

Poppy love

PERSONAL VIEW Janet Gillespie

I spread out the crumpled note the patient had given me while he spoke: he had been to the pain clinic “for his back,” and they had recommended this to help his pain. If he took the note to his (implied) trusty GP, he or she would sort it out for him; and if the treatment was unsuccessful, the pain clinic suggested, he could be referred to a neurosurgeon for assessment. Mercifully, the trade name was scrawled in block capitals. The *British National Formulary* revealed it to be a methadone transdermal patch.

I sat back and considered the matter. It was not an entirely unreasonable suggestion: the patient was already taking paracetamol, tramadol, and amitriptyline, with only moderate control, and his sleep was still disturbed. What surprised me was that the opiate prescription had come before a referral for a surgical opinion.

In the mid-1980s, when I trained as a general practitioner, opiate patches were only the proverbial twinkle in a pharmacologist's eye, and use in the community of “Brompton cocktail” was considered avant-garde. Ten years later, when I left the partnership, syringe drivers and Macmillan nurses had become a routine part of the primary healthcare service. But that was for terminal care; pain that merited further investigation or had a possible alternative solution was managed by an appropriate referral.

Perhaps part of the reason for this reluctance to prescribe opiates was the need to handwrite prescriptions for “controlled drugs” in words and figures. Individual doses were easily remembered: scripts were for small amounts and were therefore often repeated. In the days before computer searches, a straw poll of the partners would have produced a complete list of all patients taking opiates regularly.

Opiate prescribing dates back to Sir Thomas Sydenham, who, in the 1660s, promoted laudanum (from the Latin “laudare,” to praise), a tincture of opium and alcohol. Writing at the end of the 19th century, William Osler called it “God's own medicine.” For the first time there was a reliable means of controlling diarrhoeal symptoms, while in moderate doses it acted

as a sedative and in larger doses as a powerful painkiller. People bought it in much the same way as they buy aspirin today: opium was more widely available in 1870 than tobacco was a century later. Patent medicines such as Dover's powder were kept in the kitchen cupboard. Godfrey's Cordial or Street's Infants' Quietness not only reduced colic in infants but made it easier to sedate children so that they were indeed “seen and not heard.” The intoxicant effects of opium were also appreciated: one Ely brewer added it at source.

As early as the 1830s, however, it was recognised that opium use reduced life expectancy, and by the 1860s it had become a matter of national concern. A third of all fatal poisonings were opium related, and accidental poisonings were so common that information leaflets were published to warn of the risks. The 1868 Poisons and Pharmacy Act listed opium as one of 15 poisons whose use became restricted, but it wasn't until 1920 that Britain had its first formal legislation on the regulation of drugs, with the Dangerous Drugs Act. Today, we practise in the shadow of Harold Shipman and his profligate opiate misuse. It is somewhat paradoxical, then, that prescriptions for opiates are now computer generated for accuracy and legibility but by this method are less onerous to issue.

I recently returned to general practice after a break of seven years and was struck by the large number of opiate prescriptions. The NHS's Prescription Pricing Division confirms this increase: from 2000 to 2005 the largest increase in painkiller prescribing was in opioid analgesics, with morphine prescription increasing by 32% and fentanyl patches nearly sixfold. This trend continues: data from Octo-

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ber to December 2006 show that prescribing of opioids rose by 62%, accounting for 25% of all analgesic prescribing (www.ppa.org.uk/news/pact-032007.htm). Notably, morphine prescribing rose by 57%.

Over my professional lifetime I have witnessed the consequences of iatrogenic benzodiazepine dependency, these drugs having originally been promoted as a safer substitute for barbiturates. This was yet another example of the British love of problem solving by substitution: Wellington's Beer Act (1830) promoted beer to solve the misuse of gin, a drink that was first promoted by William III to reduce the wine trade with France, the old enemy. So what are we prescribing opiates as a substitute for? Since the rise in opiate use clearly predates the “loss” of co-proxamol, is our prescribing a substitute for action? What has changed in medical practice that patients in 2008 seem to be in so much more pain than in 1988, when treatments were fewer and surgical techniques less refined?

Or have the opiates now become an end in themselves—an easy, computer generated solution with the slight annoyance of constipation and the benefits of a mildly sedated patient?

If so, our profession is at risk of sleepwalking into another iatrogenic dependency and forgetting the age old miseries of opiate addiction.

My patient and I discussed the pain clinic's recommendation and assessed the risks and benefits of such an action. He left with a prescription for opiates, and I am writing to expedite his assessment by

a neurosurgeon. That just leaves the matter of our poppy love.

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A fat chance

FROM THE
FRONTLINE
Des Spence



I always enjoyed the university annual eating competitions: five contestants at the zenith of their ability, swallowing whole pickled onions or boiled eggs, but only one winner. Gluttony was celebrated, and like many young people I never believed I would gain weight. But times change. Obesity is now common in the young and endemic to epidemic in adults. When we won the battle for wealth we lost the war of contentment. Doctors have foolishly rushed into this haemorrhaging of happiness.

Obesity is now a big medical business, with a rapid expansion in the number of specialist clinics. Likewise drug companies are active, lurking behind advocacy groups that endorse drug treatment as a solution to the irresistibly personalised pain of obese people. Recently, however, rimonabant, a cannabinoid receptor antagonist anti-obesity drug, joined the long list of withdrawn drugs (*BMJ* 2008;337:a2301). An all too familiar tale was the unforeseen side effects of the drug.

We must stop the medical advance on obesity and bring the troops home, for once again we are destabilising self control and personal responsibility. Medicine alone cannot solve the problem of obesity, and nor should it try—obesity is not an illness or syndrome. Solutions

already exist, and they are neither new nor complex. We need to restore to people's lives a balance between energy input and output. The scale of the problem, however, requires a political, not a medical, change.

We have a decaying and neglected food culture, with families offering just readymade meals amid unconvincing excuses of "pressure of time." But the key problem is our sedentary life. Current recommendations on activity are woefully low, reflecting a poverty of expectation. And the education system is so fevered with targets it is blind to our national disgrace: inactive children. Furthermore, we are so plagued by spectres of mistrust that our children are kept virtual prisoners indoors.

An urgent and fundamental change of infrastructure and schools policy is needed. We need to create safe places for our children to play in, to allow them to cycle, pedestrianised streets and to restrict car use, along with education and financial incentives to get people to prepare food themselves. Medical interventions will serve only as an irrelevant policy distraction and have a fat chance of working.

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The bottom line

STARTING OUT
Kinesh Patel



"I've just passed a 12 inch stool," said the voice over the telephone with a degree of solemnity commensurate with such a statement. "Is that normal?"

"Well, I'm not sure," replied the secretary, a little baffled as to what the appropriate response was to such a question, while no doubt at the same time wondering why anyone would bother to measure a stool, let alone share that information with anyone else.

Although such an anecdote makes us snigger quietly to ourselves, it does illustrate how trusted we are as professionals that people feel prepared to tell us anything and everything.

It is easy to dismiss what we perceive as the crazed ramblings of patients with functional syndromes but harder to remember that to these patients those symptoms are very real. Each specialty has its own condition that makes clinicians throw their hands up in exasperation: from fibromyalgia

to irritable bowel syndrome (gastroenterology seems to have more than its fair share).

The bottom line is we're not very good at assessing patients' mental state, let alone offering appropriate treatment for their conditions. It is much easier to comment matter of factly on the large ulcerating carcinoma you've discovered than to explore environmental influences on diseases affecting the human condition.

Patients with cancer need surgery, chemotherapy, and emotional support, whereas those with commoner functional ailments mainly need just emotional support and reassurance. This takes time and effort, often without a satisfying tangible result such as ceremoniously dropping a neoplastic lesion into a pot with the command "Send that to histology."

Modern financing structures, such as the NHS's Payment by Results, do not help encourage a psychologically supportive

approach. Time spent regularly with a patient is largely regarded as "waste" time that could have been used to see a new referral, thereby keeping the hallowed "follow-up to new ratio" (abbreviated, rather ironically, to FUN) within target.

And while I have no doubt that such reforms have led to shorter waiting times for patients with organic disease, those with debilitating conditions that do not fit neatly into any pathologically proved diagnosis have surely suffered as they are bounced from hospital to GP and then back again.

What can we do to solve this quandary? Taking an interest is an important first step—for although these conditions are not glamorous or popular with clinicians, they affect far more people than do the rarer diseases we often seek. And just in case you were wondering, a 12 inch stool is entirely normal.

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In small town America

There are two doctors in *Winesburg, Ohio*, Sherwood Anderson's book about a fictional small town in middle America. It is an episodic novel of loosely connected stories in which Anderson depicts the lives of ordinary people for whom the American dream has not come true, partly because of circumstances and partly because of human nature—we are not made for permanent, or even for very prolonged, happiness.

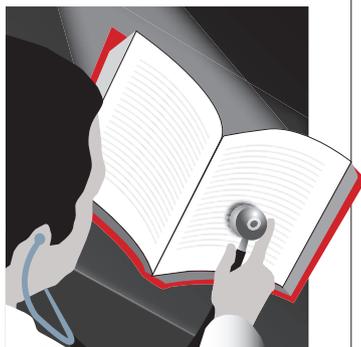
The two doctors, it must be admitted, are not the finest flower of our great profession. Neither has many patients or seems to go in much for diagnosis, let alone treatment. Indeed, Dr Parcival's qualification as a doctor seems to be in some doubt: after all, these were the days (1919) before validation, let alone revalidation, at least in towns such as Winesburg, Ohio. Dr Parcival says only that he knows as much of medicine as anyone in the town, which is about as ambiguous as the famous reference once given to a junior doctor: you will be lucky to get this man to work for you.

Dr Parcival doesn't need patients, because he has enough money for his slender needs. How he came by the money is a mystery: he has a rackets past, and he implies, though never actually claims, that he came by his money in a seriously criminal fashion. It emerges that he is mad (his father died in an asylum, at least if he is to be believed).

One day there is an accident in Winesburg and a child is killed. Dr Parcival refuses to attend and spends the rest of his life believing that a crowd of townsfolk will one day come to lynch him for his cruel indif-

BETWEEN
THE LINES

Theodore Dalrymple



Neither doctor has many patients, or seems to go in much for diagnosis, let alone treatment

ference. "Everyone in the world is Christ," he says, "and they are all crucified." Nowadays, of course, we all fear lynching by coroner's court and public inquiry.

The other doctor is Dr Reefy. His practice, too, is exiguous, and he spends his days writing things down on scraps of paper and then screwing them up into little pills that he puts in his pocket or throws on to the floor. His life has been emptied of meaning by the deaths of two women, both patients, with whom he has fallen in love, and to one of whom he was briefly married before her death.

The other is a woman married to the town's hotel keeper, who in her youth dreamt of romance and adventure but who has been ground down by everyday banality. Though very ill, she goes to Dr Reefy not in search of a cure but because he is the only man who understands her. Falling in love, their one moment of passionate embrace is interrupted by an employee of the Paris Dry Goods Company Store, above which Dr Reefy has his office, as he comes up the stairs to deposit a box on the stairwell. The lovers never meet again; their sole moment of human connectedness is evanescent. The episode is reminiscent of Chekhov's *Lady with the Lapdog*.

Of course, no such thing as happened to Dr Reefy and Mrs Willard could happen nowadays, at least not in the NHS, if for no other reason than it is so difficult to get to see the same doctor twice.

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MEDICAL CLASSICS

The Death of Ivan Ilych By Leo Tolstoy

First published in 1886

In one of his letters Tolstoy defined his novel *The Death of Ivan Ilych* as "a description of an ordinary death of an ordinary man." It is based on the real story of Ivan Ilych Mechnikov, a lawyer who died at the age of 45 from cancer. His younger brother, the Nobel medical laureate Ilya Ilych Mechnikov, wrote that Tolstoy had given "the best description of fear of death."

Ivan Ilych, a lawyer in a provincial Russian town, had led a life that was, Tolstoy wrote, "most simple and most ordinary, and therefore most terrible." A successful careerist and head of the family, Ilych one day noticed a queer taste in his mouth and felt some discomfort in his left side, accompanied by irritability. His wife demanded that he visit a doctor. But "it was all just as it was in the law courts," Ilych finds:

The doctor put on just the same air towards him as he himself put on towards an accused person. The doctor said that so and so indicated that there was so and so inside the patient, but if the investigation of so and so did not confirm this, then he must assume that and that. If he assumed that and that, then . . . and so on. To Ivan Ilych only one question was important: was his case serious or not? But the doctor ignored that inappropriate question. From his point of view it was not the one under consideration, the real question was to decide between a floating kidney, chronic catarrh, or appendicitis.

Ilych consults several doctors who diagnose different diseases and administer different treatments. In search of a cure he is prone to irrational behaviour: "One day a lady acquaintance mentioned a cure affected by a wonder-working icon. Ivan Ilych caught himself

listening attentively and beginning to believe that it had occurred." Soon he understands that "it's not a question of appendix or kidney, but of life and . . . death . . . There was light and now there is darkness. I was here and now I'm going there! Where?"

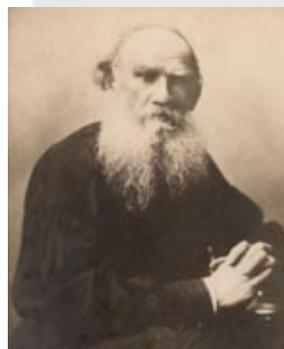
Tolstoy is known for his pejorative and unfair attitude to medical doctors. All the doctors

in this novel are shown as hypocrites who constantly lie and who are indifferent to Ilych.

The death of Ilych from cancer is described in such detail that it has been proclaimed the strongest description of this disease in literature. The veracity of the depiction is such that, a Russian professor of medicine said, not only a physician but any third year medical student would be able to diagnose the disease as an abdominal cancer localised either in the caecum or the right kidney. "Every doctor of any specialty should read this story with utmost attention to reveal a sea of horror and doubts experienced by cancer patients," wrote A T Lidsky in a Russian medical periodical in 1929.

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Tolstoy: veracity of depiction

REVIEW OF THE WEEK

Lessons from the killing fields

A remarkable textbook will allow for the rapid application in surgery of lessons from the wars in Iraq and Afghanistan, finds **Jonathan Kaplan**

Combat conditions in Iraq and Afghanistan are producing new patterns of wounds. Advances in body armour allow soldiers to survive explosions that would previously have been mortal, though at the expense of limbs ripped off by blast. The addition of a tourniquet to each soldier's field kit—and the training to apply it before excessive blood loss—has reduced the death rate through shock from traumatic amputation by 90%, while ultra-rapid evacuation allows soldiers with previously unsurvivable injuries to reach advanced surgical care with vital signs still present. One consequence has been bold advances in the treatment of major trauma. Another consequence, perhaps equally dramatic, has been the rewriting of the war surgery textbook.

Far from a traditional reference, *War Surgery in Afghanistan and Iraq* is instead a series of individual case studies in which treatment decisions and their consequences are followed through to their rigorously analysed conclusions. Cases cover every surgical discipline, crossing anatomical and specialty boundaries to include neurological, abdominal, thoracic, orthopaedic, faciomaxillary, vascular, and soft tissue injuries. The first case report—a badly injured man subjected to complex surgery that occupies the entire surgical team in a forward hospital for hours and empties the blood bank, only for him to die in the evacuation helicopter—illustrates the book's central message: damage limitation as the primary intervention.

Its raw materials are vivid digital camera images and contemporaneous case notes written amid the surgical battle. Teleconferencing and computer based tracking of patients have allowed constructive use of this data, making possible the rapid application of clinical lessons. An example is the principle of damage control resuscitation, taught in theory for the past decade but prone to wide variations of practice. Now, rapid comparisons of outcomes—and a brisk flow of casualties on which to accumulate an evidence base—are making possible the standardisation of what had previously been somewhat intuitive practices, turning them into scientific principles with replicable, consistent results. Such protocols are essential to counter the surgeon's instinct to make things right, to repair all damage, which launches the patient along the path of diminishing survival through hypothermia, acidosis, and coagulopathy.

Not all the discoveries are new. The use of rapidly cross matched, fresh whole blood as a first line treatment for haemorrhagic shock was pioneered by Norman Bethune in 1936 during the Spanish civil war—but advances in platelet apheresis, together with transfusion protocols that combine set ratios of blood, platelets, and fresh frozen plasma, have greatly reduced mortality after massive transfusion (10 or more units of blood in 24

hours) from 65% to 19%. Another result has been the overturning of established practice in emergency fluid replacement, concentrating on hypotensive resuscitation (up to a systolic blood pressure of 90 mm Hg), with thawed plasma advocated for the colloid restoration of circulating volume, while crystalloid use is relegated to the humble task of keeping intravenous lines open.

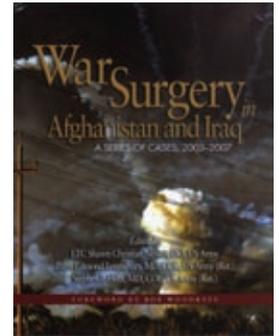
Vividly depicted is the arena in which those decisions and interventions are made—"the white-hot moments in the surgical theatre where nothing is spared to save a life." It is to the credit of the authors and editors that despite the imperatives of their work and the pressure to deliver effective trauma care under extreme conditions they have tried to adhere to principles of respect for patients. There are instances when such fastidiousness almost jars. A mortar victim is shown on arrival at a combat support hospital, legs shredded, with medics pressing on the avulsed ends of the femoral artery in each groin. After radical surgery amounting almost to bilateral femoral disarticulation, the pelvis is rephotographed, and again during treatment at a military hospital in the United States. In each image the genitals are covered with a decorous black square, demarcating even in this extremity some grade between information and poor taste. Later, though, when the man is seen at various stages of recovery and restoration of mobility, the preservation of his modesty seems exactly his due.

While "host country national" casualties are generally lost to follow-up, an attempt is made to trace the progress of each US casualty through tertiary care and rehabilitation, which allows for display and discussion of advances in these fields as well. Changes in surgical practice towards length preservation in the primary amputation have greatly improved eventual function, with new prostheses that are mouldable to almost any stump shape. Awareness is growing of the prevalence of mild traumatic brain injury: 29% of battle injured patients passing through Walter Reed Army Medical Center show some degree of neurocognitive impairment, usually through exposure to blast, that may not have been associated with loss of consciousness at the time of injury. And the wounded are bringing back new pathogens, with multiple drug resistant *Acinetobacter baumannii* colonising medical facilities along the evacuation chain from Iraq through European hospitals to tertiary care institutions in the US.

New lessons are being learnt in every aspect of combat surgical care, and this book is an exemplary and vivid document of that evolution.

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War Surgery in Afghanistan and Iraq: A Series of Cases, 2003-2007

Eds Shawn Christian Nesson, Dave Edmond Lounsbury, Stephen P Hetz
Office of the Surgeon General, US Army,
pp 442, \$71

Copies may be ordered through the US Government Bookstore (www.bookstore.gpo.gov)
ISBN: 978-0981822808

Rating: ★★★★★

Vividly depicted are "the white-hot moments in the surgical theatre where nothing is spared to save a life"