mistakenly referred to deaths instead of cases. The fourth sentence should have read: "It has been estimated that the Italian programme, which uses the bivalent vaccine, would prevent 295 more cases of cancer [not "295 more deaths from cancer"] but 25 848 fewer cases of genital warts than if it used the quadrivalent vaccine."

Management of hypertension: summary of NICE guidance

In a rapid response to this Practice article by Taryn Krause and colleagues (*BMJ* 2011;343:d4891, print publication 3 September, pp 474-6), Kate Harding and colleagues write that it "does not mention that women of child bearing potential should not be treated with either ACE inhibitors or ARBs without a detailed discussion of the teratogenic potential of these drugs, and advice to discontinue them preferably prior to conception" (www.bmj.com/content/343/bmj.d4891.extract/reply#bmj_el_269620). In reply, the authors acknowledge the omission from this summary document but point out that the full NICE guidance does contain specific recommendations on the subject (www.bmj.com/content/343/bmj.d4891.extract/reply#bmj_el_270204).

Plotting surrogate outcomes: Arrow plots show results of meta-analyses of surrogate and clinical outcomes

In this letter by Robert Badgett and colleagues (*BMJ* 2011;343:d6126, print publication 1 October, p 654), an editorial error in the graph led to the arrow for the ACCORD study being dashed. The arrow should be solid, however, because the ACCORD study showed significant increase in mortality.

Voluntary approaches work in removal of artificial trans fats

In this letter by Barbara Gallani (*BMJ* 2011;343:d6115, print publication 10 October, p 653) part of reference 1 was wrong . The reference was correct except for the elocator, which meant that it linked to the wrong article on bmj.com. The correct elocator is d5567, so the full reference should have read: "Coombes R. Trans fats: chasing a global ban. *BMJ* 2011;343:d5567, doi:10.1136/bmj.d5567. (7 September.)"

Diagnosis and management of autism in childhood

In this clinical review by Stephanie Blenner and colleagues (*BMJ* 2011;343:d6238, print publication 29 October, pp 894-9) the authorship and title of reference 4 were wrong. The correct reference is: Ronald A, Hoekstra RA. Autism spectrum disorders and autistic traits: a decade of new twin studies. *Am J Med Genet* 2011;156B:255-74.