divert the air flow through the artificial fistula during forced expiration. This leaves the patients free to gesticulate with both hands to make their points more forcibly. Good functional results with these speech buttons have been reported from all over the world, and long term complications seem to be relatively few.[20-22] Many patients who have been unable to acquire oesophageal speech have been successfully treated: fluency rates of 90% have been achieved.[18]

The success of these valves has been so well publicised that the relations of many patients in the United Kingdom ask why so few have had speech buttons fitted. Cost is not a limitation—it is similar to that of a routine intermediate procedure in ear, nose, and throat surgery, and the cost of annual maintenance is no more than £150-200. The reason probably lies more in the conservatism of British surgeons and past experience of unplanned and uncontrolled pharyngeal fistulas complicating laryngectomy. No doubt primary puncture at the time of laryngectomy will receive the same circumspect approach, though it is being performed in a few British centres. Dedicated and well trained auxiliary staff are necessary to provide a speech button service, but no good reason exists why this cannot be realised in any centre performing a reasonable amount of surgery for cancer of the head and neck.

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Failed hip replacements

All replacements will fail eventually; revision needs to be done by specialists

Total hip replacement is big business. As many as 40 000 of these operations are performed each year in the United Kingdom, and 98% of patients are said to be satisfied with the result. After early reports of the prosthesis loosening,[1] much attention is now paid to the longevity of replacement hips. Results vary widely, with failure rates of up to 24% being reported.[2] Once a primary hip replacement has failed it needs to be revised, but revision arthroplasty is more time consuming, more complicated, and more expensive than the primary procedure.[3] Some practices claim that over half of all total hip replacements are revisions and that workload is likely to increase.[4]

Hip replacements fail for several reasons. About 5% of patients have a serious complication associated with surgery, though most complications resolve themselves or are correctable.[5] The main problem is more long term and is simply the failure of the components to remain fixed to bone owing to fractured cement,[6] loss of bone stock,[7] and the wear products produced by the friction between the metal femoral component and the high density polyethylene acetabulum.[8]

Because most hip replacements will fail given time the right patient must be chosen for the operation in the first place. Those over 60 years old are likely to place less strain on the hip and thus improve its lifespan.[9] Younger patients and those who are overweight do not do so well.[10]

The surgeon can do much to delay the onset of problems. Surgical technique is vital to the success of the procedure, particularly the use of advanced, pressurising, cementing techniques.[11] The design of the component is also important, clinical experience suggesting that femoral components with rounded edges and a rectangular cross section give better results.[12] Thicker acetabular components also tend to do better than thinner ones.[13] The risk of deep infection can be minimised by the prudent use of antibiotics and clean air operating theatres, such that the unacceptably high infection rates of early studies[14] can now be reduced to less than 1% for primary procedures.[15]

The method of fixing the prosthetic components to bone may also influence the performance of the replacement. Some centres now favour uncemented replacements instead of the traditional cemented fixation. The idea that bone should integrate precisely with the components without the need for any grout has attractions, but prosthetic integration is actually very limited[16] and the results are not universally convincing. There is therefore now a trend towards use of the hybrid hip replacement, cement being used to secure the femoral component while the acetabulum is seated in a press fit, uncemented manner. Initial results are favourable.[17]

Despite all these efforts, total hip arthroplasties do eventually fail, and the problem of the revision procedure has to be addressed. The commonest form of revision replacement in the United Kingdom is the conversion of a failed cemented primary hip replacement to a cemented revision. The frequency of early postoperative complications after revision arthroplasty may be twice that after primary intervention.[18] Also though the early results of revision surgery can be nearly as good as results for the primary operation,[19] the failure rate of the revision replacement is much higher[20]—occasionally as

high as 60% in revisions of revisions.[21] Use of modern cementing techniques does not seem to reduce the failure rate.[22]

Despite great advances in improving the lifespan of the primary hip replacement the capacity to correct a loose, aseptic, failed replacement is still poor,[5] with rerevision within four years not being abnormal.[18] A strong case can therefore be made for some surgeons to specialise in revision hip surgery and build on their familiarity with advanced bone grafting techniques, bone banking, custom made components, and sophisticated microbiological advice. Such specialist facilities are not widely available in all countries.

As the number of primary total hip replacements performed rises so will the number of revision procedures. Proper surgical technique may reduce the chance of failure but cannot entirely eliminate it. Pressure to increase the number of joint replacements performed must not be allowed to diminish surgical standards, otherwise this revision epidemic runs the risk of bringing orthopaedic surgery to its knees.

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Prescribing at the interface between hospitals and general practitioners

Like all interfaces, it demands good communication

Conflict over who is responsible for prescribing for hospital outpatients has recently caused sparks to fly at the general practice-hospital interface. The concern is that cash limited hospitals are increasingly seeking to transfer prescribing costs, particularly of new and expensive agents such as recombinant human growth hormone and erythropoietin, to non-cash limited general practice drug budgets.

Several issues are raised by the present difficulties. Firstly, general practice drug budgets are now coming under pressure from the indicative prescribing scheme. Although these budgets are not cash limited, general practitioners, and especially fundholders, are concerned that the increased expenditure they incur may create problems when scrutinised by their family health services authorities and their medical advisers. Secondly, general practitioners may be anxious about accepting clinical responsibility for prescribing a drug when they are unfamiliar with its mode of action, adverse effects, and monitoring requirements. Such responsibility is implicit in the provision of a prescription and has both ethical and legal implications for the doctors concerned.

In this issue Professor Paul Freeling's group from St George's Hospital, London, report on the outpatient prescribing policies adopted by major acute hospitals in England and the impact of these policies on general practitioners and hospital consultants (pp 29, 31).[1,2] The period for which outpatient prescriptions were issued varied widely, although most hospitals prescribed for 14 days. Almost half of the hospitals that responded to the survey asked general practitioners to prescribe drugs such as fertility treatments, growth hormone, drugs used in renal failure, and zidovudine for treating HIV infection. This was confirmed by the general practitioners studied, 46% of whom commented that they were asked to prescribe drugs for which they felt unable to take clinical responsibility. Their reasons included cost but also related to lack of knowledge about the drugs themselves. Conversely, 78% of the consultants in the study said that they expected general practitioners to prescribe while retaining clinical responsibility themselves; almost two thirds of them asked general practitioners to prescribe in order to circumvent restrictions imposed by their hospitals.

The trends and tensions revealed by the St George's group will inevitably worsen as further important, but expensive, products are marketed. The means of their resolution lie both with central government and at the professional interface between hospitals and general practice. (Some suggestions about responsibility for prescribing between hospitals and general practitioners are contained in the NHS Management Executive circular letter EL(91)217.) Disputes over responsibilities for prescribing specific expensive drugs might best be resolved by regional policies; Orme has suggested that a regional funding policy for prescribing would quickly lead to overall savings to the regional drug budget.[3]

The convergence of district health authorities and family health services authorities is under discussion, driven by the obvious need for unitary strategic planning, health needs assessment, health care provision, and health promotion. The agenda should also include unitary financing. Separate funding for the acute hospital services and the family practitioner services was introduced many years ago to prevent the potential drift of money from general practice to hospitals. Each budget is voted separately by parliament, and virement between hospital and general practice drug budgets would be illegal. The problems of prescribing at the hospital-general practice interface, though accounting for only a small percent-