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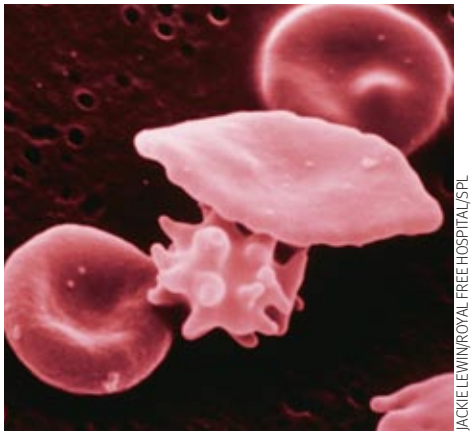
LETTERS



JACKIE LEWIN/ROYAL FREE HOSPITAL/SPL

SICKLE CELL DISEASE

Beware of transfusions and hyperhaemolysis

de Montalembert touches on important aspects of managing sickle cell disease, including the use of red blood cell transfusion as acute or regular top-ups and red cell exchanges.[1]

Hyperhaemolysis is a life threatening complication of red cell transfusions seen in 4% of paediatric and 1% of adult patients with sickle cell disease.[2] Multiply transfused patients with thalassaemia, myelofibrosis, and anaemia of chronic disease are also described. Two forms are recognised: acute (which usually presents within seven days of a transfusion) and delayed. Hyperhaemolysis is dangerous because both transfused and autologous red blood cells are destroyed. Haemoglobin counts after transfusion are therefore lower than before transfusion, and further red cell transfusion exacerbates ongoing haemolysis.

Patients have symptoms of fever and haemolysis, with haemoglobinuria. However, serological findings are usually negative (direct antiglobulin test/DAT and red cell alloantibodies), and anaemia is compounded by reticulocytopenia, not due to parvovirus B19 or red cell aplasia.

Subsequent cautious transfusions should be covered with intravenous immunoglobulin (adult dose 1 mg/kg/day for 2 days or 0.4 mg/kg/day for 5 days) and corticosteroids (adult dose 0.5-1 g intravenous methylprednisolone and/or 1 mg/kg prednisolone subsequently) with a course of erythropoietin to maintain haemoglobin at safe levels.[3 4] In some settings, such as elective surgery,[5] prophylactic postoperative continuous positive airway pressure can safely avoid transfusions. However, when necessary, subsequent transfusions are safe with sufficient therapy as recurrence is uncommon,[3] but vigilance should be maintained as risk factors are poorly defined.

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Competing interests: None declared.

1 de Montalembert M. Management of sickle cell disease. *BMJ* 2008;337:a1397. (8 September.)
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Malarial chemoprophylaxis

Education on the risks of malarial illness in children with sickle cell disease should occur alongside routine penicillin prophylaxis and immunisation—a public health message that was not discussed in de Montalembert's review.[1] Children with sickle cell disease are at increased risk of severe malaria associated with enhanced haemolysis.[2 3] Inadequate chemoprophylaxis among short term travellers visiting friends and family abroad is responsible for the bulk of imported childhood malaria in the United Kingdom.[4]

Families should be counselled about the additional risks for children with sickle cell disease, and practitioners should emphasise the incomplete protective nature of sickle cell trait.[5] Practical mosquito avoidance measures alongside chemoprophylaxis are beneficial for everyone travelling to endemic areas.

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Competing interests: None declared.

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Palliative care

Patients with a severe phenotype for sickle cell disease experience many complications resulting in end organ damage and early death, but the review article did not mention palliative or end of life care.[1]

These patients have many unmet end of life issues. Symptoms such as pain and dyspnoea are severe, and social issues result from recurrent or long hospital stays and increasing dependency in activities of daily living. Much psychological and spiritual distress comes from declining health and the knowledge of a short prognosis. Patients with severe disease should be referred to palliative care to work in partnership with the haematologist to deliver end of life care in line with the government's recently published strategy.

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1 de Montalembert M. Management of sickle cell disease. *BMJ* 2008;337:a1397. (8 September.)

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Primary or secondary care?

The clinical review by de Montalembert seems a useful and comprehensive summary.[1] However, I am not clear whether there is any role for conservative management in primary care, or whether all presentations of acute sickle cell related problems should be referred to secondary care. Can anyone advise?

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1 de Montalembert M. Management of sickle cell disease. *BMJ* 2008;337:a1397. (8 September.)

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CONSENT FOR PUBLICATION

Simplifying consent for publication of case reports

As a foundation year 2 trainee keen to publish interesting case reports, I appreciate the need to protect patients, but I have also been frustrated by the current consent process.[1]

The Information Commissioner has advised doctors to think ahead when writing up cases,[1] but such forward planning is hindered by the current publication process. I recently decided to write up a case report, and initially it was not clear which journal would be most interested in publishing the case as the story was still unfolding. What was clear, even on initial presentation, was that the case would be interesting enough to warrant publication.

We therefore obtained consent for publication in advance while the patient was in hospital under our general surgical care, and subsequently wrote the case up on the patient's discharge. However, when it came to submitting the case I discovered each journal had its own specific consent form, and would not accept our generic one that the patient had signed.

To make the consent process easier for both authors and patients I therefore propose that the International Committee of Medical Journal Editors agree a consent form that would be valid for submission across medical journals to complement their excellent guidelines.[2] This would allow authors the ability to gain consent in advance and on a single occasion. If the case report was rejected by one journal the consent obtained would still be valid for submission elsewhere.

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Competing interests: None declared.

1 Smith J. Patient confidentiality and consent to publication. *BMJ* 2008;337:a1572. (10 September.)
2 International Committee of Medical Journal Editors. *Uniform requirements for manuscripts submitted to biomedical journals: writing and editing for biomedical publication*. Philadelphia: ICMJE, 2007.

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Good idea. We will pursue. – Ed

What happens to papers rejected by the *BMJ* on ethical grounds

The paper rejected by the *BMJ* but subsequently published by the *Journal of Paediatrics and Child Health* raises a further issue.[1] What happens to those papers that the *BMJ* committee rejected?

After permission we reviewed the committee's minutes and documentation for the period 2004-5 and identified six papers rejected on ethical grounds and subsequently published elsewhere in a form that did not take account of the ethical recommendations of the committee. This was a snapshot view, and we cannot guarantee that all such papers were picked up. We contacted all six lead authors but only received replies from three, agreeing to further discussion of the problem and permission to quote their own paper. Hence we cannot be more specific than state the following.

Two failed to get consent; one used an intrinsically unethical intervention; one relied on previously published papers by the same author, which were highly questionable in terms of data presented; one presented data that had already been published by the *BMJ*, and this was not made clear in the new submission but was offered as "new data"; and one was rejected because ethical approval had not been sought.

Clearly this raises issues about differing practices or standards in different journals. It also raises the issue that perhaps any submitted paper to any journal needs to confirm whether it has previously been rejected by another journal and if so on what grounds.

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Competing interests: NP is a member of the BMJ Ethics Committee. SS works at the *BMJ*.

1 Godlee F. Getting a patient's consent for publication. *BMJ* 2008;337:a1633. (11 September.)

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Editors and authors vexed and confused by consent

Smith points out the potential legal pitfalls when submitting papers that might breach patient confidentiality.[1] This is often discussed at the regular quarterly meetings of editor members of the Committee on Publication Ethics (COPE).

In my role as editor of *BMJ* fillers, this is a daily problem with most contributions under such rubrics as "My most interesting patient," which are unaccompanied by consent. When its necessity is pointed out to authors, many are amazed and some outraged. I have been accused of political correctness and the journal of unnecessary bureaucracy and cowardice.

Authors and editors have often been misled by their belief in a "public interest" defence, as outlined in the General Medical Council's current advice.[2] Notwithstanding that the law and professional regulation are not identical, and while Smith points to a helpful questions and answers section on the GMC website, the GMC's written guidance deals with research, clinical audit, administration, and epidemiology but not with such mundane matters as the publication of case reports or small case series. The GMC is currently consulting on a new edition. Hopefully these types of publication will be included, so helping to clarify the situation for editors and authors.

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Competing interests: HM chairs GMC fitness to practise panels. The views expressed are his own and do not purport to be those of the GMC. He is also an associate editor of the *BMJ* but has no idea whether the journal agrees with his opinions.

1 Smith J. Patient confidentiality and consent to publication. *BMJ* 2008;337:a1572. (10 September.)
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CONTRACT RESEARCH ORGANISATIONS

Truly independent research is impossible

Lenzer is perhaps a bit harsh on contract research organisations (CROs).[1] "Total independence" by all parties involved in clinical trials is a utopia. The belief system of the clinicians and academics, the "publish or perish culture" and research assessment exercise of universities, the drive to increase research activities by healthcare organisations, to name a few, can influence and erode independence of the thought processes of the people involved.

The way to maximise the integrity of research is to bring rigour to the research governance framework[2] and impose sanctions for misconduct on individuals and organisations. The article outlined several pitfalls—researchers or CROs not declaring all affiliations, gifts to investigators and institutions, incomplete declarations of all personal and institutional conflicts of interests, study protocols with design or research question or outcome measure that are likely to favour industry, and studies not adding anything worth while to the existing body of knowledge.

We need robust implementation of the standards set out in the framework for dealing with research misconduct ,[3] comprehensive peer review of research proposals and articles submitted for publication, and ethics committee appraisals. The launch in 2007 of the CRO model clinical trial agreement—a tripartite contract between CRO, sponsor, and healthcare organisation—is a welcome step towards transparency, but it is not mandatory.

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Competing interests: None declared.

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Cite this as: *BMJ* 2008;337:a1881