LETTERS

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METAL ON METAL HIP IMPLANTS

Cobaltism associated with metal on metal hip implants

Our initial experience with metal on metal hip implants[1] was favourable. But several years later an uncharacteristically high proportion of patients developed progressive, unresolved, or new hip pain, some showing metal debris around the hip with tissue damage. Two patients had remarkably high cobalt concentrations, cognitive decline, cranial neuropathy, and early cardiomyopathy.[2]

We have just identified a fifth case of probable arthroprosthetic cobaltism in a patient awaiting revision of a Birmingham hip resurfacing arthroplasty. The device functioned well for 15 months, and he remained well. Over the next 23 months he developed pain and noise at the hip, new onset of anxiety and major depression, tinnitus, high frequency hearing loss (audiographically confirmed), peripheral neuropathy, and cognitive decline. Serum cobalt concentrations ranged between 64 and 74 µg/L three years after implantation (normal values <1 µg/L).

Two of our five patients received articular surface replacement and three a Birmingham metal-metal hip. All had a prodrome of depression and anxiety. Four later developed tinnitus, and one had new onset vertigo. Four had notable high frequency hearing loss on audiography. Three had early cardiomyopathy. Two required increased drug treatment for hypertension. Two developed hypothyroidism and one hyperparathyroidism. Four patients had hip noise or pain before new neurological, cardiovascular, or endocrine problems were noted. The other had no hip symptoms but had notable periprosthetic tissue damage at revision surgery.

Four patients received ceramic-plastic hip revision. Histopathology showed metallosis, necrosis, and chronic inflammation. Serum cobalt concentrations fell rapidly in all of them, although values were still toxic (>5 µg/L) in one patient a year later. In the two previously reported cases, neurological and cardiovascular function had improved significantly two years after revision.

Patients with arthroprosthetic cobaltism may present with new neurologic, cardiovascular, or endocrine problems with or without symptoms attributable to their prosthetic hip. Blood cobalt concentrations greater than 10 µg/L would support this suspicion.

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Competing interests: None declared.

Patient consent obtained.

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Cite this as: *BMJ* 2012;344:e430

MOBILE PHONES: UNHELPFUL APPS

Doctors using mobile phones to take pulse may spread MRSA

We undertook a one day survey of bacterial contamination of doctors' fingertips before and after using their mobile phone to take a patient's pulse.[1] Mobile phones are known to act as a reservoir for bacteria,[2 3] but their role in onward transmission of bacteria has not been adequately analysed. We enrolled 20 doctors of all grades and asked them to clean their hands with alcohol gel. When their hands were dry they applied their fingertips to an agar plate. They then took a radial pulse using their usual timepiece—phone or watch kept in pocket or handbag or attached to clothing. They then applied their fingertips to a second agar plate and all plates were incubated for 24 hours.

The mean bacterial colony counts increased from 34 to 47 per plate after use of a timepiece, and the number of plates containing *Staphylococcus aureus* increased from two to five. Three of the five plates grew meticillin resistant *S aureus* (MRSA) and all three positive plates were from doctors who used a mobile phone.

Thus the use of mobile phones to take a pulse or respiratory rate, a trend that is increasing with the removal of wristwatches from clinical areas,[4 5] could help spread nosocomial pathogens across hospital wards. A clinical procedure carried out at the start of the examination could be undoing the benefits of alcohol gel based hand cleaning. At a time when mobile phone based applications are being rapidly introduced into clinical areas to improve information flow, we should be aware of their propensity to spread MRSA between patients.

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Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e412

NICE AND THROMBOEMBOLISM

Guideline development group was not in the pocket of pharma

Welfare makes valid observations about the lack of good quality evidence for prophylaxis against venous thromboembolism in general medical patients and criticises the use of surrogate end points—in principle, he is right.[1] If ample randomised evidence with the end points of fatal bleeds versus fatal embolism had existed we would have used that alone. The National Institute for Health and Clinical Excellence (NICE) guideline group found that, when major and lesser outcomes were available, both sets of outcomes showed a similar trend in individual studies and meta-

analyses.[2] There are underpinning biological reasons to accept that deep vein thrombosis (DVT) and pulmonary embolism have a common cause and empirical reasons to believe that DVT and death from pulmonary embolism are associated. We therefore decided to take the line that a continuum between fatal pulmonary embolism and asymptomatic DVT exists, and that reducing lower limb thrombosis would reduce death from pulmonary embolism. We are not alone in taking this approach.[3] This may be imperfect, but it is better to use the evidence available than to waste it.

Welfare then departs from cogent arguments by implying that the guideline developers were in the pocket of pharma and that, by implication, NICE acquiesced by putting its name to a deliberately flawed guideline. Perhaps Welfare has an incomplete understanding of how NICE guidelines are developed. Be that as it may, the guideline members, unfairly accused by Welfare, might be owed an apology. We must defend our reputations against the implication that an independent guideline development group could be so easily suborned by self interest and that due vigilance on behalf of each other was not exercised. Every meeting started with a rigorous update on conflicts of interest and an interrogation by the chair if doubt existed. It is natural that leaders in the field are involved in funded meetings and help with clinical drug trials, but during the guideline development we ensured that they distanced themselves from these involvements.

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Competing interests: The authors are members of NICE CG92 group.

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Lifeblood responds to criticisms in personal view article

Any belief that the charity Lifeblood is controlled by big pharma is a misconception.[1] Lifeblood has always striven to be independent; around

58% of our income is from public donations. All funding from drug companies is ring fenced for educational or awareness projects.

In 2008 an article suggested that Lifeblood endorsed a new oral anticoagulant without Lifeblood's knowledge and consent. Lifeblood reported Boehringer Ingelheim for breaching the code of practice of the Association of the British Pharmaceutical Industry, and the company was admonished.[2]

The figure of 25 000 preventable deaths caused by hospital acquired venous thromboembolism comes from the VITAE study of six European countries.[3] This modified incidence based model took into account hospital episode statistics, prophylaxis rates, and published event rates. A conservative figure for the UK was 60 000 deaths, 42 000 being hospital related. Of these, 20% might have been in terminally ill patients, leaving about 34 000 patients with survival prospects. Assuming a recommended prophylaxis rate (medicine and surgery) of half and a reduction in pulmonary embolism mortality of two thirds, then 25 000 deaths might have been prevented with prophylaxis.

In support of this estimate, pulmonary embolism was mentioned on 16 670 death certificates in 2007 in England and Wales. Pulmonary embolism is greatly underdiagnosed—in one postmortem study of hospital deaths, for every pulmonary embolism diagnosed in life, another two were not recognised until after death.[4] Applying this principle to the death rate in England and Wales, and given that a proportion of patients receive thromboprophylaxis in hospital and have their deaths prevented, gives similar results to the VITAE study.

Although thromboprophylaxis in medical patients has not yet been shown to reduce death, it does reduce morbidity, including post-thrombotic syndrome. Surely drugs should be used to reduce suffering, whether or not deaths are reduced?

We welcome any support for our Spot the Clots campaign; Lifeblood was the healthcare and research charity of the year in 2010, and we are proud of our involvement in patient safety initiatives.

Annya Stephens-Boal executive officer
Shelley Webster chair, **Kim Carter** trustee, **Ian M Franklin** trustee, **Brian Gardner** trustee, **Simon Hart** trustee, **Beverley J Hunt** trustee, **Simon Noble** trustee, **Robin Offord** trustee, Lifeblood: The Thrombosis Charity, PO Box 58, Llanwrda SA19 0AD, UK
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Competing interests: See www.bmj.com/rapid-response/2011/12/15/re-nice%E2%80%99s-recommendations-thromboembolism-are-not-evidence-based.

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Are we going over the top with VTE prophylaxis tick boxes?

If I got a penny for every venous thromboembolism (VTE) form I did, I would be able to retire before having to apply for a consultancy. I am currently struggling to understand the rationale behind having to consider VTE prophylaxis for day case patients having stress echocardiography, who stay for hardly an hour.[1] I have to prepare a new drug chart purely to tick off the VTE box because many of these patients are not prescribed any drugs. The patients are anything but immobile, and the drug charts obviously don't come free.

Of course, I tick the box in question and put a comment saying that prophylaxis wasn't prescribed because the patient attended for day case echocardiography. I am often hunted down by the nurses if I forget. At this rate, we may be asked to start doing these forms for outpatients, who often wait for well over an hour. Are we going over the top?

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Competing interests: None declared.

1 Welfare M. NICE's recommendations for thromboembolism are not evidence based. *BMJ* 2011;343:d6452. (7 December.)

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BMJ CHRISTMAS APPEAL

Why donate pulse oximeters when they have no effect?

The aim of the *BMJ* Christmas Appeal 2011 (Lifebox) is to make surgery safer by putting an oxygen monitor in every operating room in the world, "monitors that we know save lives."

A Cochrane review on perioperative monitoring with pulse oximetry was first published in 2001. It currently includes data from 22 992 patients—a huge amount of evidence.[1]

However, pulse oximetry did not affect the outcome of anaesthesia for patients. It did not seem to influence cognitive function, length of hospital stay, incidence of postoperative complications, or in-hospital deaths. Of course, pulse oximetry can detect hypoxaemia, but this is irrelevant when it seems to have no positive effect on clinical outcomes.

I therefore wonder why the *BMJ* supported this initiative and how Gawande can know that perioperative monitoring with pulse oximetry "saves lives." What is his evidence for this?

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Competing interests: None declared.

1 Pedersen T, Hovhannisyan K, Møller AM. Pulse oximetry for perioperative monitoring. *Cochrane Database Syst Rev* 2009;4:CD002013.

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Lifebox replies to Gøtzsche

Gøtzsche's argument that pulse oximetry provides no benefit is fundamentally flawed. No anaesthesiology department in the world would forgo pulse oximetry. It forms an essential part of the measures that have improved the safety of anaesthesia in the past two decades, and every anaesthesiologist has an experience where oximetry alerted the team to serious danger.

This is like saying that the benefit of parachutes is unproved. Oximetry during anaesthesia will never be subjected to a large enough randomised controlled trial to measure harm reduction because clinicians would refuse to take part, patients would not consent, no ethics committee would permit it, and professional organisations mandate the technology.

As would be expected, our initial findings from bringing oximetry to Chisinau, Moldova, with training in basic safety procedures, reduced major complications from 24% to 9% (P<0.001).[1] Mortality fell from 3.7% to 2.9% (P=0.09).

All patients in the industrialised world are monitored using oximeters. It is time this low cost simple technology is made available for all.

Others raise the possibility of cheaper options. However, cheaper spot check pulse oximeters provide none of the basic standards needed for safe surgery (continuous measurement, audible alarms, plethysmography). We also needed a manufacturer that had shown long term quality and reliability for use in these settings. We found that target hospitals were being charged $2000 (£1300; €1564) for operating room grade monitors and simply forgo using them because of the cost. Lifebox is changing that.

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Competing interests: AT is founder and chairman of Lifebox.

1 Kwok A, Funk L, Baltaga R, Lipsitz S, Merry A, Dziekan G, et al. Implementation of the World Health Organization surgical safety checklist and pulse oximetry in a resource-limited setting. *J Am Coll Surgeons* 2011;213:S113.

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Why are the chosen oximeters so expensive?

The *BMJ*'s Christmas appeal is to buy £160 (€186; $250) Lifebox pulse oximeters for low resource countries to make surgery safe.[1] Pulse oximeters are available from Amazon for £21 and from several online sites for under £50, so someone seems to be making a considerable profit.

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Competing interests: None declared.

1 Feinmann J. *BMJ* Christmas appeal. *BMJ* 2011;343:d8085. (14 December.)

Cite this as: *BMJ* 2012;344:e210

Lifebox replies to Savage

The Lifebox pulse oximeter was selected after a tendering exercise that entailed considering many models from different manufacturers against the World Health Organization's specifications for use in operating theatres.

The Lifebox oximeter must be robust (able to withstand being dropped from 1 m on to concrete) and powered by mains electricity and rechargeable batteries, as well as having accurate performance, configurable alarms, a pulse tone that falls with decreasing saturation, a clear display, and a waveform. The replaceable probe (adult or paediatric) and battery must be low cost.

An oximeter of this quality is usually considerably more expensive than the Lifebox oximeter, as are the replacement probes (Lifebox probe $25 (£16; €19)). Lifebox buys the oximeters direct from the manufacturer so there are no further profits down the line. In a few cases import duties have been charged.

The Lifebox oximeter is of a much higher quality than the cheaper fingertip all in one models often found online, and it was selected because of its performance and quality. Many of the fingertip and other cheaper models depend on replaceable batteries, which would be expensive and unavailable in many hospitals. In addition, many of these models are small, difficult to read, and delicate and would be difficult to use effectively in operating theatres.

Each Lifebox oximeter package includes education materials on pulse oximetry and the WHO's surgical safety checklist; these are suitable for classroom learning and self teaching and available in six languages.

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Competing interests: IHW is Lifebox trustee and president of the Association of Anaesthetists of Great Britain and Ireland.

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FEATURE P 20

DEATH CAN BE OUR FRIEND

Preparation is key

Everybody dies. I remind medical students of this and explain that dying well is not only important to the person, but also to the care giver—psychologically and physically.[1-3]

The deaths of people who accept their situation and use the time before death to heal relationships, cement their legacy, and prepare themselves for death and their families for a future without them can be beautiful, peaceful, and even joyful times of celebration. Of course they are sad times too. This contrasts sharply with the deaths of people who deny death and often die without the preparation that is so helpful.

Denial comes from both patient and doctor. My view is that everybody involved knows the prognosis but they enter a "dance of denial," where no one wishes to make a move towards reality. Some people never take that step, which allows the preparation that is so helpful.

Anna Donald, whose illness was chronicled in a remarkable *BMJ* blog,[4] described the duality of preparing for the worst but hoping for the best in the following way. You reach for Everest (physical healing, life prolongation) but accept that you may not make it and prepare for that possibility. Once you have prepared (yourself and others) then you can focus on Everest until you're ready to focus elsewhere—the sacred, saying goodbye. Allowing patients to express their wishes about care at the end of life early in the trajectory of illness and treatment is empowering. It frees people to hope rather than diminishing hope. It is a conversation that continues throughout the journey, until its end.

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Competing interests: None declared.

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Anticipatory palliative care allows dignity in dying

I recently chaired a working group that aimed to identify ways to reduce inappropriate acute hospital admissions in the last days of life and improve the quality of end of life care, allowing people to die with dignity.[1]

By applying simple protocols to the population of local residential care homes and nursing homes cared for by two GP practices we had a huge impact in preventing unnecessary admissions and promoting good quality end of life care. This entailed identifying patients using the gold standards framework prognostic indicator guide, completing a preferred priorities for care document, instituting anticipatory prescribing for such eventualities as an exacerbation of chronic obstructive pulmonary disease or urinary tract infection, and discussing "do not attempt cardiopulmonary resuscitation" decisions. Resulting discussions with patients, families, and professionals—and the sharing of this information—ensured a person centred approach to care.

Of 43 patients assessed as being "anticipatory palliative care," 13 of the15 patients who died during the pilot study did so in their preferred place. Although acute admissions were reduced, local NHS reforms mean we no longer have support for wider dissemination of this work. At Hill Brow we continue to work as a team with the community matron, district nurses, and homecare staff and have the support of our out of hours provider. Each month our after death analyses show that death was anticipated and appropriately provided for in many cases.

Anticipatory palliative care seems to be a frame of mind, and I fear that many colleagues regard "end of life" issues as relating to the last hours or last two days of life, when the coming of death can be recognised and catered for many months before the end.

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Competing interests: None declared.

1 Enkin M, Jadad AJ, Smith R. Death can be our friend. *BMJ* 2011;343:d8008. (21 December.)

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THE GRIM REAPER'S WALKING SPEED

Brisk prolonged daily walking needed to outpace Death

Stanaway and colleagues reported that 1.36 m/s is the optimal walking speed to avoid the Grim Reaper.[1] With the aim of transposing this to clinical practice, we wondered how far Death can walk each day. A minimum of 30 minutes' daily walking is recommended to achieve health benefits, such as reduced mortality.[2 3] But physical activity depends on intensity and duration, and the last American College of Sports Medicine recommendation was 150 minutes a week (around 20 minutes a day) of moderate exercise or 75 minutes a week (around 10 minutes a day) of vigorous exercise, or a combination thereof.[4]

We estimated the Grim Reaper's walking capacity from Death's greatest performance: the 14th century great plague in Europe. The plague is assumed to have reached Marseille (France) in February 1348. It progressed to Bordeaux and Paris at a mean speed of 5 miles (8 km) a day (~0.09 m/s).[5] This slower speed might be because of a difference in the Grim Reaper's walking speed between Australia and Europe; an increase in the Grim Reaper's walking speed since the 14th century because of regular training; the distance walked being much longer; or newer scythes weighing less. None of these explanations can be excluded, but we favour the idea that Death can sustain a fast walk at 1.36 m/s (4.9 km/h), but only for 1.5 hours a day.

New Year's resolutions should include not only brisk but also prolonged daily walking for those wishing to avoid their allotted fate.

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Competing interests: None declared.

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See FEATURE, p20

ORTHOPAEDIC SURGEONS

Smart doctors playing stupid?

Your recent article poses a serious threat to one of the great benefits of orthopaedic surgery—strategic incompetence.[1] When dealing with other specialties an orthopaedic surgeon can always look mildly puzzled by such challenges as an electrocardiogram. This leads the opposing specialist to believe that the orthopaedic surgeon is out of his or her depth and to take over the patient's care as soon as the operation is done.

This new study, however, exposes orthopaedic surgeons not as stupid doctors playing smart, but the opposite. This will lead to a less helpful attitude from the rest of the hospital staff because they will realise that we can manage on our own. Thanks a bunch for that.

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Competing interests: None declared.

1 Subramanian P, Kantharuban S, Subramanian V, Willis-Owen SAG, Willis-Owen CA. Orthopaedic surgeons: as strong as an ox and almost twice as clever? Multicentre prospective comparative study. *BMJ* 2011;343:d7506. (15 December.)

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MATERIALS FOR HERNIA REPAIR

Bring back nylon string vests

Local surgical folklore has it that a surgical consultant in the 1970s regularly bought the then popular nylon string vests from M&S. He used sterilised pieces of these for hernia repairs with good effect until M&S discontinued the line.[1]

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Competing interests: None declared.

1 Stephenson BM, Kingsnorth AN. Inguinal hernioplasty using mosquito net mesh in low income countries: an alternative and cost effective prosthesis. *BMJ* 2011;343:d7448. (15 December.)

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