

LETTERS

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FOCAL LIVER LESIONS

Algorithm doesn't apply to hepatocellular carcinoma

I was surprised that Patel and colleagues' article on focal liver lesions in a patient with apparent chronic liver disease did not discuss hepatocellular carcinoma (HCC) or intrahepatic cholangiocarcinoma.¹

Several of the authors' statements deserve clarification. Firstly, an ultrasound scan suggestive of fatty infiltration in a South Asian man with raised liver enzymes does not mean the patient has non-alcoholic fatty liver disease. This non-specific radiological appearance can also be found in chronic hepatitis, ethanol misuse, drug induced liver injury, and autoimmune liver disease.²

Most cases of HCC arise on a background of chronic liver disease and the risk of malignancy in focal lesions in this setting is very different from that seen in low risk populations.³ For example, in one study of 1982 patients with cirrhosis, 50% of lesions characterised radiologically as typical haemangiomas were subsequently shown to be hyperechogenic HCC.⁴

Similarly, the authors' enthusiasm for contrast enhanced ultrasound should be balanced by recent data showing that, unlike contrast enhanced magnetic resonance imaging, the technique fails to discriminate between HCC and intrahepatic cholangiocarcinoma in patients with chronic liver disease.⁵

Thus, Patel and colleagues' algorithm for investigating focal liver lesions applies only to patients at low risk of HCC. In those with cirrhosis of any cause or in cases of chronic viral hepatitis B or C, the diagnostic algorithms advised by international liver societies should be followed.⁶

Richard J Aspinall consultant hepatologist, Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital, Portsmouth PO6 3LY, UK
richard.aspinall@porthosp.nhs.uk
Competing interests: None declared.

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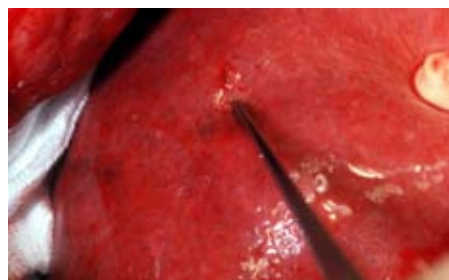
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Biopsy is not appropriate for incidentally detected lesions

Patel and colleagues' recommendations on liver biopsy for incidentally detected liver lesions are worrying.¹ We see up to 10 such newly detected lesions each week in our cancer network hepatobiliary multidisciplinary team. By using high quality computed tomography, magnetic resonance imaging with hepatocyte specific contrast agents, and contrast ultrasound scanning, it has been more than five years since we have resorted to image guided biopsy to diagnose such lesions.

The authors cite a paper that reviewed the safety of image guided liver biopsy in general,² with only 81/539 biopsies to diagnose focal liver lesions and no reporting on oncological complications (needle track tumour seeding; figure). Because most of these lesions are benign, the risk of tumour seeding is low,³ but when malignant liver tumours are biopsied, the risk of tumour seeding of potentially curable primary and metastatic liver tumours is real.⁴ Biopsy of colorectal liver metastases before hepatectomy with curative intent is associated with a 50% reduction in overall survival at four years.⁵



Operative photograph of histologically confirmed implanted metastatic hepatocellular carcinoma on Glisson's capsule of the liver in a patient with a resectable and potentially curable tumour at the site of an earlier ultrasound guided percutaneous biopsy. The patient developed abdominal wall recurrence of disease one year after hepatectomy and died a year later from atypical widespread recurrence of disease

In 2012 the diagnosis of such lesions should be made by a combination of state of the art radiology, accurate clinical history, and appropriate biochemical investigations by an experienced specialist hepatobiliary multidisciplinary team. Image guided biopsy of liver lesion(s) should be carried out only when recommended by the team, usually to obtain a histological diagnosis to guide palliative chemotherapy for patients with inoperable and incurable cancer.

Declan F J Dunne surgical research fellow
ddunne@nhs.net
Robert P Jones surgical research fellow
Hassan Malik consultant hepatobiliary surgeon
Stephen Fenwick consultant hepatobiliary surgeon
David White consultant radiologist
Graeme Poston professor of hepatobiliary surgery, Hepatobiliary Surgical Service, Aintree University Hospital NHS Foundation Trust, Liverpool L9 7AL, UK
Competing interests: None declared.

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Authors' reply

Our article was intended to provide an overview of the imaging options available for the characterisation of incidental focal liver lesions. It was aimed mainly at primary care and, as Aspinall rightly points out, a different investigative algorithm should be applied to a more select population at high risk of hepatocellular carcinoma (HCC). In our practice, contrast enhanced ultrasound is used initially to characterise incidental lesions into broadly “non-malignant” or “malignant” and to guide further investigation if needed. In the case of HCC versus intrahepatic cholangiocarcinoma, although intrahepatic cholangiocarcinoma often shows a distinctive pattern of peripheral enhancement in the arterial phase, its enhancement pattern can overlap with that of HCC.¹ In such cases, magnetic resonance imaging would be recommended

to characterise lesions further and obtain local staging information.

We fully endorse Dunne and colleagues' views on the risks of liver biopsy, which should not be undertaken without due thought and ideally a multidisciplinary team discussion. Despite thorough radiological and biochemical investigation, however, some lesions remain indeterminate and not fully characterised, particularly in cases of coexistent pathologies, and biopsy remains in the current updated algorithm for suspected HCC in cirrhosis. Such a situation is becoming less common with the increasing use of hepatocyte specific magnetic resonance imaging contrast agents, although these agents may not be routinely available in all centres. As shown in our article (fig 2), biopsy should be considered a last resort option.

Dhruv Patel specialist registrar radiology
dhruvpatel1979@gmail.com

Victoria Scott foundation year 2

James Pilcher consultant radiologist, St George's Healthcare NHS Trust, London SW17 0QT, UK

Competing interests: None declared.

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TREATING SCIATICA

Editorial fundamentally flawed

I cannot understand why the editorial on treating sciatica in the face of poor evidence was published when it is full of fundamental errors¹:

(1) L4/5 and L5/S1 are disc levels. The roots are L5 and S1

(2) Cochrane reviews and at least two randomised prospective trials show the efficacy of surgery²⁻⁵

(3) Pain occurs in a dermatomal distribution, which is less specific than a dermatomal distribution

(4) The commonest anatomical locations for nerve compression by disc protrusion are in the spinal canal—typically, the posterolateral and the central protrusions. The far lateral extraforaminal protrusion is rather rare.

The author clearly does not understand the condition he is writing about. I hope he does not have to treat it.

Jason Bernard orthopaedic surgeon, St George's Hospital, London SW17 0QT, UK

Competing interests: None declared.

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Epidural steroid is effective

In his editorial on treating sciatica in the face of poor evidence, Chou seems not to have heard of epidural injections with steroid.¹ There is plenty of evidence of the efficacy of this treatment in sciatica,² so it is wrong for an editorial to suggest otherwise. Non-specialist doctors reading this editorial will get a completely wrong impression. Oral drug treatment is not enough.

Michael F Grayson rheumatologist and musculoskeletal physician, Private Consulting Rooms, Royal National Orthopaedic Hospital, London W11W 5AQ, UK
m.f.grayson@gmail.com

Competing interests: None declared.

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Author's reply

Bernard and Grayson both suggest that an editorial on drugs for sciatica/radiculopathy should have addressed surgery and epidural steroid injections. However, both my editorial and the systematic review it commented on focused on the benefits and harms of systemic

drugs.¹ Other types of treatment for sciatica, including surgery and epidural steroids, have been reviewed elsewhere.^{2,3} Indeed, most trials of epidural steroids for radiculopathy show some short term benefit compared with a sham procedure, but no long term benefits.² Some trials of surgery also find that short term benefits compared with non-surgical therapy were no longer present long term.³

As Bernard points out,⁴ L4/L5 and L5/S1 refer to disc levels. The nerve roots affected by disc herniations at these levels vary depending on the location of the herniation, although the corresponding nerve roots usually affected are L5 and S1. Pain and motor deficits associated with L5 and S1 radiculopathy are

usually in typical dermatomal and myotomal distributions, although overlap and variation can occur.⁴

I did not state that radiculopathy is primarily caused by far lateral extraforaminal protrusions. In fact, compression can occur anywhere along the nerve root after it emerges from the spinal cord. In any case, the specific location of nerve root compression and the dermatomal distribution of symptoms have no bearing on drug effectiveness or drug choices for this condition.

Roger Chou associate professor of medicine, Department of Medicine and Department of Medical Informatics and Clinical Epidemiology, Oregon Health and Science University, Portland, OR 97225, USA
chour@ohsu.edu

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Cite this as: *BMJ* 2012;344:e2562

EPISTAXIS

Try ice in the mouth

The recent article on epistaxis by Mulla and colleagues covers a simple condition that can be fatal.¹ The authors suggest that placing ice packs on the nose can stop further bleeding. Despite this method being widespread, evidence suggests that application of ice packs to the nose or the neck (also common) has little effect on blood flow to the nasal mucosa.²

Ice placed in the mouth, however, decreases nasal mucosal flow by as much as 23%.³ We suggest that this is a more effective and evidence based method for stopping further bleeding and find it to be an effective adjunct for more posterior bleeds while definitive treatment is planned. Children can be encouraged to suck on flavoured ice lollies.

Joseph G Manjaly core surgical trainee year 2
joemanjaly@doctors.org.uk
Kasia Konieczny specialist trainee year 3
N Julian Holland consultant ENT surgeon, Portsmouth Hospitals NHS Trust, Portsmouth PO6 3LY, UK

Competing interests: None declared.

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TRACHOMA CONTROL

Don't let misinformation derail the programme

Chisholm and colleagues' paper is important to policy makers,¹ so serious errors in the trachoma analysis require correction.²

Firstly, "mass treatment with azithromycin" for trachoma was defined as azithromycin treatment for all children aged 1-10 years,³ whereas the World Health Organization recommends treatment of all residents.

Secondly, data from a 1998-9 western Nepal trial were extrapolated to estimate effectiveness of mass treatment throughout sub-Saharan Africa and South East Asia.

Thirdly, the model's coverage level parameter "does not affect the reduction in the prevalence of active trachoma"³; we doubt that this is true.

Fourthly, disability weights were assigned only for the outcomes visual impairment and blindness.³ Trichiasis has considerable physical, social, and economic effects from its onset, not just after low vision ensues. Furthermore, active trachoma was denied a disability weight, and the ancillary savings in disability adjusted life years (DALYs) of mass azithromycin treatment (which may include reduced all cause mortality in children⁴) were ignored.

Fifthly, WHO and partners aim to eliminate trachoma as a public health problem by 2020. An elimination programme derives positive externalities (in economic terms) from protection of future generations. It is a mistake to assess infectious diseases in the same way that cataract is assessed.

Lastly, costs were assigned for azithromycin purchase using a theoretical price.² Azithromycin for trachoma control is donated by the manufacturer.

On the basis of analyses that are flawed on both sides of the cost effectiveness equation, Chisholm and colleagues concluded that saving a DALY with mass azithromycin treatment in trachoma endemic areas of sub-Saharan Africa or South East Asia costs more than the per capita gross domestic product of each region. International commitment to trachoma control has never been stronger,⁵ and it would be tragic for poor communities affected by trachoma if programme momentum was lost through misinformation.

Anthony W Solomon, lecturer, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK anthony.solomon@lshtm.ac.uk

On behalf of David C W Mabey, Clare Gilbert, Ulla Griffiths, Anne Mills, Allen Foster, Sheila K West, Paul Courtright, Joseph Feczko, Wondu Alemayehu, Catherine Cross, Thomas M Lietman, Danny Haddad, Caroline Harper, Paul Emerson, Richard Le Mesurier, Peter Ackland, Dirk Engels, Silvio P Mariotti

Competing interests: AF, AWS, SKW, PC, JF, WA, and CC are the chair and members of the International Trachoma Initiative's Expert Committee. AWS, DCWM, AF, SKW, and PC have received research grants from the International Trachoma Initiative and/or Pfizer, the manufacturer of azithromycin. This is a shortened version of a rapid response, which appears in full at: www.bmj.com/content/344/bmj.e586/rr/577307.

- 1 Chisholm D, Baltussen R, Evans DB, Ginsberg G, Lauer JA, Lim S, et al. What are the priorities for prevention and control of non-communicable diseases and injuries in sub-Saharan Africa and South East Asia? *BMJ* 2012;344:e586. (2 March.)
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- 5 International Coalition for Trachoma Control. The end in sight: 2020 INSight. 2011. www.trachomacoalition.org/category/resource-type/documents.

Cite this as: *BMJ* 2012;344:e2579

Authors' reply

Solomon and colleagues inappropriately label our analysis of trachoma control erroneous, but their comments are largely related to methodological issues in (standardised WHO-CHOICE) cost effectiveness analysis and present gaps in knowledge.¹

Firstly, mass treatment with antibiotics of all residents is probably more effective and costly than treatment of children. Whether the first intervention is cost effective according to international thresholds, and more cost effective than trichiasis surgery, is an area for further research.

Secondly, to derive internally consistent results, we retrieved costs and effectiveness from a single study, while verifying that effectiveness estimates were similar to those from other countries.² Sensitivity analyses showed robustness of study conclusions.^{1,3}

Thirdly, WHO-CHOICE analyses use different coverage rates to capture (dis)economies of scale in intervention costs. Coverage rates do not affect effectiveness estimates.

Fourthly, the natural course of trachoma and benefits of intervention are uncertain. Our model, developed and published with trachoma control experts, provides a first quantification of these benefits and captures the most important ones.³

Fifthly, although we agree that, in principle, cost effectiveness analysis should include any future effect, there is much uncertainty around these effects and their discounting. This may explain why analyses of—for example, measles elimination programmes—use time horizons up to 40 years. WHO-CHOICE uses a time horizon of 100 years.

Lastly, the valuation of donated drugs hinges on assumptions about whether donations will continue. Regrettably, our careful discussion of this and many other disease specific debates cannot adequately be reflected in the summary paper.^{1,3,4} We previously reported that treatment of children in a zero cost scenario would be cost effective,³ and it would be fair to evaluate current programmes under the zero cost scenario. This would show their ranking compared with other trachoma control interventions and establish the basis for efficient trachoma control.

R Baltussen senior researcher, Department of Primary and Community Care, Radboud University, Nijmegen Medical Centre, Netherlands r.baltussen@elg.umcn.nl

A Smith honorary professor, International Centre for Evidence and Disability, London School of Hygiene and Tropical Medicine, London, UK

D Chisholm health economist, Department of Health Systems Financing, WHO, Geneva, Switzerland

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This is a shortened version of a rapid response, which appears in full at: www.bmj.com/content/344/bmj.e586/rr/577307.

- 1 Baltussen R, Smith A. Cost effectiveness of strategies to combat vision and hearing loss in sub-Saharan Africa and South East Asia: mathematical modelling study. *BMJ* 2012;344:e615. (2 March.)
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SPOTLIGHT ON CLIMATE CHANGE

Invest now in strategies to cope with weather instability

Climate change will increase weather instability and the occurrence of extreme hot and cold episodes, even in regions and populations not usually affected.¹ From the end of January to mid-February 2012 Italy experienced record



MAURO FERMARELLO/SPL

low temperatures over 10–18 days. Mean daily temperatures were 10°C lower than normal, and snow of up to 3 m deep was recorded in northern and central regions during the first half of February. Entire communities were isolated and cut off from energy and food supplies principally because of the snow.

Fourteen large urban areas showed an increase in mortality among those aged 75 and over, with an overall 1578 (25%) excess deaths, ranging from 22% in Bologna to 58% in Turin. In Rome the increase in daily deaths occurred with the decline in temperatures and remained high till the end of February, while in Genoa the effect was observed several days after the temperature fell.

Italy, like many other Mediterranean countries, lacks adaptive strategies to prevent cold related health effects. The impact of this recent episode shows that investing in a cold plan is important even in a time of economic crisis. Identifying those most vulnerable to extreme temperatures is important. Preparedness may be achieved through introducing warning systems and local prevention measures according to the degree of risk, with targeting of vulnerable people. Information campaigns are needed to raise awareness among doctors, vulnerable groups, and the general public.

Paola Michelozzi head, Environmental Epidemiology Unit, p.michelozzi@deplazio.it

Marina Davoli head, Department of Epidemiology, Lazio Regional Health Service, Italy, Rome, 00198, Italy

Competing interests: None declared.

1 McMichael T, Montgomery H, Costello T. Health risks, present and future, from global climate change. *BMJ* 2012;344:e1359. (19 March.)

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Opportunity missed

Voluntary family planning as a relevant intervention was mentioned only briefly in two of the nine articles of the spotlight on climate change and was not mentioned at all in the article entitled “What needs to be done.”^{1–3} Otherwise, population growth featured not as something for humankind to address—wisely and compassionately—but as a given to which we must try hopelessly to adapt.

Why hopelessly? Because the required scale of reduction in humankind’s gluttonous use of fossil fuels and mean greenhouse gas production will not happen, realistically, in time to prevent the >2°C global temperature rise that leads to uncontrollable positive feedbacks. Indeed, emissions have increased by around 49% since 1990¹: unsurprisingly, given a net population increase of around 2000 million, with all striving for and many—for example, in China, India, and Brazil—now achieving the



TIM GRAHAM/GETTY IMAGES

increased energy consumption inseparable from escaping poverty. This is good, but shows how minimising carbon footprints, everywhere, is crucial but never sufficient: we must also, by all appropriate and never coercive means, reduce the number of feet doing the footprinting.

Only three factors affect human environmental impact⁴—namely, the “greenness” or otherwise of technology on average per person; the mean affluence and effluence per person; and the number of people. Since there are only three factors, why neglect any one? The *BMJ*’s muted stance on population is strange, given the medical profession’s obvious—if inadvertent—responsibility for the ongoing dangerous imbalance between world death rates and birth rates.

Our goals must be to comprehensively resource voluntary contraception, removing numerous barriers to access,⁵ in a rights based framework, correcting misinformation through education and the media (see www.populationmedia.com). Future children should come not by chance but by educated parental choice, in the rich North too, since the lifetime carbon dioxide saving through one less high consumer equates to around 750 tonnes of carbon, or driving 3.75 million miles at 50 miles per gallon [6.04 million km at 5.6 L/100 km] (www.populationmatters.org).

John Guillebaud emeritus professor of family planning and reproductive health, University College London, Elliot-Smith Clinic, Churchill Hospital, Oxford OX3 7LJ, UK
j.guillebaud@lineone.net

Competing interests: JG receives fees for lectures on family planning, population, and related environment/development issues, as well as royalties for his books on the same subjects.

1 McMichael T, Montgomery H, Costello T. Health risks, present and future, from global climate change. *BMJ* 2012;344:e1359. (19 March.)

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Wake up and smell the coffee

The blinkered views of the academics and administrators who contributed to articles on climate change have been repeated for decades with notorious lack of enthusiasm and credibility, while the global population has nearly doubled, with an ever increasing number of people living in abject poverty and being largely dependent on food, medicine, and other aid given by rich countries via non-governmental organisations.¹

With the other hand, these rich countries take natural resources and share only some of the profits with a corrupt local minority who spend that money abroad.

It is difficult to calculate how the legitimate aspirations of billions of new proletarians to share the energy and polluting resources that will allow them a decent standard of living will be met, but the feeble noises coming from your pages support the status quo and echo the complacent attitude of Louis XV of France, “après moi, le déluge [after me, the flood].”

Adrian A Pierry general practitioner, freelance, Penarth, UK pierry@aol.com

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1 Godlee F. Will doctors now take a lead on climate change [Editor’s Choice]? *BMJ* 2012;344:e2232. (22 March.)

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DIGNITY IN CARE OF OLDER PEOPLE

Identify hearing impairment and take action

When reading the article by Morris we noticed the findings of the Patients Association annual report—*We’ve been listening; have you been learning?*—which specifies unnoticed hearing impairment as one example of poor hospital care in elderly patients.¹

We therefore performed an audit in our hospital and found that neither nurses nor doctors routinely recorded elderly patients’ hearing status. Even if hearing impairment is noticed, no one seemed to take action to rectify it. We are now taking steps to make sure that action is taken to manage any identified hearing impairment, such as reminding general practitioners to refer these patients to audiology or arranging a hearing aid for patients with severe impairment while they are in hospital.

Narveshwar Sinha general practitioner specialty trainee, narveshwar.sinha@gmail.com

Jason Raw consultant physician, care of the elderly Shabana Zafar foundation year trainee, Fairfield General Hospital, Pennine Acute NHS Trust, Bury BL9 7TD, UK
Competing interests: None declared.

1 Morris J. Ensuring dignity in the care of older people. *BMJ* 2012;344:e533. (26 January.)

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