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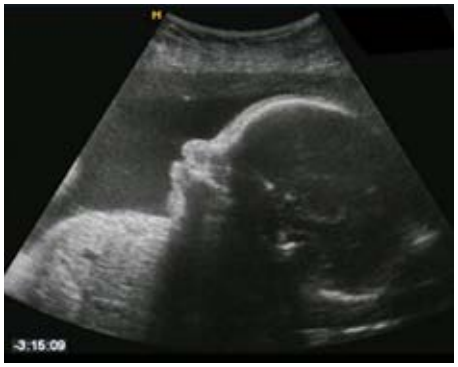
LETTERS

EARLY LIFE RADIATION EXPOSURE

Withholding imaging in pregnancy may be hazardous



Failure or reluctance to image pregnant women contributes to maternal mortality.[1] Rajaraman and colleagues state that x ray imaging of mothers during pregnancy increases the risk of childhood cancer and leukaemia.[2] However, the risk is small and not statistically significant. Although controls were similar for many identified confounding factors, a family history of cancer was not accounted for. Furthermore, radiography was mostly performed for obstetric pelvimetry, a practice that is outdated. The results from this study are therefore not applicable to modern day imaging of pregnant women. The fetal effects of plain chest and bone radiography and computed tomography of the head and chest are more relevant to current practice. With lead shielding the radiation dose to the fetus is minimal and far less than for plain radiographs of the abdomen or pelvis.[3]

The study's conclusion about a "possible risk of cancer from radiation at doses lower than those associated with commonly used procedures such as computed tomography" is weak given the results are not statistically significant. This sends out the wrong and potentially dangerous message that imaging in pregnancy is harmful. Scaremongering and implying that vulnerable sick pregnant women may be harming their baby if they undergo radiological procedures is a retrograde move and contradicts recommendations from the latest Confidential Enquiries into Maternal Deaths.[4] Computed tomography to aid diagnosis of potentially fatal conditions such as subarachnoid haemorrhage, pulmonary embolus, or aortic dissection should not be withheld because of unsubstantiated concerns about fetal risk.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1486

UTILITY OF LIFETIME RISKS

In defence of lifetime risk

Implicitly, McCartney considers the lifetime risk of disease to be confusing and uninformative.[1] But it does provide a useful and understandable summary of risk in a population.

The lifetime risk of breast cancer is a measure of the proportion of the women you know who have had or will get breast cancer. Lifetime risk can be criticised, but so can every (univariate) measure of risk. The 10 year risk, seemingly favoured by McCartney, only makes sense if one has a table of risks at different ages. Averaging the age specific risk (as is done in the age standardised rate) is less informative because it mixes the risk of a child (essentially zero for many diseases) with that of a 75 year old. It is like the statistician who, with one foot in a bucket of ice water and the other in a bucket of scalding water, said that on average the water is pleasantly warm.

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Competing interests: PDS is a former employee of Cancer Research UK and continues to have substantial research funding from the charity. He has done work for Breakthrough Breast Cancer. He has received funding from the NHS Cervical Screening Programme for a number of small projects. He is the author of a number of statistical papers on lifetime risk, including one on standardised lifetime risk and one, as yet unpublished, on adjusting for second primary cancers.

1 McCartney M. How useful are lifetime risks of disease? *BMJ* 2011;342:d1046. (16 February.)

Cite this as: *BMJ* 2011;340:d1490

GETTING WELFARE TO WORK

Response from the General Medical Council

Cooper is mistaken in thinking that the principle of making the care of your patients your first concern does not apply to doctors when they are assessing benefits claimants on behalf of Atos.[1] Our guidance is for all doctors, and it uses the term "patient" to refer to all those whom doctors test, treat, or assess in their professional capacity as a doctor. This includes employees, benefits and insurance claimants, and athletes.

The first duty of all doctors is "to make the care of your patient your first concern." But that is not the only duty doctors have. Being open and honest and acting with integrity is also an essential part of medical professionalism. Good medical practice provides guidance, not a set of rules, so doctors must use their judgment to apply the duties and principles defined in our guidance to the various situations they face, whether or not they routinely see patients in a therapeutic role or any other role.

Dishonesty in writing reports cannot be justified by reference to the first duty of doctors. Further advice on disclosing information for employment, insurance, and similar purposes can be found in our supplementary guidance.[2]

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Competing interests: None declared.

1 Cooper ES. Health professionals' advice: the ethics. *BMJ* 2011;342:d1155. (22 February.)
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Cite this as: *BMJ* 2011;342:d1623

INDUSTRY SPONSORED TRIALS

Best practice for statisticians in industry sponsored trials

In light of CONSORT 2010,[1] the recently proposed best practice for statisticians in reporting industry sponsored trials should be highlighted.[2] The eight recommendations below were explained in two accompanying articles.[3 4] A forum for editors, industry, and academia to discuss the issues raised would be beneficial.

(1) The statistical author should be responsible for the statistical aspects of the paper—the authoring statistician should take responsibility for the statistical content of the published paper.
(2) The person responsible for statistical aspects of the trial should be recognised as an author—the statistician responsible for the design, conduct, analysis, and reporting of a trial should be identified and named as a coauthor.
(3) Protocols should be published or made publicly available, or both, in a timely manner—methods should be reported appropriately to enable reviewers and editors to confirm pre-defined study objectives, end points, and analysis.
(4) Financial and other conflicts of interest should be disclosed—there should be a clear statement identifying who sponsored the trial. The trial statistician should also declare any financial interest and potential conflicts of interest.
(5) The authors should have freedom to act—the primary investigator and coauthors should not be pressured to suppress or delay publication of trial results, or to present the results in a manner that they think is inappropriate.
(6) All authors should have full access to trial data—the authors should have appropriate access to the data collected and should play a full part in the interpretation.
(7) The trial results should be published—in line with legal expectation, trial results should be published in publicly accessible registries and, whenever possible, in peer review journals.
(8) Independent statistical review should be highlighted—if industry sponsored clinical trials undergo statistical review by independent experts the nature and scope should be described.

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Competing interests: These are the authors' personal views but they are endorsed by the board of Statisticians in the Pharmaceutical Industry (PSI).

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Cite this as: *BMJ* 2011;342:d1636

MEPHEDRONE

Banned but still available on the internet

Before April 2010, when mephedrone became a class B substance in the UK, the drug was sold lawfully online, either using its correct name or under fantasy names that did not specify its presence.[1]

A recent study has reported the results of an online survey of UK mephedrone users,[2] carried out in June 2010, two months after the drug was banned.[3] Of the 150 respondents, 95 admitted to using mephedrone after the law had changed, but now sourced it from local dealers rather than the internet, which they had used before.

The impression given, that mephedrone is no longer available on the internet, is incorrect. Most of these products disappeared from the internet after April 2010, but one product called "green granules" is still sold online. In May and early December 2010 we purchased green granules and a new product called "jelly bomb caps"—capsules filled with green granules.[4] Nuclear magnetic resonance spectroscopy, mass spectrometry, and high performance liquid chromatography confirmed that mephedrone is the only active component of both products.

Mephedrone is still widely available in the UK, not only through street dealers but also through the internet market, which remains effectively uncontrolled.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1629

HYPERTENSION RISK IN THE YOUNG

Pre-eclampsia is a risk marker

Williams did not mention the role of pregnancy in highlighting risk in women of childbearing age. Women who develop pre-eclampsia have a relative risk of 3.7 of developing hypertension later in life; the risk being greatest in those who develop pre-eclampsia at earlier gestations.[1 2]

Such women should be screened for high blood pressure and dyslipidaemia, with additional advice on lifestyle change and potential pharmacoprophylaxis after and outside pregnancy. However, this rarely happens. Such surveillance in primary care may lead to reductions in premature morbidity and mortality.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1631

DEMENTIA AS CHRONIC DISEASE

Rigorous health infrastructure is needed

Under the current general medical services (GMS) contract, clinicians are incentivised to monitor patients presenting with a selective group of common chronic diseases.[1] The prevalence of dementia is lower than many of the chronic diseases assessed under the clinical domain of the Quality and Outcomes Framework (QOF). Nonetheless, it contributes to 11.2% of all years lived in disability for people aged 60 years and above.[2] This is considerably higher than the years of disability lived with cardiovascular disease (5%) or with all forms of cancer (2.4%), conditions measured under QOF.[3]

We are not proposing that a similar form of monitoring is established for dementia, because the relative infancy of dementia research would make this ineffective. However, because prompt verification of disease onset is essential for good quality of care,[4] it is crucial that future government health policies provide support and explicitly indicate the need for clinicians to be alert to presentations of dementia, as much as they are to common chronic diseases.

Whether dementia should be regarded as a chronic disease is debatable.[5] However, it is imperative that, similar to the rigorous health infrastructure present for chronic disease management, an analogous support system be devised for dementia. Only then will the NHS be equipped to absorb the implications of a growing prevalence of dementia.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1634