We are concerned about three recent cases of imported malaria in travellers returning from the Gambia. All three were UK nationals who had booked holidays to the Gambia using the same travel website (two had made late bookings). They had failed to take adequate medical advice before travelling so did not take adequate malaria chemoprophylaxis. Within a fortnight of returning to the UK they all presented to hospital with severe Plasmodium falciparum malaria.

Imported cases of malaria are relatively common in the UK, mostly from west Africa (813 of 1495 cases in 2009), with a considerable proportion occurring in holidaymakers (57 in 2009). The Gambia is a popular “winter sun” destination for UK travellers. Malaria is highly endemic there and is a risk to travellers throughout the year. This risk can be reduced through appropriate chemoprophylaxis and bite avoidance interventions.

The increasing use of websites to make late holiday bookings can make it more difficult to organise medical advice and malaria chemoprophylaxis. In addition, many travel websites and holiday brochures, including the website used by our patients, make no specific reference to the risk of contracting malaria.

Travel websites need to include explicit messages about taking medical advice and effective chemoprophylaxis before travelling to malaria endemic areas. Advice on allowing sufficient time to organise this might reduce the particular risk to people making late bookings.

John Widdrington
specialist registrar in infectious disease
john.widdrington@nhs.net

John Williams
consultant in infectious diseases

David R Chadwick
consultant in infectious diseases

Brendan McCarron
consultant in infectious diseases, James Cook University Hospital, Middlesbrough TS4 3BW, UK

Competing interests: None declared.


Cite this as: BMJ 2011;342:d2771

THROMBOLYSIS IN ELDERLY PEOPLE

Observational data insufficient to change treatment

The paper by Mishra and colleagues suggests that age should not be a barrier to stroke thrombolysis, but caution is advised when using observational data to change clinical practice.

SITS is a voluntary register, so does not include all patients who receive recombinant tissue plasminogen activator (rt-PA), and those who have adverse events (such as haemorrhage and death) may be omitted. VISTA is a trials registry, so includes all patients without selective loss. Therefore a selection bias could produce the apparent difference between outcomes observed in the SITS and VISTA data (attributed to rt-PA).

A further weakness is the lack of data on time to treatment. SITS is a registry of rt-PA use generally within licence and therefore largely refers to patients treated within three hours, at most four and a half hours, after stroke. The neuroprotective trials in VISTA had time windows of six hours. Were the cases matched by treatment delay? These two biases could explain the beneficial absolute decrease in deaths of 3.5% at three months seen in the alteplase treated patients in their analyses, which differs from the systematic review data (showing no mortality benefit). The increased risk of symptomatic intracranial haemorrhage in those over 80 (<1%) v those of 80 and under (<8.3%) (odds ratio 4.9, 95% confidence interval 1.2 to 16; P<0.001) in their study is worrying and consistent with other data suggesting that treatment of those over 80 may result in poorer outcomes.

Thrombolysis is a promising treatment for those over 80 years, but until the results of the third international stroke trial (www.ist3.com) are reported (expected in the first half of 2012), doctors should randomly allocate appropriate patients to the ongoing trials (IST-3, TESPI) to ensure that evidence of effectiveness is robust for the 21st century.

Richard I Lindley
professor of geriatric medicine, University of Sydney, NSW 2006, Australia
richard.lindley@sydney.edu.au

Joanna M Wardlaw
professor and honorary consultant neuroradiologist

Peter A G Sandercock
professor of medical neurology and honorary consultant neurologist, Western General Hospital, University of Edinburgh, Edinburgh EH4 2XU, UK

Competing interests: The authors have spent more than a decade running the third international stroke trial (www.ist3.com) to provide reliable data to expand the current limited indications for stroke thrombolysis. RIL has received support to attend national stroke meetings, and received honoraria from Boehringer Ingelheim for services as a scientific committee member. PAGS has received modest fees as a member of the Independent Data Monitoring Committee of the RELY trial funded by Boehringer Ingelheim. JMW has no financial conflicts of interests.

2 Wardlaw JM, Murray V, Berge E, de Zoppo GJ. Thrombolysis for acute ischemic stroke. Stroke 2010; published online April 15. doi: 10.1161/ STROKEAHA.109.575530.

Cite this as: BMJ 2011;342:d306

Authors’ reply

Our paper details the measures taken to preclude bias and acknowledges potential overestimation of effects, but residual caution over design issues should be assuaged by the simple expedient of comparing the treatment effect in the elderly against that in young people. These controlled data now encompass 2612 very elderly patients who received alteplase plus a similar number of controls. Intriguing as further randomised data will be, subgroup analysis of an open label trial spanning 13 years will require close scrutiny since these will be selected patients, treated with unblinded assessment of early responses by centres that had doubts about their capability to deliver alteplase safely, or about treatment efficacy even within three or four and a half hours, or about other patient characteristics that may increase risk or diminish benefit.

What do we know reliably about risk and benefit in elderly people? The risk of symptomatic
bleeding is equal in 81–90 year olds (n=1731) compared with 71–80 year olds (n=7846): 1.8% v 2.3% (P=0.22) per SITS-MOST definition and 9.3% v 9.7% (P=0.68) per NINDS definition. 4

Neither is serious bleeding more common in 91–95 year olds (n=53): 2.3% (1.9 to 2.8) per SITS-MOST definition and 12.9% (6.7 to 21.3) per NINDS definition. 5

With this evidence, we would find it challenging to defend randomisation to placebo of an otherwise suitable candidate for treatment, simply on grounds of age. Stroke is a disease of elderly people: let us not deprive them of proved treatment.

Kennedy R Lees professor of cerebrovascular medicine k.r.lees@clinmed.gla.ac.uk

Nishant K Mishra doctoral candidate, Acute Stroke Unit and Cerebrovascular Clinic, Western Infirmary, Division of Cardiovascular and Medical Sciences, University of Glasgow, Glasgow G11 6NT, UK

Competing interests: KRL has received honorariums from Boehringer Ingelheim, Lundbeck, Thrombogenics, Talaris. NKM has no competing interests.

1 Lindley RI, Wardlaw JM, Sandercogk PAG. Observational data insufficient to change treatment. BMJ 2011;342:d306.


Cite this as: BMJ 2010;342:d312

### FRENCH DRUG REPS

### Say no to seeing sales reps

Silversides claims that promotional information is better regulated in France than in Canada or the United States. 2 She mentions the French code of practice for sales representatives of 2004, but in 2009 a report by the French National Authority for Health (Haute Autorité de Santé, HAS), which monitors the code, acknowledged that visits by sales representatives are not effectively regulated. These facts were reported in the independent French continuing education journal Prescrire. 3

The situation in France is no more satisfactory than that in Canada or the US. Prescrire monitored the information provided by sales representatives in France for 15 years, from 1991 to 2005. 5 Sales representatives cannot be depended on to provide fair and balanced comparative information on the drugs they promote, and they will never provide that kind of information. Whether they give fewer or more gifts to doctors, they are duty bound to provide, and have a vested interest (higher bonus) in providing, non-comparative and commercially biased information.

And putting a positive spin on visits by French sales representatives is particularly galling with a scandal about benfluorex brewing in France. 6 Although not the primary culprits in this health scandal, they were implicated in promoting an anorectic agent under the guise of an antidiabetic, which was also associated with heart valve defects.

Regulated or unregulated, promotional information provided by sales representatives cannot be redeemed. The most effective strategy is for health professionals to refuse to see sales representatives and to rely on information sources that are independent of pharmaceutical companies. 3

Christophe Kopp editor, Prescrire International, Paris, France ckopp@prescrire.org

Competing interests: None declared.

1 Silversides A. Tight regulation of French drug reps mean French doctors get more balanced information than doctors in the US. BMJ 2010;341:c6094. (23 December.)


Cite this as: BMJ 2011;342:d2593

### A FRENCH KING’S HEAD?

Was it Henri IV’s head?

Charlier and colleagues use an international multidisciplinary approach to identify the head of Henri IV. 1

However, the evidence for positive identification seems to be meagre, particularly from a medical point of view. Earrings were commonly worn by men in the 16th century. The maxillary bone lesion looks like a cyst, and the nasal naevus is not obvious. Moustache and beard hairs are commonly red and white in mummified bodies because of postmortem discoloration. Postmortem baldness is also common in mummies that have been handled a lot, as in this case. The digital superimposition does not correspond, especially at the nasal bones, and in any case is difficult to assess when one person has the mouth open and the other closed.

We also have an impressive and detailed report of the exhumations of the French kings in Saint Denis. The Benedictine Dom Germain Poirier and Alexandre Lenoir, responsible for historic monuments, witnessed the exhumations of October 1793 on behalf of the Committee of Monuments and accurately described the embalmed body of Henri IV (translated from the French):

On Saturday 12 October 1793 . . . his body was found to be well preserved, and the features of his face could be recognised perfectly . . . The skull of this corpse, considered a dry mummy, had been cut with a saw, and contained, in place of the brain, which had been removed totally, some tow imbued with an aromatic liquid, which gave out a smell that was so strong it was almost impossible to bear. 2

Therefore attribution of the head to Henri IV should be reconsidered.

Gino Fornaciari professor of history of medicine and director, Division of Paquoptahology, History of Medicine, and Bioethics University of Pisa, Medical School, 56126 Pisa, Italy g.fornaciari@med.unipi.it

Competing interests: None declared.


Cite this as: BMJ 2011;342:d2593

### Authors’ reply

An osteo-archaeological identification must be based on both solid anthropological and historical data. Professor Fornaciari’s doubts can be easily assuaged. 1

Hair characteristics, particularly the natural red and white colour of all the hairs studied,
POINT OF CREDULITY

Professor McLachlan’s fraud

McLachlan contacted the Jerusalem International Conference on Integrative Medicine asking to present his research findings. He attached 11 impressive pages with his publication record, list of grants, and 70 scientific conferences he had lectured at. When a researcher of such status asks to present his work no one will refuse him, and he was offered 15 minutes for his presentation (flight and accommodation were not included).

McLachlan lied about research he never did and results he never got. But who would inquire into the credibility of someone who is professor, associate dean of medicine, and member of the school of medicine and health at Durham University, or doubt his written declaration that he conducted research?

No scientific committee in the world can be a perfect barrier to deceitful intentions. The main way to prevent deception is public exposure: anyone who claims research findings must publish them, and it is only a question of time until frauds will be uncovered.

This is why McLachlan immediately broke off contact with the conference organisers once asked to confirm his arrival. Confirming his participation would have led to the preliminary publication of his abstract, and Jerusalem would probably have been the last conference in the world at which he could have lectured.

If I were an academic member of Durham University, I would be concerned that a researcher on my campus had written to a scientific committee about research he never did and results he never got, while signing with his campus’s official title. On reflection, researchers around the world should be concerned by this phenomenon.

Author’s reply

Fried makes two points. Firstly, that the abstract was accepted because of my credentials. But that was one of the points I was trying to make. My impression is that the world of alternative medicine is peculiarly susceptible to “arguments from authority,” while rational science and medicine ought to focus solely on evidence.

The second point relates to “fraud.” I would distinguish between fraud and “comic hoax,” with the distinction lying in intent. A comic hoax always intends to reveal the truth in time, but fraud is meant to remain secret. Hoax tactics can be legitimate, even when the subject is not comic. The subject of the “lie,” the idea that the buttocks map meaningfully to body organs is intrinsically risible to believers in rational medicine but not to believers in “alternative universe medicine.” One commentator on the internet said: “Once you open your mind wide enough to find reflexology or homeopathy ‘not implausible,’ then you have no defence against any nonsense that might wander in”—this is a fair summary of my position.

I thought seriously about the ethical aspects and had helpful discussions with colleagues, friends, and BMJ editorial staff. But part of my motivation was to create a “true anecdote” as an antidote to the simplified and false anecdotes used in alternative universe medicine, increasingly disguised in integrative medicine clothing, and I hope I did this.

I did think about attending the conference and would have revealed the hoax during the presentation. I don’t think it would have been one of the last conferences that I could have participated in. My motives for not attending were as described, and not as imputed by Fried.

Those who hold positions that are not supported by rational means cannot readily be challenged by rationality. How then to address these positions? Surely a little humour is not misplaced?

John C McLachlan

Surely a little humour is not misplaced?

PHANTOM VIBRATION SYNDROME

Sixty eight per cent of us hallucinate

This survey showed that 68% of medical staff have sensory hallucinations. I have experienced similar sensations when carrying a mobile phone with a vibrate function. Hallucinations are perceptions in the absence of a stimulus, and the authors are right to describe these sensations as such.

The authors suggest mechanisms that contribute to these hallucinations, and these can be synthesised through a cognitive formulation. An emotionally salient stimulus (a vibrating bleep indicating a potential medical emergency) experienced repeatedly in an aroused state (being on call) leads to a hypervigilant state where a similar perception is experienced in the absence of the stimulus. The authors suggest that this is more likely in junior medical staff, their inexperience possibly heightening their anxiety that a mistake made in responding to a medical emergency will have catastrophic consequences. The role of sleep deprivation, which lowers the threshold for hallucinations, is not reported but may contribute.

This formulation can also explain other common hallucinations. The lifelong companionship of couples experienced as repeated stimuli in all modalities leads to some bereaved people feeling, seeing, or hearing their loved ones soon after...
bereavement.2 This formulation can also help us understand the association between repeated abusive experiences in childhood and subsequent derogatory and intrusive voices in adults given a diagnosis of schizophrenia.1 Acknowledging that 68% of doctors hallucinate and that “normal brain mechanisms” may be involved in the generation of hallucinations can reduce stigmatising attitudes towards severe mental illness and improve our attempts to help patients make sense of distressing and overwhelming experiences.

Dave W H Baillie consultant psychiatrist, North East London Foundation Trust, London, UK dave.baillie@nelft.nhs.uk

Competing interests: None declared.


Cite this as: BMJ 2011;342:d299

TOO MANY REFERRAL FORMS?

Hail, universal referral form

Having spent nine months collating an electronic repository of local referral forms, I found that there are indeed too many referral forms.1

The repository was my attempt at dealing with the difficulty of maintaining stock of the right forms by having a library of scanned or electronic versions on each practice computer for use as and when. Forms are listed alphabetically on a locally hosted web page, and clicking on a title brings a form up instantly for printing. Updates are automatically cascaded out to everyone in the practice.

Collecting the forms and organising them was instructive, demonstrating the large number of forms but also highlighting several referral services that have ended with their referral forms still circulating. Locally around 10 separate services treat mild depression and anxiety—is this choice or waste?

In local views of Map of Medicine referral information can seemingly be integrated into care pathways, but it took three months for one referral form to be included, so I did it myself. Theoretically, Map of Medicine is a good place to store referral forms, but there may be neither the will nor the money to do so quickly.

Our 67 local referral forms, with their attendant pathways, guidelines, and leaflets, take up 57.4 Mbytes of space. Bring on the universal referral form—a blank sheet of paper on which a clinical letter is written.

Marcus J Baw GP registrar, Wigan, UK marcusbaw@gmail.com

Competing interests: None declared.

1 McCartney M, Ewart P, Scott C. Are there too many referral forms? BMJ 2010;341:c6576. (13 December.)

Cite this as: BMJ 2011;342:d285

DENIALISM IN PUBLIC HEALTH

Beware SLEAZE tactics

Tobacco and processed food companies typically deny scientific evidence of harm1 by using SLEAZE tactics:

• Scientific conspiracies are alleged (but which are a solid scientific consensus)
• Logical flaws feature in arguments (but which may initially sound plausible)
• Evidence is severely selected to suit their case (with all conflicting facts ignored)
• Absolute perfection is demanded of public health advocates (“Why is there no randomised controlled trial for passive smoking and cancer?”)
• Zany arguments are used to take attention away from the main issue (and dissipate limited public health resources in refuting them)
• Experts are bought to undermine good science or publish conveniently contradictory findings (Google can supply a rogues’ gallery).

Simon Capewell professor of clinical epidemiology, Division of Public Health, University of Liverpool, Whelan Building, Liverpool L69 3GB, UK capewell@liverpool.ac.uk

Ann Capewell consultant physician in medicine for older people, Whiston Hospital, Prescot L35 5DR, UK capewell@liverpool.ac.uk

Competing interests: None declared.

1 McKeel M, Diethelm P. How the growth of denialism undermines public health. BMJ 2010;341:c6950. (14 December.)

Cite this as: BMJ 2011;342:d287

MIDDLE EAR FORCEPS

Likened to pike in German

Phillips and colleagues highlight the comparative morphology of crocodile and alligator skulls in describing the middle ear forceps.1 In several German-speaking ear, nose, and throat units this type of forceps is termed Hechtmaul, or pike mouth.

Why might the same instrument be likened to different animals in European languages? As neither alligators nor crocodiles are native to middle European countries, people there might have preferred referring to a native European species. Unfortunately I do not have ready access to a biology laboratory to measure the snout ratio1 in pike.

Michaela Ranta ENT specialist, Landeskrankenhaus Feldkirch, 6800 Feldkirch, Austria michaela.ranta@lkh.at

Competing interests: None declared.


Cite this as: BMJ 2011;342:d292