Positioning after stroke
Here is a trial of liedownumab compared with propupizumab for the management of acute stroke. Billions of dollars hang on the efficacy of these new agents. Actually, this is not true: they cost absolutely nothing. It was just a trial of positioning the patients in bed: lie them down or prop them up. In this Australian cluster randomised trial, 11 093 patients with acute stroke (85% of the strokes were ischaemic) received care in either lying flat or sitting up, with the head elevated to at least 30° for 24 hours. There was no difference between groups in death, disability, or rates of pneumonia. How good to see a simple, well powered trial that puts a clinical question to bed. Flat out or propped up. Fair dinkum.

BRCA1 and BRCA2 mutations and cancer risk
An analysis of several databases from the UK, Netherlands, and France provides new quantification of the risk of breast or ovarian cancer in nearly 10 000 women with BRCA1 and BRCA2 mutations. The cumulative breast cancer risk to age 80 years was 72% for BRCA1 and 69% for BRCA2 carriers, and the figures for ovarian cancer were 44% and 17%, respectively. But the great value of this study lies in the detail on the time course of these risks and their relation to family history and mutation location. It’s a step towards being able to offer the individualised advice that these women badly need.

Women with abdominal aortic aneurysms fare badly
Although abdominal aortic aneurysms are four times commoner in men than women, that’s not a sufficient excuse for the relative paucity of information about the management of female AAA compared with male. A new systematic review helps to make up for that. It’s a painstaking analysis of the trials that contain enough information about the characteristics of the unruptured aneurysms to make meaningful comparisons between outcomes in women and men. They are much worse. Fewer women have aneurysms that are morphologically suitable for endovascular repair, and those who are suitable have a 30 day postoperative mortality of 2.3% compared with 1.4% in men. The overall estimate for open repair also was higher in women (5.4%) than in men (2.8%). In observational studies, the difference tends to be even greater.

A better, faster flu vaccine?
At present, influenza vaccines are made by growing viruses in eggs. Recombinant techniques produce vaccines much more quickly (within 6-8 weeks instead of six months) with haemagglutinins that are identical to those of the target viruses, and without any extraneous material. In the future it might even be possible to introduce additional protective antigens to these vaccines. That’s the sales pitch from Protein Sciences, which trialled its flu vaccine in Americans aged over 50. Their quadrivalent, recombinant influenza vaccine (RIV4) was about 30% better than the vaccine derived from eggs: 2.2% of participants got influenza as confirmed by polymerase chain reaction, compared with 3.2% in the egg based vaccine group. Personally I’d be rather blasé about such a risk difference in an ordinary flu season, but come the next lethal pandemic, I might feel differently. A tailored flu vaccine that could go into scaled production within eight weeks has to be a comforting thought.

High dose vitamin D use in US adults
While academics and guideline writers argue about the optimal dose of vitamin D, the great American public has taken matters into its own hands. The National Health and Nutrition Study for 1999-2000 showed that 0.3% of the population sample were taking vitamin D at doses above 1000 IU per day. This had risen to 18% overall by 2013-14. In fact, over a quarter of American women and 38.5% of over 70 year olds now take high dose vitamin D. The US populace doesn’t have gun control, and they soon won’t have healthcare, but they will go to their graves well saturated with calciferols.
Aural microsuction

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A 48 year old man is referred to an ear, nose, and throat (ENT) clinic. He has pain and deafness from impacted ear wax, and the use of wax softening drops and aural syringing have not improved his symptoms. You feel that aural microsuction is indicated and want to explain this procedure to the patient.

Impaction of the ear with discharge, debris, wax, or a foreign body can often result in discomfort, pain, ringing in the ear, and hearing impairment, and is a common reason for presentation to primary care services. Some commonly used methods for wax removal are detailed in the table.

Most patients with symptoms respond to aural syringing. In a small proportion of cases, this method fails to either dislodge the wax or clear the wax sufficiently to improve symptoms, particularly if the ear canal is narrow. In these cases, referral to ENT might be needed for consideration of other methods to extract wax. Aural microsuction is an alternative method of clearing the ear canal using a suction device guided by microscope visualisation. It is the most commonly used method of ear wax removal at ENT clinics.

Following microsuction, patients with wax impaction generally experience immediate relief from symptoms of deafness, pain, and pressure.

Microsuction might also be indicated for patients who have a mastoid cavity, the resultant bony defect in the ear canal that occurs after surgery for removal of infected mastoid cells. These patients require regular microsuction to avoid impaction of keratin and wax. Microsuction is also beneficial in external and middle ear infections, as removal of discharge and debris facilitates better penetration and distribution of topical drugs.

<table>
<thead>
<tr>
<th>Methods of ear wax removal</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aural syringing or irrigation (primary care)</td>
<td>A narrow jet of water is directed into the ear canal using a pressure controlled irrigation machine. Patients are generally given wax softening drops before treatment</td>
</tr>
<tr>
<td>Aural microsuction (ENT department)</td>
<td>Vacuum suction pressure is used to break up and extract impacted wax. This is performed using direct visualisation through a microscope</td>
</tr>
<tr>
<td>Probes, hooks, or forceps</td>
<td>These instruments can be inserted into the ear canal to remove wax using a microscope. They are primarily used as an adjunct to microsuction, though might be occasionally used on their own</td>
</tr>
</tbody>
</table>

What you should cover
Assess each patient to gauge their symptoms, confirm the diagnosis, and explore what they have tried so far.

Useful questions may include
- Have you received other treatment for your hearing problems, such as ear syringing?
- How many times have you had these other treatments? Have any treatments been successful in resolving your symptoms?
- Have you had aural microsuction before?
- Did you experience any problems like pain, dizziness, or ringing in your ears during or after the procedure?
- Do you suffer from hearing loss, dizzy spells, or ringing in your ears? These symptoms can be exacerbated by microsuction because of the high noise levels generated, and cooling of the vestibular apparatus.
- Have you ever had ear surgery? After surgery, the anatomy of the ear canal and ear drum can be substantially altered. Additionally, implants inserted, such as those in middle ear surgery, can become dislodged following microsuction.
- Have you ever suffered a perforated ear drum? A healed perforation is vulnerable to damage during microsuction.
- Have you any underlying skin complaints such as dermatitis or psoriasis? In these conditions, the ear canal skin can be fragile, necessitating more caution during the procedure.

Aural microsuction is noisy, and the patient needs to be able to sit or lie still (fig). Consider to what extent it is the best option for children, or for patients who are confused, agitated, or have a learning disability.

Education into practice
- How might you identify those patients that are receiving inadequate relief from ear syringing and might benefit from referral to ENT for aural microsuction?
- Based on this article, is there anything you might do differently in your practice?

How patients were involved with the creation of this article
We asked 30 patients in our ENT outpatient department. 15 patients were undergoing aural microsuction for the first time. Patients felt they would appreciate knowledge of the common complications, particularly those experiencing the procedure for the first time. They felt they would be better prepared mentally for coping with the discomfort and dizziness that can often occur during and after the procedure.
What you should do

In our experience, microsuction can be daunting for patients, particularly those undergoing the procedure for the first time. An explanation of procedure can help to address the patient’s concerns. Important details about the procedure include the following:

- The procedure is likely to last up to 10 minutes
- Typically, in addition to the operator performing aural suction, an assistant (usually a nurse) will also be present. The operator will examine the ear canal first by gently pulling on the pinna (outer ear), inserting an aural speculum, and focusing the microscope
- Once the suction is started it will be noisy. If the suctioning tip becomes blocked it might be taken out of the ear canal, unblocked, and then re-inserted.
- During the procedure, the operator might need to re-position the head
- The patient might experience discomfort, pain, and dizziness during the procedure
- The patient can ask for a pause in the procedure at any time, for example if they find it uncomfortable
- It is difficult to estimate the likelihood of side effects, as the incidences of these have not been sufficiently reported in literature. Some limited guidance is available (box).

An observational study showed no statistically significant change in hearing levels, as measured by audiometry, after microsuction compared with controls in patients undergoing microsuction regularly to clear debris, suggesting that repeated exposure to the high noise levels generated are not likely to affect subsequent hearing. The incidences of infection, tympanic membrane damage, middle ear damage, or permanent hearing loss have not been quantified, but are thought to remain potential complications, at a similar rate to other manual methods of ear wax removal (table), not including aural syringing, which carries a higher risk of complications.

Following the procedure, patients should experience resolution of their symptoms within a very short time. The operator will be able to explain whether further sessions of microsuction are likely to be required.

The operator will also advise specific water precautions in patients with evidence of infection or inflammation of the external ear canal. Water precautions aim to keep the ear canal dry, and include inserting cotton wool balls smeared with Vaseline into the ear canal of the affected side before showering or bathing, and using earplugs during swimming. This can help to avoid recurrence of the original problem. Advise patients to avoid attempting to clean the ear canal using cotton buds, as this can predispose to impaction and can also damage surrounding structures.

Competing interests: None declared.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.j2908
Managing disclosure of gender dysphoria

It can be very distressing for a person to tell a health professional about conflict between their sense of self and the sexual characteristics they were born with. They will need reassurance, and careful guidance about what kinds of treatment are available.

1. **Acknowledge disclosure**
   - Common fears for those expressing distress about their gender identity:
     - Ridicule
     - Being judged mentally unwell
     - Dismissal
     - Judgment
   - Acknowledge the person’s disclosure, and explain that people can find it hard to raise and often have reservations about disclosure.

2. **Explore patient’s background**
   - How long have they felt this way?
   - Have they disclosed to:
     - Family
     - Friends
     - Others
   - Have they changed name or sex on official documents?

3. **Update records**
   - Clarify how a patient with a new role would like to be addressed
   - Amend records accordingly

4. **Ask about self medication**
   - Ask if they are self medicating with hormones from online “pharmacies”
     - What are they taking?
     - How much/often?
     - Are there side effects?
   - Advise about the risks of self medication sensitively
   - Encourage openness about self medication if they want to continue despite risks

5. **Consider referral**
   - Refer to a gender identity clinic quickly, especially if person is experiencing distress
   - Explain safe, well established treatment is available, although there may be a long wait
   - Consider referral even if the person isn’t sure whether they want medical or surgical treatment
   - Alert patients to informal support groups to explore while awaiting specialist assessment

**Gender identity clinic**

- **Assessment**
  - Normally 2–3 appointments

- **Investigations**
  - Psychological and endocrine

- **Investigation of circumstances**
  - Social
  - Occupational
  - Psychological
  - Family

- **Advice about consequences**
  - Medical
  - Legal
  - Other

**Management (if indicated)**

- Hormone treatment
- Facial hair removal
- Psychological therapy
- Speech + communication therapy

**Discussions about surgical options**

- Mastectomy
- Hysterectomy
- Oophorectomy
- Genital reconstruction
- Augmentation mammoplasty
- Ear, nose, and throat surgery
- Facial surgery

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Gender dysphoria: assessment and management for non-specialists

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About 0.6% of the population identifies as transgender according to healthcare records, although the actual number might be higher. In the 50 years since UK NHS services started, more than 130,000 people have changed social gender role. A variety of doctors, including non-specialists, might at some time in their career be approached for help by someone with gender dysphoria.

Various specialist clinicians are involved in the care of patients being assessed and treated at a gender identity clinic. Specialist clinics obviate the need for any psychiatric assessment in advance of referral. Gender dysphoria is not a mental health disorder. After treatment is complete, doctors from all specialties will encounter patients who earlier changed gender role.

People with gender dysphoria have described their experience of interacting with healthcare services as variable to poor, according to the Women and Equalities Parliamentary Select Committee. In the UK, the General Medical Council has recently emphasised medical duties in this regard, advising that treatment for transgender patients should be as respectful as for any other group. Feelings of “inexperience” with the field can prompt learning by collaboration with a gender identity clinic, rather than act as a justification for non-involvement.

This article offers guidance on how to manage an adult patient who is distressed by feelings of gender incongruence. We discuss appropriate language to use, referral processes, and options for management that are typically led by specialist teams, including hormonal, surgical, and cosmetic treatments.

The practical suggestions on how to assess and manage patients are based mainly on the experience of the authors and other members of the British Association of Gender Identity Specialists. They are also based on the few existing broad national and international guidelines on the management of transgender patients.

What is gender dysphoria?

Gender dysphoria is a distressing sense of incongruity between individuals’ sense of themselves and the sexual characteristics they were born with. Most often there is a sense of feeling female although born male (or vice versa) but sometimes a sense of mixed gender or neutrality.

What to say, do, and explain if a patient expresses distress about their gender identity not fitting their body

Anecdotally, the biggest fears for any patient making such a disclosure are of being ridiculed, being judged as mentally unwell, or being roundly dismissed and inappropriately judged afterwards. Clinicians can allay some of those concerns by acknowledging the disclosure, and by explaining that other people in a similar position can find it hard to raise the subject, or have reservations about the implications of the disclosure.

Clinicians might begin to explore how long the patient has experienced these feelings, and what steps, if any, they have taken already to disclose to family and friends, trusted workmates, or employers. Has there been any formal name change or sex marker change on work documents or social profiles online?

Specifically, ask whether patients are self medicating with hormones from online “pharmacies.” Explore this medication use as you might with any other non-prescribed drug, asking what and how much the patient is taking and how often.

Screen for side effects and explain that self medication carries risks, including the loss of natural fertility. To avoid further risk, patients are advised to stop self medication until seen in a specialist clinic for further assessment. The person might not want to stop medication, especially as there can be a long wait to be seen at a gender identity clinic (typically nine to 15 months in the UK, although it is anticipated that referral to treatment times will fall to 18 weeks within the next five years). If patients are unwilling to stop self medication, encourage them to share with you any side effects they experience, and encourage them to inform healthcare staff if they are seen in other settings.

Explain to the patient that you will make a referral to gender services. Explain that their experience isn’t uncommon and that treatment (NHS funded treatment in the UK) is available, although sometimes associated with long waiting lists. These treatments are generally well established and safe, but should be considered on an individual basis according to the patient’s preferences.

Usually it is not necessary to inquire directly about gender dysphoria if a patient does not raise it themselves. If it is suspected, a suggestion of open mindedness about the topic might be useful. For example, you might say that you have noticed an increasing degree of masculinity or femininity in the person over time, and wonder if this reflects an increasingly authentic self expression.
When to refer to a gender clinic

Some form of treatment for gender dysphoria is available in most northern European and English speaking countries, although usually not wholly state funded. Elsewhere, availability is more patchy and of variable quality. There are few places to seek help in countries with widespread poverty or cultures hostile to people with gender dysphoria.

If gender dysphoria is distressing a patient, refer them to a gender identity clinic as swiftly as possible, as “watchful waiting” confers no benefit. Refer regardless of whether they are actively seeking medical or surgical treatment. It is useful to alert patients to informal support groups (eg, www.tranzwiki.net) that they can explore while they wait for a first assessment at a clinic. If gender dysphoria is sufficiently marked to cause low mood or deliberate self harm, a concurrent referral to local psychiatric services might be helpful. Rates of mental illness in patients treated for gender dysphoria are in line with the general population, although rates of deliberate self harm and autistic spectrum disorder are raised. If required, make a psychiatry referral concurrently with referral to a gender identity clinic.

WHAT YOU NEED TO KNOW

- Refer patients with gender dysphoria directly to a multidisciplinary gender identity clinic
- People in a new gender role usually need a lifelong prescription of maintenance hormone therapy, which is often provided by primary care under guidance from a gender identity clinic
- A person’s earlier change of gender role is rarely clinically relevant and does not need to be mentioned unless it is relevant
- Consider birth gender when offering routine screening for cervical and breast cancer and aortic aneurysm
- Clarify how a patient with a new role would like to be addressed and amend records accordingly to avoid subsequent upset

EDUCATION INTO PRACTICE

Do you know how to change gender assignments on the IT systems at your place of work? Do you know how to make individual exceptions when recalling for standard screening, such as cervical screening or mammography?

Do you know how to refer to your local gender identity clinic or contact them for advice regarding hormone prescriptions?

Do you feel able to ask your patients how they would prefer to be referred to, and do you use gender neutral language if appropriate?

What will you do differently as a result of reading this article?

WHAT HAPPENS AT A GENDER IDENTITY CLINIC IN THE UK?

Treatment at a gender identity clinic is intended to offer a safe and sustained relief of gender dysphoria and thereby improvement in quality of life. A clinic team might contain psychiatrists, psychologists, speech and language therapists, nurses, occupational therapists, counsellors, endocrinologists, general physicians, and general practitioners with a special interest in the area, and will have close links with associated surgeons. Practitioners from all these disciplines will have had additional training as well as the core training of their discipline.

Assessment

- Typically two and rarely more than three appointments
- Establishes a diagnosis
- Psychological and endocrine investigation to consider differential diagnoses
- Exploration of patients’ social, occupational, psychological, and family circumstances to enable specific, personalised advice on changing gender role
- Advice on the medical, legal, and other possibilities (and consequences) for the patient

Management

- If indicated, hormone treatment is initiated by clinic (patient needs to be physically fit for treatment)
- Speech and communication therapy is offered
- Facial hair removal prescribed and funded (in England, not in Wales)
- Referral for surgery arranged and funded by clinic:
  - Bilateral mastectomy with male chest reconstruction
  - Genital reconstructive surgery
  - Recommendation for surgery that is arranged and funded by primary care
  - Hysterectomy
  - Oophorectomy
  - The NHS does not fund ear, nose, and throat surgery, augmentation mammoplasty, or facial surgery.

How can non-specialist doctors support other health needs?

Assessment and treatment that are the same

Patients established in a new gender role develop the same medical problems as everyone else. Standard treatment for those conditions is indicated, and the change of gender role need not be a focus.

Assessment and treatment that can differ

Hormone treatment is initiated in a gender identity clinic, but ongoing prescribing will occur in primary care because it is not challenging and will need to be life long. Gender identity clinics can provide support with this ongoing prescribing if required.

Patients who were assigned female at birth and who are living as men might require a hysterectomy and oophorectomies. This, when required, can be undertaken by local gynaecological services. In making or receiving these referrals consider preserving dignity. For example, ask whether patients would prefer to be seen in general surgical rather than gynaecological outpatient clinics. If seen in a gynaecological clinic, patients might feel less conspicuous if accompanied by a woman. Similarly, consider whether ultrasound scans can be performed in general rather than specifically gynaecology imaging departments, and whether the patient might be admitted to a general rather than a gynaecological ward.

Routine screening tools for cardiovascular, respiratory, and bone health are difficult to apply because normative data risk factors are not available for transgender patients. Share this uncertainty about gender related risk factors with the patient, use common sense, and consider the many non-gender related factors that might elevate or reduce their risk of such conditions.

Gender specific screening—be aware that gender reassignment can alter routine recall systems for common
cancer screening. Communicate to those setting up recall and processing testing why the sample might appear to come from a person allocated to the opposite sex from that which they might expect.

Consider birth gender when offering routine screening for cervical and breast cancer and aortic aneurysm. For example, women who were assigned male at birth do not need routine mammography. Their risk of breast cancer is very low because there is no progesterone in their hormone treatment (they don’t need it as they have no uterus to protect from unopposed oestrogen induced malignancy). These patients are eligible for aortic aneurysm screening if they have a history of smoking, but will not be called up automatically.

Anybody with a cervix should be offered routine smear tests but the NHS recall system cannot register men. General practitioners can remind patients and alert the cytology services that they have not made a mistake when sending a sample from a man and do require it to be examined.

Complications of gender related surgery
Where possible, problems with both phalloplasty and vaginoplasty should be referred to a urological surgeon with an interest in gender reassignment. A general gynaecological referral for someone who has undergone a vaginoplasty is not appropriate because the patient’s anatomy, unremarkably female as it might look on initial inspection, did not start out as gynaecological and won’t be familiar to most gynaecologists.

Record keeping and communication in the new gender role
Ask patients who change gender role if they want to be registered in their new role and sex and ensure administrative records are changed.¹

Greet, seat, and treat the patient in their new role. Ask which pronoun they would prefer to be used and be careful to use it.

Consider suggesting that transgender patients might use whichever lavatory facilities they feel comfortable with, rather than direct them to accessible toilets that they don’t need unless they are disabled. Patients with the active phases of treatment long behind them often live lives indistinguishable from anyone born into their gender role, and disclosures by clinical and administrative staff can be very distressing.

Psychological and peer support
Many larger cities contain active transgender support groups, usually with an online presence. These offer excellent help to patients with problems that arise outside medical care, or with the stress of waiting for a clinic appointment and, later, with the transition process. Counselling services that are run with trans people in mind can be transformational. Investigate if such a service is available locally. Otherwise counselling and support services run for the general population are quite acceptable for trans people in general, but might struggle with trans specific issues.

Competition interests. See bmj.com.
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Find the full version with references at http://dx.doi.org/10.1136/bmj.j2866

WHAT YOUR PATIENT IS THINKING

I am your trans patient

For the first time we are publishing a What Your Patient is Thinking article by a group of people. These transgender authors share their experiences of healthcare and the important messages they would like doctors to know.

Trans people are diverse and don’t fit the myth that everyone comes in two types—“male” and “female”—and you can tell without asking. There is no single “trans experience,” but trans inclusive medicine fosters respect, cooperation, and the best outcomes; the research shows time and again that how trans affirming you are has a direct impact on my health outcomes.

What you call me matters
You don’t have to be an expert on trans issues: just treat me with kindness and respect. I’m likely wary of talking about being trans, or asking you to use the right pronouns and title (such as the gender neutral pronoun “they” or title “Mx”). You can make it easier: show me you understand that everyone is the expert on themselves.

Check in: “How should I refer to you?” Always respect my preferences in referral letters, medical records, and when discussing me with colleagues—even if this means using different names in conversation and in writing. This is important because otherwise you can distress or endanger me by drawing unnecessary attention.

“One clinic called people for appointments with names on a screen. I was so scared waiting for mine. They had my name right, but my title was ‘Mr.’ When I stood up, everyone in the room stared at my skirt.”

Thinking outside the “M/F” tickbox
Knowing I’m trans doesn’t tell you my medical needs, especially around gendered issues like genital and sexual health. I probably won’t fit the narrative of “full medical transition” from “birth sex” to “opposite gender”: I might be distraught about my body, or I might be okay with it.

“Sometimes, dysphoria isn’t caused by my body, but how the rest of the world perceives me. Follow my lead with the language I use about myself.

WHAT YOU NEED TO KNOW

- A person’s trans status is not always relevant to a consultation and needn’t always be mentioned.
- Language is important—ask people what they would like to be called in different settings and update their medical records accordingly.
- NHS gender services are over-subscribed and waiting for assessment can cause distress, so support at the waiting stage is important.
“Visiting a trans-centred clinic was a revelation. They had to register me as ‘female’ for the system to accept a smear sample, but they apologised, explained, and scribbled out the gender marker on my label. I’m definitely going back.”

“Social marginalisation means I’m more likely to experience anxiety, depression, substance abuse, or violence. These shouldn’t be barriers for referral to a gender specialist, and for some, that’s the only way to help.”

Trans-specific care

“Maybe I’m openly trans, or perhaps it’s a 40 year old footnote in my records. Sometimes there’s no need to bring up my trans status like if I’m here to talk about tonsillitis or back pain. I might however come to you for help with my medical transition. This may be routine, post-transition care: a prescription for hormone replacement therapy and management. Sometimes, though, I’ll need you to refer me to a specialist for assessment or treatment. Do this swiftly, and you’ll be supporting me to access treatment with one of the highest satisfaction rates in medicine. Speed is particularly important if I’m just starting puberty, when I’m at risk of permanent changes caused by inappropriate hormones. Gender services are oversubscribed, and waiting times can be years, but you can help make the wait less agonising by keeping me updated, and thinking creatively about how best to support me.

“The first doctor I came out to was my gynaecologist. We got on well, but I’d known him for ages—and started seeing him without my mum—before I felt able to come out. I was worried about his reaction, but he pointed out we could try managing my endometriosis with androgens.”

We are your trans patients, one in 100. You won’t always know who we are: two of us have already written for this series, but our trans status wasn’t relevant so we didn’t mention it. We’ve written this piece together to illustrate our diversity of experience. We know it’s difficult, sometimes, when your systems struggle to include us, or the literature you rely on doesn’t tell you how to treat us. But we’re here, we exist, and we’re counting on you.

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Competing interests: None declared.

Cite this as: BMJ 2017;357:j2963

Find the full version with references at http://dx.doi.org/10.1136/bmj.j2963
A 75 year old man who lived in a nursing home complained of itching and a rash that had lasted for four months. The man had experienced a traumatic cervical cord injury six months earlier and had sensory impairment but no other substantial medical history. On examination, he had markedly thickened crusts and hyperkeratosis on his hands and feet bilaterally, with involvement of his finger (Fig 1) and toe web spaces. There were excoriated erythematous papules over his trunk and axillae (Fig 2) and erythematous papules or nodules on his glans penis. A fungal scrape was performed and this was negative for fungal elements.

1 What is the diagnosis?
2 What are the differential diagnoses?
3 What are the management options for this patient?

Submitted by Valencia Long and Henry Foong
Patient consent obtained.

Cite this as: BMJ 2017;357:j2912

CASE REVIEW A case of generalised papules

A 75 year old man who lived in a nursing home complained of itching and a rash that had lasted for four months. The man had experienced a traumatic cervical cord injury six months earlier and had sensory impairment but no other substantial medical history. On examination, he had markedly thickened crusts and hyperkeratosis on his hands and feet bilaterally, with involvement of his finger (Fig 1) and toe web spaces. There were excoriated erythematous papules over his trunk and axillae (Fig 2) and erythematous papules or nodules on his glans penis. A fungal scrape was performed and this was negative for fungal elements.

1 What is the diagnosis?
2 What are the differential diagnoses?
3 What are the management options for this patient?

Submitted by Valencia Long and Henry Foong
Patient consent obtained.

Cite this as: BMJ 2017;357:j2912

An unusual case of aphasia

A 93 year old man with a destructive scalp squamous cell carcinoma causing bony erosion into the calvarium was admitted with sudden onset aphasia. Neurological examination was otherwise unremarkable. A computed tomography (CT) scan was performed to investigate the cause of the aphasia (figure). What finding is present on the cranial CT?

Submitted by Rebecca Mortimer, Emma Owens, and David C Howlett
Patient consent obtained.

Cite this as: BMJ 2017;357:j2792

Fig 1
Thickened crusts in the digits and palm

Fig 2
Excoriated erythematous papules over the trunk

Fig 3

SPOT DIAGNOSIS
Crusted scabies (Norwegian scabies) (fig 3).
Psoriasis, eczema, tinea, and seborrhoeic dermatitis.
Topical permethrin and malathione are options, or oral ivermectin. Close contacts should also be treated. The patient’s local environment should be decontaminated.

CORRECTIONS AND CLARIFICATIONS

An article on iron studies by Alison Kelly and colleagues appearing in the 17 June print issue of The BMJ (BMJ 2017;357:j2513) contained some inaccurate information in figure 1.

In the figure:
1. The head of the orange arrow labelled “erythropoiesis” is facing in the wrong direction. Iron from the bone marrow/reticuloendothelial system is incorporated into haemoglobin during erythropoiesis.
2. The orange arrow labelled “destruction of old/damaged red blood cells” is missing. Damage to the red blood cell can result in destruction of the cell in the spleen or bone marrow.
3. The arrow between hepcidin and the red cross faces in the wrong direction. Hepcidin impedes mobilisation of iron from the liver.

In the same article, the sentence “Monitor ferritin in those with haemochromatosis undergoing venesection to deplete iron until ferritin is less than 50 μg/L, and maintain ferritin 50-100 μg/L thereafter” should have read:

“For example, standard practice in haemochromatosis is to continue regular venesection to deplete iron until ferritin is less than 50 μg/L, and maintain ferritin 50-100 μg/L thereafter.”

The authors’ intention was to give an example of standard practice, not to provide clinical guidance on this point.
MINERVA A wry look at the world of research

Blunt trauma to the eyebrow

A 15 year old boy experienced minor blunt trauma to the left eyebrow. Three hours after the trauma, he had a visual acuity of no light perception in the left eye. Funduscopic examination was normal. Three days later, a pale macular area with a cherry red spot was noted in the left eye (fig 1A). Fluorescein angiography (fig 1B) showed central retinal artery occlusion, which is likely to have resulted from either compression of the central retinal artery by a swollen optic nerve, or reflex spasm of the retinal artery after injury to the smooth muscle of the nerve. Clinicians should be aware of the potential for blunt trauma resulting in optic nerve damage and central retinal artery occlusion.

Patient consent obtained.
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Still 41% reporting decisions “about me without me”

The slogan “No decision about me without me” was adopted by health secretary Andrew Lansley in 2010 as part of his vision for liberating the National Health Service. At that time, 52% of inpatients in the UK felt that they were fully involved in decisions about their care. This has now risen to 59%. So there has been some progress in shared decision making, as well summarised for a German readership in ZEFO (doi:10.1016/j.zeqf.2017.05.010). But there is still a lot of work to be done in making it an automatic part of good clinical practice.

Guidelines for ST elevation myocardial infarction

What if the patient arrives in hospital with acute myocardial infarction? A comparison of four clinical guidelines for the management of myocardial infarction found that there was an extraordinary lack of consistency in the systematic reviews they were based on (Am J Emerg Med doi: 10.1016/j.ajem.2017.06.010). All the guidelines omitted a large subset of available systematic reviews cited by other guidelines: in fact only one out of 72 was cited by all four.

Minimally invasive skills are maximally variable

When abdominal surgeons followed their gynaecological colleagues in the 1980s and finally discovered the laparoscope, many who were good at open procedures found their skill set ill adapted for fiddly work in a reversed optical field. Even in the present era of much improved training, a survey from Michigan (JAMA Surg doi:10.1001/jamasurg.2017.1527) shows a threefold range of 8.8% to 25.9% in complication rates during minimally invasive colectomy by different individual surgeons. Although open colectomy carries a higher absolute risk of complications, rates between surgeons diverge less than twofold: from 25.9% to 43.8%.

Ethics and reality in Afghanistan

Senior clinicians faced a range of ethical issues when they worked as deployed medical directors to the British Field Hospital in Afghanistan. A qualitative study gave them an opportunity to explore these both individually and in focus groups (J R Army Med Corps doi:10.1136/jramc-2016-000701). Typical dilemmas included decisions about soldiers who were certain to die, and prioritising the predicted needs of army personnel against the pressing needs of the local population.

Gut infection, irritable bowel, and chronic fatigue

A database of 10 million Bavarians shows that gastrointestinal infections in primary care are associated with greater risk of having a subsequent diagnosis of irritable bowel syndrome or chronic fatigue syndrome (Gut doi:10.1136/gutjnl-2017-313713). This accords with previous studies that link outbreaks of gastrointestinal infection with these conditions, but importantly shows that it applies across a range of bacterial, viral, and protozoal infections seen in primary care.

Neurology inpatient dangers

Hospitals are dangerous places for people with neurological conditions. A survey from Alberta found that those with spinal cord injury had an almost 40% risk of an adverse event during admission (Neurology doi:10.1212/0000000000004111). The figure was 11% across an aggregate of Alzheimer’s disease and related dementia, brain tumour, epilepsy, motor neurone disease, multiple sclerosis, parkinsonism/Parkinson’s disease, spinal cord injury, traumatic brain injury, and stroke. The predominant events were infections and respiratory complications.

The plutocratic proposal

The history of drug development is strewn with hopeful developments, which for one reason or another were never taken up by the pharmaceutical giants who control drug production. A witty paper in J Med Ethics (doi:10.1136/medethics-2016-104050) suggests addressing this with a plutocratic proposal. The central idea of the proposal is that any patient who rescues a potential therapeutic agent from neglect by funding early phase clinical trials (either entirely or in large part) should be offered a place on the trial. Nice idea: but would it apply equally to senior executives from plutocratic drug firms?

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