The safe sex messenger, p 1002

(Not) warts and all

PERSONAL VIEW **Phil Hammond**

"You'd be mad not to protect your daughter against genital warts if you can afford to." So advised Peter Greenhouse, a sexual health consultant in Bristol, when I asked him which human papillomavirus vaccine I should choose for my daughter. The NHS vaccination programme may have opted for the bivalent vaccine (Cervarix) to concentrate resources on preventing cervical cancer, but every doctor I've spoken to has chosen the quadrivalent vaccine (Gardasil) for their own daughters (and the odd son, though of course this is off licence).

Genital warts are common (100 000 new cases in England each year), and the condition is on the rise, particularly among young people: in women 60% of cases occur in the 16-24 years age group. They don't kill you, but they can kill your sex life, and in some people they can be recurrent and extensive. The health minister Dawn Primarolo claims that warts are "preventable," but meticulous condom use cuts transmission of the human papillomavirus by only 50%. A far safer option is to vaccinate.

The NHS Choices website (www.nhs.uk) promotes Cervarix but doesn't return a single hit for Gardasil. Having chosen one vaccine for us, the government has decided we don't need information about another that could prevent 90% of warts (as well as 70% of cervical cancer). Those administering Cervarix at my daughter's school offer no information about Gardasil. Whatever happened to informed choice?

The NHS vaccination site (www.immunisation.nhs.uk) is also a Gardasil free zone. An editorial in *Sexually Transmitted Infections* (2008;84:251, doi:10.1136/sti.2008.032755) describes the government's decision as "a sad day for sexual health." The decision also doesn't seem to make long term economic sense. Within three or four years, the editorial says, the use of Gardasil "would begin to have a big financial payback, as the current estimate of treating genital warts in England every year is £23 million [€30m; $40m]."

So why did the government opt for Cervarix? The Joint Committee on Vaccination and Immunisation is most illuminating. "If the vaccines were offered at similar prices, then the committee recommended choosing the quadrivalent vaccine, which would protect against cervical cancer and genital warts," said a committee statement (www.advisorybodies.doh.gov.uk/jcvi/HPV_JCVI_report_18_07_2008.pdf). The *British National Formulary* gives exactly the same price (£80.50 for each of three injections) for the two vaccines, so GlaxoSmithKline (GSK), which makes Cervarix, offered a discount to undercut Gardasil's manufacturer, Sanofi Pasteur.

I have no issue with this. New drugs are ludicrously expensive, and the NHS deserves credit for beating GSK down. Or perhaps GSK was desperate to break into a market dominated in most other developed countries by Sanofi Pasteur. The size of the discount is "commercially confidential," said my MP, Dan Norris. I asked him about this because I wanted to "top up" the difference so that my daughter can have Gardasil with her classmates, within the NHS programme. But this choice, apparently, is not allowed.

Parents who choose Gardasil will almost certainly have to pay privately for it. The going rate in local general practices seems to be £350 to £400. We can (reluctantly) afford this, but many parents can't. My primary care trust allows those in the vaccine programme to have Gardasil if there is "a specific clinical need," without defining what this means. For girls who are particularly at risk of genital warts (for example, those with type I diabetes or extensive verrucas or hand warts) or skin conditions that make genital warts particularly unpleasant (such as extensive psoriasis or eczema), it seems unethical not to offer them Gardasil. And how long will it take for a woman with warts to sue the NHS for not offering her the choice? Doctors are supposed to use clinical judgment in individual cases, but the pressure to reduce prescribing costs is relentless.

The cheap GSK deal for Cervarix applies only to vaccines in the programme. Outside the programme many doctors will recommend Gardasil, because of the extra protection it offers, so we may end up with all women in the programme getting Cervarix and most outside it getting Gardasil. This clearly has the potential to undermine the programme (or at least it would if anyone was brave enough to shout about genital warts).

BARRY BATCHELOR/PA ARCHIVE/PA PHOTOS

If it was breast cancer, there would doubtless be an industry supported march on Downing Street, but the genital warts lobby is largely under cover

For any licensed treatment, the public (and NHS staff) need quick and easy access to unbiased data on efficacy and safety, updated as it emerges. The NHS website would seem to be a logical gateway for this, but it currently restricts information about treatments it doesn't wish to fund. Vaccination programmes have a coercive flavour, but some parents, quite legitimately, may want to delay vaccination until more comprehensive safety and efficacy data emerge (http://content.nejm.org/cgi/content/full/359/8/861). Others simply don't trust data presented and controlled by drug companies. They should not be made to feel guilty if they decide against vaccination.

I have worked in sexual health and seen plenty of people whose warts have been successfully treated. I've seen others with extensive, recurrent warts that need prolonged and fiddly treatment and florid anogenital warts that resisted just about every treatment. We've opted to pay for Gardasil. Unlike the Blairs I'm happy to go public about vaccination of my children. I tell parents what vaccine we've chosen if they ask me, and I've written about it in *Private Eye*. If it was breast cancer, there would doubtless be an industry supported march on Downing Street, but the genital warts lobby is largely under cover. There are no letters to the *Times*, and warts have never made it to the cover of the *Mail*. But go to www.chestersexualhealth.co.uk/genitalwarts.htm to see what we could be preventing.

Phil Hammond is a general practitioner, writer, and broadcaster hamm82@msn.com

Competing interests: PH has been paid to speak at dinners by many drug companies (including GSK and Sanofi Pasteur) and NICE.

Cite this as: *BMJ* 2008;337:a2186

A capital idea

FROM THE FRONTLINE
Des Spence

I handed over my Visa card. The assistant disappeared, and the queue grew long and noisy. I twitched. "Sir, your card has been refused," he said, confiscating the card. I flushed. I was a young and stupid student, so why had the bank given me the credit card?

From a red call box in the dark driving rain I phoned my bank manager in Orkney. He knew me—his son had been in my class at school. Over the crackling line he gave me a thunderous rebuke on conservative fiscal management. He assessed the risk, lent me the money, and saved me from being placed on the credit blacklist. I still use the same bank: loyalty has no price.

But these days I can no longer phone my branch in Orkney. Instead I spend hours listening to a panpipe version of *Copacabana* only to be passed to a call centre in Delhi to be asked for a long forgotten password. Or I am sent endless letters for loans "for any purpose" or seductive glossy pamphlets offering a limitless platinum credit card because of "my high status." But I have long learnt my lesson with credit cards. Gone, it seems, is personal judgment; and knowledge of the customer has been replaced by tick list credit rating. Now, however, banking has come unstuck as a result of feckless lending and greed. These days the talk is of a return to "old fashioned banking."

Medicine has seen similar changes. We have expensive, new "quality assured" NHS call centres, with the same sweet apologies about the volume of calls, illogical menus, and, eventually, a tick list medical algorithm that always seems to end in "call a 999 ambulance." Traditional local general practices are under threat of closure from shiny new polyclinics whose smart managers have implausibly impressive titles and who are driven by short term targets. Cottage hospitals and district general hospitals continue to disappear.

We see the rise of superspecialists and the end of the consultant generalist. Doctors are left no longer knowing their patients or the community and are therefore unable to assess risk. Uncertainty is sold on through the medical derivatives market of more referrals, feeding yet more medical demand and the hugely indebted public finance initiative projects. This is a medical expansionist bubble.

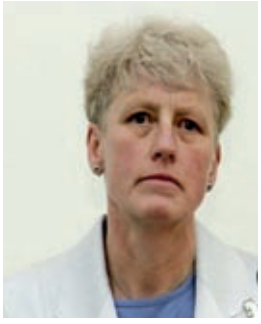
When the bubble bursts we will be left with junk NHS bonds. The time has come for a return to old fashioned medicine and conservative and restrained medical practice. Above all, we need to regain the ability to evaluate whether an individual can afford the personal costs and risk of medical interventions.

Des Spence is a general practitioner, Glasgow
destwo@yahoo.co.uk

Cite this as: *BMJ* 2008;337:a2203

Saving lives

OUTSIDE THE BOX
Trisha Greenhalgh



The other day I gave a careers talk at a local school. A boy came up to me afterwards and said, "Miss, have you ever saved anyone's life?"

"Of course," I replied. "I'm a doctor. Saving lives is my core business."

"Tell me about some," he pleaded.

I picked some stories to entertain and inspire the lad. I told him of shocking someone out of ventricular fibrillation when carrying the cardiac arrest bleep; the hypovolaemic teenage victim of a road crash I managed to get a drip into; and the woman gasping with pulmonary oedema who responded within seconds to my syringe of frusemide.

"I'd like to do that," he said, with shining eyes. "How many would you save in a week?"

I explained that those stories were from a previous life as a hospital doctor and that I didn't save many lives now as a general practitioner. He was disappointed, so I recounted how I had once spotted the rapidly spreading rash of meningococcal septicaemia and given the urgent shot of penicillin and another time called a "no delay ambulance" for a pregnant woman with advanced pre-eclampsia: two lives saved. And I told him about administering adrenaline and hydrocortisone to a patient with anaphylactic shock.

Afterwards I wondered why I had chosen all these heroic examples. What is it, to "save a life"? Why did I not tell him of the hundreds of middle aged people attending with sore throats or sore knees to whom I've said, "Let's just check your blood pressure while you're here"? Or the countless smokers who have left my consulting room with a dose of what is known in the literature as "brief advice"? Or those interminable diabetes clinics where I've worked with patient after patient in an effort to align the medical ideal of "tight control" with the lived reality of work and family life?

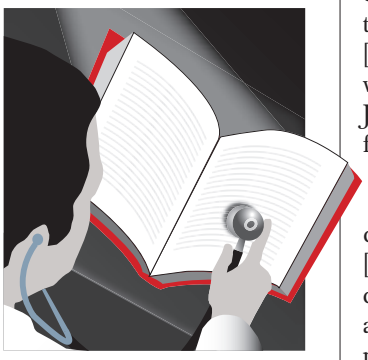
It's 25 years since I qualified as a doctor. Depending on how you define "saving a life," my personal tally amounts to fewer than a dozen in my entire career—or several thousand.

Trisha Greenhalgh is professor of primary health care, University College London
p.greenhalgh@pcps.ucl.ac.uk

Cite this as: *BMJ* 2008;337:a2202

Victorian values

BETWEEN THE LINES
Theodore Dalrymple



But were all cases of brain fever in Victorian novels encephalitis? The current incidence in Britain is four cases per 100 000 people a year, whereas the incidence in Victorian novels must be many, many times higher

We all dislike emotional shocks, of course, but it seems that only in Victorian novels are they regularly followed by "brain fever" lasting several weeks. Pip in *Great Expectations* and Catherine in *Wuthering Heights* both get it, and for a time it is touch and go with them whether they will survive. It sometimes seems as if no Victorian novel is quite complete without a bout of brain fever.

Sir John Maltravers, in J Meade Falkner's *The Lost Stradivarius*, published in 1895, has a fairly typical bout of this fell disease. Falkner (1858-1932) was a man of parts, perhaps the only chairman of a major arms manufacturing company (Armstrong Whitworth) also to have achieved some literary prominence as a novelist. He was an antiquarian, too, and really rather preferred mediaeval manuscripts to machine guns, receiving a medal from the Pope for his researches in the Vatican library. He collected a very valuable library himself.

The Lost Stradivarius is a Gothic ghost story. As a student at Oxford the protagonist, Sir John, is a keen musician; in his rooms, hidden behind a bookcase, he finds a lost Stradivarius that once belonged to Adrian Temple, an ancestor of his fiancée (who is destined to die of puerperal fever later in the novel).

Now this Adrian was an evil man, talented but dissolute and completely amoral, whose shade is called up every time Sir John plays a certain piece of 18th century Italian music. One night, at the Temple ancestral home, Sir John catches a glimpse of a portrait of Adrian Temple (by Pompeo Battoni, the Italian painter who specialised in portraits of Englishmen on the Grand Tour and who was recently the subject of an exhibition at the National Gallery) by the light of a flash of lightning. This has so strong an effect on Sir John that he falls immediately into a swoon; Dr Empson is called, and the inevitable happens: "His [Dr Empson's] verdict was sufficiently grave: John was suffering from a sharp access of brain-fever; his condition afforded cause for alarm; he [Doctor Empson] could not answer for any turn his sickness might take."

Although Sir John recovers, he is never quite the same again. His personality has changed: he is not so much in love as he was, becoming inattentive and even cruel towards his fiancée and later wife; he is distracted and distant even from his friends; and he is preoccupied by the life of Adrian Temple to the exclusion of everything else.

Was his brain fever viral encephalitis, with subtle after effects? Falkner wants us to believe that his change of personality was of supernatural cause, effected by the evil spirit of Temple, but we doctors know that it was really organic in origin.

But were all cases of brain fever in Victorian novels encephalitis? The current incidence in Britain is four cases per 100 000 people a year, whereas the incidence in Victorian novels must be many, many times higher. Perhaps encephalitis was much more common in those days, however. And the question remains to be answered as to whether a severe emotional shock, or state of stress, renders someone susceptible to viral encephalitis. It is easy enough to find research on postencephalitic effects on the state of mind but more difficult to find research on pre-encephalitic states of mind.

Could so many Victorian novelists have been wrong?

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2008;337:a2230

MEDICAL CLASSICS

Diseases of the Heart and Circulation

By Paul Wood **First published 1950**

As a senior house officer at the Royal Brompton Hospital in 2005 I came across several exceptionally detailed records of examination findings dating back to the 1950s. These entries were by the late Paul Wood. My subsequent inquiries helped me discover *Diseases of the Heart and Circulation*, the legacy of one of the greatest names of British cardiology. Born in India in 1907, Wood attended medical school in Australia. He was house physician at the Royal Brompton before becoming a consultant in the late 1940s. Wood was a master of clinical cardiology, renowned for his extraordinary bedside examination skills and diagnostic powers.

He first published *Diseases of the Heart and Circulation* in 1950. He was not fond of anatomy but was fascinated by cardiovascular physiology and was thus greatly motivated by the recently discovered cardiac catheterisation. This allowed him to investigate and corroborate his clinical suspicions with precision.

Much of Wood's own experiences in day to day practice inform the book, and many passages are written in the first person. The clinical deductions he was able to make in the days before tests such as echocardiography were available are astounding. Much of the text is still relevant today. He realised that the decisive factor in surviving cardiac arrest is the speed with which chest compressions are started. He avidly describes the difficulties of treating bradycardia-tachycardia syndrome, so easily dealt with today by pacemakers. He explains at great length the foods that are "permitted, doubtful, or forbidden" in heart failure and in fact dedicates four whole pages to this exhaustive list. He advocates the use of olive oil in cooking rather than butter and the importance of a low sodium diet.

For me the book's highlight is the first chapter on history taking—one of the most astutely written passages of medical text I have come across. Wood highlights the fact that answers often reflect the way questions are framed and insists on thorough cross examination of all answers. An example of his level of attention to detail was his classification of haemoptysis in mitral stenosis into five distinct categories: the sudden profuse haemorrhage of pulmonary apoplexy; blood streaked mucoid sputum as a result of winter bronchitis; blood stained sputum of paroxysmal cardiac dyspnoea; pink frothy sputum complicating pulmonary oedema; and frank haemoptysis from pulmonary infarction.

The clinical deductions Wood was able to make in the days before tests such as echocardiography were available are astounding

The book was an instant hit, and a second edition followed in 1956. Tragically Wood died prematurely after a heart attack in 1962 while working on the third edition. He analysed his own electrocardiogram and knew his fate. What might Wood have made of today's practice of percutaneous revascularisation, which could have dealt with his single coronary thrombosis?

Benoy N Shah, specialist registrar in cardiology, Poole General Hospital, Poole, Dorset benoy@doctors.org.uk

Cite this as: *BMJ* 2008;337:a2125

REVIEW OF THE WEEK

The safe sex messenger

A documentary profiling the work in the 1980s of safe sex warrior Richard Berkowitz is still highly relevant, finds **Khalid Ali**

Sex Positive
London Film Festival, 27 October, National Film Theatre, London
www.bfi.org.uk
Rating: ★★★☆

With the resurgence of HIV and other sexually transmitted diseases in the United Kingdom, *Sex Positive* is a timely documentary about Richard Berkowitz, one of those who pioneered the safe sex message to the gay community in the United States in the mid-1980s. Studies in the past two years show that HIV transmission is on the rise again and that, among men who have sex with men, those who know they are HIV positive are more likely to indulge in risky sexual behaviour than those who are not infected or those who don't know their HIV status (*Sexually Transmitted Infections* 2007;83:392-6; *AIDS* 2008;22:1063-70).

Berkowitz, a former hustler who specialised in sadomasochism, is interviewed alongside fellow gay activists from the 1980s, HIV researchers, patients, and porn stars. They talk about the turbulent times at the beginning of the HIV epidemic in the US, when misinformation was rife about the causes and routes of transmission. Berkowitz speaks candidly about being a liberal Jew from a working class family coming out as a gay man in a conservative environment. From his college days in New Jersey he was involved in organising marches against homophobia. In a dramatic turn of events he became a commercial sex worker.

Richard Berkowitz: his safe sex message was misinterpreted

A chance encounter in a sexually transmitted disease clinic with the virologist and microbiologist Joseph Sonnabend was a turning point. Sonnabend persuaded him that sexual promiscuity promoted HIV transmission. Berkowitz, Sonnabend, and the singer and gay activist Michael Callen then started to campaign among the New York gay community to raise awareness of HIV. Sonnabend publicised the "multifactorial theory" that AIDS was caused by a combination of infection with more than one virus and an underlying susceptibility to the disease modified by lifestyle factors such as diet, drug use, and multiple sexual partners. Berkowitz appeared on national US television condemning the lifestyles of many gay people, thus antagonising the gay community, which labelled him a self hating gay man with a "sex negative" attitude. He was quoted as saying that "people deserve to have the disease as they brought it upon themselves" and calling for "a quarantine for gay men."

His stance was interpreted by some as a call for the federal government to stop funding research into HIV. Amid this hostility he wrote *How to Have Sex in an Epidemic*, a revolutionary pamphlet thought to be the first community driven publication advocating safe sex. But his safe sex message was misinterpreted by some as advocating celibacy or monogamy. Even after his book *Staying Alive: The Invention of Safe Sex* was published,

In the midst of this hostility he wrote *How to Have Sex in an Epidemic*, a revolutionary pamphlet thought to be the first community driven publication advocating safe sex

Berkowitz continued to be marginalised and ridiculed by the gay community. His former job was used to discredit him: his antagonists cried out that "a former S&M hustler cannot dictate the ethical agenda for the future of gay men."

The film also tackles the issue of the duration and effects of antiretroviral treatment. People with HIV describe the pressure put on them by health professionals and governments to start treatment as soon as possible. It is now known that the lifespan of HIV positive patients is approaching that of the general population (*JAMA* 2008;300:51-9), but at what cost? The film argues that antiretrovirals generate a false sense of security, encouraging more risky sexual behaviour, despite the fact that unprotected anal intercourse with multiple partners and drug use is associated with a higher risk of HIV seroconversion (*Sexually Transmitted Infections* 2008;84:8-13). "Be safe and alive" was (and still is) Richard's motto, and it rings as true today as it did back in the 1980s.

Khalid Ali is a senior lecturer in geriatrics, Brighton and Sussex Medical School Khalid.Ali@bsuh.nhs.uk

Cite this as: *BMJ* 2008;337:a2235