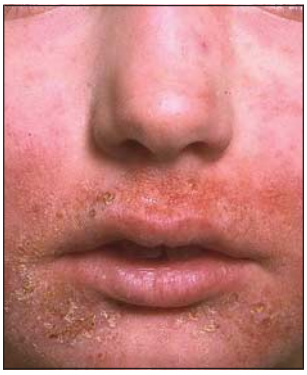
programmes, can have a beneficial impact on orphans' school attendance, training, and productivity.

The cost of treating one person with antiretroviral drugs for a year is equivalent to that of preventing almost 50 cases. Potts and Walsh (p 1389) state that the priority should be prevention, not antiretroviral treatment. They explain the current impact of the epidemic in India and strategies available to contain it.



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## Fluticasone propionate reduces risk of relapse in atopic dermatitis

Fluticasone propionate cream or ointment, applied twice weekly as part of an emollient maintenance treatment, reduces the risk of relapse in patients with atopic dermatitis. Results from Berth-Jones and colleagues' randomised, double blind, placebo controlled, parallel group trial (p 1367) show that after initial stabilisation treatment, the risk of flares was significantly lower in the group applying fluticasone propionate twice weekly than in the placebo group. Median time to relapse was six weeks for emollient alone and more than 16 weeks for additional fluticasone propionate.

## POEM*

### It's all right to give analgesics to patients with abdominal pain

**Question** Is it all right to give analgesics to patients with abdominal pain before the surgeon has done an evaluation?

**Synopsis** These authors systematically searched Medline for clinical trials of analgesia and its effects on diagnosis or physical examination in patients with abdominal pain. Although they supplemented the search with a review of the bibliographies of the included papers, they didn't search other databases and don't describe looking for unpublished data or how they assessed the quality of studies. In attempting a systematic review, they report finding significant heterogeneity among the eight included studies, and therefore they refrained from pooling the data. Most of the patients included in the studies were adults. In all studies but one, the group of patients receiving analgesics reported significant pain relief. None of the studies identified significant side effects or respiratory suppression. Finally, no study reported that receiving analgesics interfered with obtaining an accurate diagnosis or masking dangerous findings.

**Bottom line** The flaws in the reporting of this systematic review notwithstanding, giving analgesics to patients does not interfere with the diagnostic evaluation.

**Level of evidence** 1a (see www.infopoems.com/resources/levels.html); systematic reviews (with homogeneity ) of randomised controlled trials.

Thomas SH, Silen W. Effect on diagnostic efficiency of analgesia for undifferentiated abdominal pain. *Br J Surg* 2003;90:5-9.

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* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

*Editor's choice*

## Changing the "leadership" of the NHS

Britain's National Health Service, one of the world's largest public sector organisations, is highly unusual in not having a leader. Most organisations—and certainly all major corporations—have a leader. Tony Blair is the leader of Britain. Greg Dyke leads the BBC, and that huge organisation—comparable in some ways to the NHS—has changed dramatically since Dyke took over from John Birt. One of the best ways to change an organisation is to change its leader. This is not a cult of personality. But it does seem to be important—perhaps simply because people prefer people to abstractions—to have somebody who embodies power and accountability.

So who is the leader of the NHS? One immediate problem is that there are four NHSs—in England, Scotland, Wales, and Northern Ireland. Who then is the leader in England? Is it Sir Nigel Crisp, the chief executive of the NHS in England and also permanent secretary in the Department of Health? If he is the leader, then he's exercising a uniquely anonymous form of leadership. I doubt if one doctor in 50 could identify him.

If there is a leader of the NHS in England then it's the secretary of state for health. Unfortunately, however, secretaries of state feel like the leaders of an occupying power. The relationship between a doctor in the NHS and the secretary of state is like the relationship between an Indian villager and the viceroy of India in the 19th century: these are far away people with different sets of values. Few doctors, I suggest, would regard the secretary of state as the leader of the NHS.

Nevertheless, the secretary of state is responsible to parliament for the NHS, and last week brought a change (p 1347). Alan Milburn resigned in order to "spend more time with his family." This is a phrase that immediately starts political antennae twitching. Old lags like me remember that a previous secretary of state, Norman Fowler, resigned for the same reason. Perhaps, however, his family didn't want to spend more time with him—because within weeks he was popping up everywhere. Is it really possible that a forceful, ambitious, bruiser like Milburn wants to spend more time with his family? Good for him if it's true, but isn't there likely to be another reason? Rumours started immediately of financial or sexual scandal, but may he simply have jumped before he was pushed?

The Department of Health is a mess—confused, demoralised, and overloaded—which is why the prime minister seemed to have great difficulty finding a replacement for Milburn. The ship is going down, and nobody wants to be captain. Press ganging was needed, and the NHS is now being led by John Reid, known as "the minister for today" because he's had five different seats in the cabinet. Might he supply the leadership the NHS desperately needs? Let's hope so—but I doubt it.

Richard Smith *editor*

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