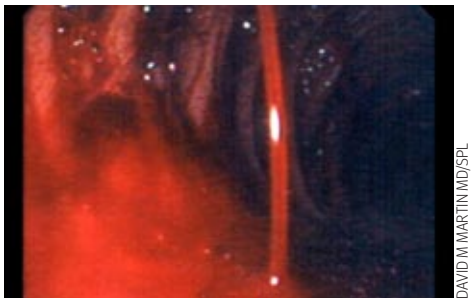
These letters are selected from rapid responses posted on bmj.com. Selection is usually made 12 days after print publication of the article to which they respond.

LETTERS



DAVID M MARTIN MD/SPL

ACUTE GASTROINTESTINAL BLEEDING

Firstly, improve availability of endoscopy

The SIGN guidelines summarised by Palmer and Nairn recommend that proton pump inhibitors (PPIs) should not be used before endoscopic therapy and that early endoscopic examination be performed within 24 hours of admission, where possible.[1]

A randomised controlled trial cited in the SIGN guidelines found that early treatment with omeprazole significantly lowered the prevalence of high risk stigmata (19.1% *v* 28.4%; P=0.007) at endoscopy and, thus, lowered the need for endoscopic therapy.[2] Preventing the need for therapeutic intervention may be particularly important when long delays to endoscopy are envisaged.

In the UK, intravenous treatment with PPIs is commonly initiated for suspected major non-variceal upper gastrointestinal bleeds before endoscopy. This may be because of the problems in obtaining out of hours endoscopy, particularly on bank holiday weekends and Fridays after working hours. In 2007, only 56% of hospitals with an accessible endoscopy unit had an out of hours endoscopy rota, even though 59% of cases present out of hours.[3]

Until the delay to therapeutic endoscopy falls significantly, many patients are likely to continue to have PPI therapy before endoscopy.

If the government produces targets for care in acute gastrointestinal haemorrhage similar to those for thrombolysis in acute myocardial infarction and stroke, then perhaps an injection of investment will follow and allow the SIGN guidelines to be completely achieved.

Mohammed A Butt specialty registrar 3, gastroenterology
adilbutt@doctors.org.uk
Umair A Mohammed medical student
Anne B Ballinger consultant gastroenterologist, Queen Elizabeth the Queen Mother Hospital, Margate, East Kent CT9 4AN

Competing interests: None declared.

1 Palmer K, Nairn M on behalf of the Guideline Development Group. Management of acute gastrointestinal blood loss: summary of SIGN guidelines. *BMJ* 2008;337:a1832. (10 October.)
2 Lau JY, Leung WK, Wu JC, Chan FK, Wong VW, Chiu PW, et al. Omeprazole before endoscopy in patients with gastrointestinal bleeding. *N Engl J Med* 2007;356:1631-40.
3 St Elsewhere's NHS Trust. *UK comparative audit of upper gastrointestinal bleeding and the use of blood.* 2007. http://hospital.blood.co.uk/library/pdf/UGI_Bleed_%20Audit_St%20_Elsewhere's_NHS_Foundation_Trust.pdf .

Cite this as: *BMJ* 2008;337:a2385

Secondly, improve availability of interventional radiology

An important element of the SIGN guidelines is evidence based advice about the management of patients who fail medical and endoscopic or sigmoidoscopic therapy.[1] SIGN advocates computed tomography angiography for diagnosis and embolisation for treatment of non-variceal haemorrhage, as well as transjugular portosystemic shunting for variceal haemorrhage.

NHS provision of the required high quality diagnostic and therapeutic radiological services both in and out of hours has been criticised by several National Confidential Enquiry into Patient Outcome and Death studies.[2,3] A recent survey into interventional radiology services by the Royal College of Radiologists found that such out of hours services were offered on a formal basis by only a minority of NHS trusts. This is despite recognition of the increasing need for these procedures in the control of bleeding.[4,5]

Interventional radiology is a small subspecialty and it may not be possible to provide it 24 hours a day in every centre. However, its provision and quality should at least match those of endoscopic services—a fact that the Department of Health and healthcare commissioning bodies need to recognise. A departmental inquiry into its provision would help commissioners ensure that there is a properly resourced, robust, and resilient interventional radiology service available in every region. Such provision might also deliver therapeutic minimally invasive treatment not only to patients with acute gastrointestinal bleeding but also to those with life threatening traumatic, obstetric, and iatrogenic bleeding.

Tony Nicholson consultant interventional radiologist
tonynick@tonynick.karoo.co.uk
David Kessel consultant radiologist, Leeds Teaching Hospitals, Leeds LS1 3EX

Competing interests: None declared.

1 Palmer K, Nairn M. Guidelines: Management of acute gastrointestinal blood loss: summary of SIGN guidelines. *BMJ* 2008;337:928-9. (10 October.)
2 National Confidential Enquiry into Patient Outcome and Death. *Emergency admissions: a journey in the right direction?* 2007. www.ncepod.org.uk/2007report1/Downloads/EA_summary.pdf.
3 Royal College of Surgeons, National Confidential Enquiry into Patient Outcome and Death. *Trauma: who cares?* 2007. www.ncepod.org.uk/2007report2/Slides/Woodford.ppt.
4 Healthcare Commission. *Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005.* 2006. www.healthcarecommission.org.uk/_db/_documents/Northwick_tagged.pdf.
5 Royal College of Radiologists. *Standards for providing a 24-hour interventional radiology service*. BFCR(08)13. London: RCR, 2008.

Cite this as: *BMJ* 2008;337:a2382

COMPLEMENTARY MEDICINE

Involve complementary medicine practitioners in research

Complementary medicine is rightly criticised for the unprincipled actions of some therapists,[1,2] which unfairly taint the many more scrupulous practitioners. However, my recent report to the Australian government indicated that complementary therapists are overwhelmingly in favour of greater regulation and tighter restrictions.[3] They also want more collaboration with evidence based medicine and more research, not less, but they want to be consulted and involved in this process.

The complementary medicine industry argues that many evaluation techniques do not accurately represent clinical practice,[4] while the scientific community argues that these medicines need to be evaluated like any other. Both arguments are valid.

Much of the research performed by those with intimate knowledge of the therapies lacks scientific rigour, but much of the research performed by experienced researchers may not accurately evaluate the treatments because of lack of knowledge. A good example is echinacea. Professional herbal texts do not recommend its use for treating acute colds and flu partly because of its long lead-in period, but most evaluation has focused on this use.[5]

Researchers and complementary therapists need to collaborate and formulate research designs to evaluate these medicines. Ernst has

previously suggested that those involved in complementary medicine should not evaluate it. This is as ludicrous as suggesting that medical doctors should be barred from medical research. More research and evaluation of complementary medicine is certainly needed, but to ensure this research accurately reflects the way complementary medicines are used, complementary medicine practitioners need to be engaged.

Jon L Wardle research scholar, School of Population Health, University of Queensland, Herston, QLD 4006, Australia
j.wardle@sph.uq.edu.au

Competing interests: None declared.

1 Godlee F. It's the evidence, stupid. *BMJ* 2008;337:a2119. (13 October.)
2 Ernst E. Treating evidence with contempt [letter]. *BMJ* 2008;337:a2063. (13 October.)
3 Wardle J. *Regulation of complementary medicines: a brief report on the regulation and role of complementary medicines in Australia*. Brisbane: Naturopathy Foundation, 2008.
4 Mason S, Tovey P, Long AF. Evaluating complementary medicine: methodological challenges of randomised controlled trials. *BMJ* 2002;325:832-4.
5 Linde K, Barrett B, Wölkart K, Bauer R, Melchart D. Echinacea for preventing and treating the common cold. *Cochrane Database Syst Rev* 2007;(3):CD000530.

Cite this as: *BMJ* 2008;337:a2389

Inconsistency over payment

It seems strange to me that cancer patients who wish to pay for potentially effective treatments that have not yet been approved by the National Institute for Health and Clinical Excellence are charged for their NHS chemotherapy, whereas cancer patients who wish to pay for their definitely ineffective complementary treatment are encouraged to do so and retain their right to NHS chemotherapy.[1]

Terry J Hamblin visiting professor of haematology, University of Southampton, Southampton SO16 6YD **terjoha@aol.com**

Competing interests: None declared.

1 Ernst E. Treating evidence with contempt. *BMJ* 2008;337:a2063. (13 October.)

Cite this as: *BMJ* 2008;337:a2388

MANAGING THEORETICAL vCJD RISK

Disposable instrument issue affects lots of doctors too

The letter from Hotchkiss brings up an important point[1]—but it doesn't apply only to chiropodists. I am a GP minor surgeon with 20 years of experience using my own autoclave and with an extremely low rate of postoperative infection—like most GPs. Recently I have been forced by my primary care trust to use poor quality steel surgical instruments that are disposed of after each operation. There is an appalling degree of waste and environmental damage entailed in their manufacture in Pakistan, transport to England, and disposal. This is intended to reduce the risk to my patients of hepatitis and possibly Creutzfeldt-Jakob disease (CJD)—although the incidence of the latter is vanishingly low. However, there is no evidence that GP minor surgery has caused significant infections. Meanwhile, dentists, barbers, and beauty salons continue to use non-disposable instruments. This naive GP thought that a public health consultant would be able to knock some common sense into trust managers. Perhaps if enough doctors make a fuss change will happen.

Edmund Willis general practitioner, Bridge Street Surgery, Brigg, North Lincolnshire DN20 8NT **ted@docwillis.co.uk**

Competing interests: None declared.

1 Hotchkiss J. Policy to reduce the risk costs the environment dear. *BMJ* 2008;337:a1776 (23 September.)

Cite this as: *BMJ* 2008;337:a2277

GENERALIST END OF LIFE CARE

Experience from Royal Marsden

The Royal Marsden Hospital2Home (H2H) pilot programme tackles the issues and overcomes many of the barriers in generalist end of life care (EOLC) identified by Shipman et al.[1] The hospital is a tertiary referral oncology centre, and therefore "progressive disease with no further active oncological treatments" was our definition of EOLC and the trigger point for referral to our programme. The H2H clinical nurse specialist assesses each patient's health, social, financial, and spiritual needs and preferences regarding preferred place of care and of death. Then, with the patient's consent, a case conference[2] is organised in their homes.

The patient, informal carer, H2H clinical nurse specialist, GP, district nurse, social worker, and community palliative care nurse are invited to attend. The patient or GP chairs the conference. Care needs are discussed, and an action plan, including any advanced care planning, is agreed. A responsible professional is allocated for each item of care, and the care plan is documented.

Analysis of the first 95 patients entering the programme is as follows: patients were discharged to 35 primary care trusts. The case conferences were attended by GPs (78 cases, 82%), district nurses (89, 94%), social workers (23, 24%), community palliative care nurse (84, 88%), spiritual advisers (2, 2%), and carers (95, 100%).

The preferred place of care was home for all 95 patients; of these 67 (71%) have now died. The preferred place of death was not discussed with nine patients. Of those who died and expressed a preferred place of death, 74% fulfilled this, with 62% dying at home and 84% dying in hospice.

Although the total numbers so far are small, comparison with the national statistics shows an impact on actual place of death, with an increase in both home and hospice deaths, and a decrease in hospital deaths (10% in the H2H population).[3]

Our programme is manageable and can be integrated into a generalist workload. We agree with Shipman et al that the way forward is to standardise definitions and to measure outcomes. We will then be able to share information and develop a contemporaneous, electronic, summary care record for palliative care patients that will be accessible to all specialist and generic professionals including the out of hours service providers.

Julia Riley head of the department of palliative medicine
julia.riley@rmh.nhs.uk
Clare Smith specialist registrar palliative medicine
Michael Thick chief clinical officer, Connecting for Health, Royal Marsden Hospital NHS Trust, London SW3 6JJ
On behalf of Nigel Dodds, Maria Owens, Diedre Adams, Fiona Wheeler, Joy Ross, David Currow

Competing interests: None declared.

1 Shipman C, Gysels M, White P, Worth A, Murray SA, Barclay S, et al. Improving generalist end of life care: national consultation with practitioners, commissioners, academics, and service user groups. *BMJ* 2008;337:848-51. (2 October.)
2 Mitchell G, et al. Do case conferences between general practitioners and specialist palliative care services improving quality of life? A randomised controlled trail. *Palliat Med* 2008;22:1-9.
3 Department of Health. *End of life care strategy: promoting high quality care for all adults at the end of life*. London: DH, 2008.

Cite this as: *BMJ* 2008;337:a2290

FAMINES AND WEATHER

People, not weather, cause mass starvation

I feel obliged to respond to the closing lines of this otherwise thoughtful editorial: "Because famines are not caused by weather only, insurance systems could be developed that take into account political and other considerations in vulnerable countries."[1]

In our modern era, famines are never caused by weather. Droughts are caused by weather. Famine conditions may be triggered by weather, but the ensuing mass starvation derives from a political dynamic.

During 1985-6, when I worked as a doctor in the refugee camp along the Ethiopian-Sudanese border, children (and adults) were experiencing mass starvation. Close by, Sudanese farmers were hoarding grain supplies to keep the prices high. Thousands of miles away, Australia was experiencing a severe drought and agricultural outputs were affected, but no Australian children died of marasmus that I know of.

Let's be clear, in this age, people starve because other people choose to let them starve, not because of the weather.

Andrew D Lynk consultant paediatrician, Cape Breton District Health Authority, Canada B1P 1P3
alynk@ns.sympatico.ca

Competing interests: None declared.

1 Gundersen C. Identifying famines. *BMJ* 2008;337:a1178. (2 October.)

Cite this as: *BMJ* 2008;337:a2383