LETTERS

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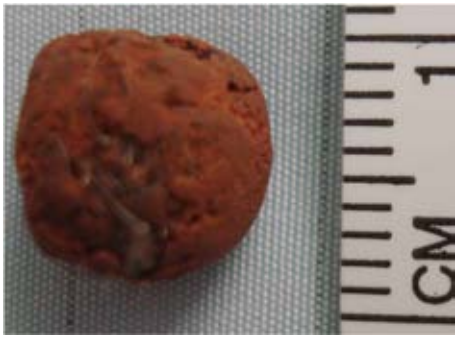
EYE INJURIES DUE TO FIREWORKS

New firework caused severe eye injuries at a public display



Firework debris removed from orbit during operation in case 2

A new type of firework caused severe eye injuries and blindness in children and adults at last year's bonfire night celebrations in Lewes, UK. That evening, eight patients presented to our hospital, five with serious eye injuries—two were blinded and the other three have a lifelong glaucoma risk (table). Police inquiries suggest the new explosive was derived from "rope banger deer scarers," which have a slow burning rope fuse that ignites multiple explosives along the rope. When cut down, the fuse and explosive can be lit and thrown. All serious injuries were consistent with blunt injury to the globe, caused by material within the explosive charge (figure).

This rate of serious eye injury was greater than expected. The British Ophthalmic Surveillance Unit 2008 report identified 7.5 serious eye injuries per bonfire night for the entire UK.[1] A call by the World Health Organization in 1984 for a worldwide ban on fireworks was unsuccessful.[2] Numbers of blinding injuries have fallen in countries with legislation that controls the use and distribution of fireworks.[3] The UK has legislation to limit distribution,[4] but deer scarers are exempt because they are not actual fireworks. We have no legislation to impose safety restrictions at firework displays. The Public Order Act 1986 relates to processions that might result in serious public disorder, serious damage to property, or serious disruption to the life of the community.[5] Serious accidental injury is not included.

In the UK in 2005, 52% of firework injuries occurred at public events,[6] so organisers must actively engage their audience in safer use of fireworks and encourage eye protection. If we cannot create effective legislation we must create a culture that does not tolerate the throwing of banger-type explosives into crowds. Extraordinarily, this remains a challenge.

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Competing interests: None declared.
Patient consent obtained in four of the five cases; other case lost to follow-up.

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Serious eye injuries from fireworks presenting to Sussex Eye Hospital on 5 November 2011

Case	Age (years)	Injury	Surgical interventions	Visual outcome*
1	58	Open globe; retinal detachment	Emergency primary repair then repair of the retinal detachment with silicone oil	Hand motion vision†
2	13	Closed globe; retinal detachment	Examination under anaesthesia and removal of firework, followed by repair of the retinal detachment with silicone oil and then removal of silicone oil	6/60
3	15	Closed globe; angle recession	Not to date	6/6; lifelong glaucoma risk
4	10	Closed globe; angle recession	Not to date	6/6; lifelong glaucoma risk
5	>18	Closed globe; angle recession; concussion of the retina (retinal commotion)	Not to date	6/9; lifelong glaucoma risk

*Last recorded in the affected eye.

†Catastrophic injury where almost no visual acuity remains—patients can recognise that a hand is being waved but cannot count the fingers on the hand.

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NECROTISING FASCIITIS

Distinguish between GAS and polymicrobial causes

Sultan and colleagues do not distinguish between classic group A streptococcus (GAS) necrotising fasciitis and polymicrobial (predominantly Gram negative and anaerobic) causes typified by Fournier's or gas gangrene.[1-3] This distinction is important because risk factors, presentation, and treatment options differ.[2] People with diabetes and injecting drug users are prone to polymicrobial infection, but GAS often infects those without risk factors, may take a very precipitous course, and can be accompanied by toxic shock syndrome.[2 3]

The severe pain, which is disproportionate to the clinical picture, helps distinguish necrotising fasciitis from other soft tissue infections.[2] Recently, a patient who was previously healthy presented three times to our emergency department over 24 hours. In this period, the patient's mild arm pain progressed to excruciating pain with septic shock. The maximum dose of morphine, ketamine, pregabalin, and intense fluid resuscitation were needed before she went to critical care. At this time there were no specific findings in the soft tissues. Clindamycin was added to empirical β lactams because the history indicated necrotising fasciitis caused by GAS. The local soft tissue features of necrotising fasciitis became apparent only 24 hours later, after GAS was isolated from debrided tissue.

Outcomes are improved by adding clindamycin, which blocks toxin production, to β lactam monotherapy.[3 4] The onset of toxic shock may warrant the use of intravenous immunoglobulin.[5] However, this combination is specifically for GAS necrotising fasciitis and is not helpful for other causes, where broad spectrum combinations and debridement are the only treatment options.

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Competing interests: None declared.

Patient consent obtained.

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MAKING A DIAGNOSIS IN VERTIGO

The ability to stand is not diagnostic

Kaski and Bronstein provide an excellent résumé of clinical diagnostic approaches to acute vertigo.[1] Some clinicians, however, may be reluctant to distinguish cerebellar stroke from vestibular neuritis by assessing the patient's ability to stand. In one recent series, ataxia (with ability to stand not specified) was present in only 31% of 407 patients with clinically and radiologically confirmed posterior circulation infarcts or transient ischaemic attacks (or both), although cerebellar events were not considered separately.[2] The ability to walk may also vary and is influenced by a range of other factors, particularly in the context of comorbidity.

Posterior circulation stroke may also be associated with vertebrobasilar dissection,[3] even in the absence of clear preceding trauma. Further evidence on the safety of performing the head impulse test before this possibility is excluded would be welcome.

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Competing interests: None declared.

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Authors' reply

We agree that the diagnosis of cerebellar stroke or vestibular neuritis cannot be made solely on the patient's ability to stand. The presence of sudden onset severe disequilibrium in patients with posterior circulation infarcts adds weight to the diagnosis, but the clinical context must be taken into account. Indeed, we highlight that the diagnosis of vestibular neuritis can be ruled in, rather than being a diagnosis of exclusion. Hence, the presence of unidirectional nystagmus, a positive head impulse test, and imbalance are highly suggestive of vestibular neuritis. Cerebellar strokes, however, can present with few clinical signs. In patients with vertigo, severe imbalance, and vomiting, but no nystagmus, stroke should be considered and ruled out first.[1] Importantly, acute hearing loss may herald impending infarction in the anterior inferior cerebellar artery territory in patients with vertigo, even when no other central signs are present.[2]

We are not aware of any reports of carotid or vertebral dissection as a result of a head impulse test or that an established dissection is worsened by this test. It seems reasonable to avoid any sort of neck manipulation if vertebral artery dissection is suspected (presence of neck pain, preceding trauma). Similarly, if there is high clinical suspicion that vertigo is caused by vertebrobasilar stroke (for example, involvement of non-vestibular cranial nerves or presence of long tract signs) the head impulse test is not strictly speaking necessary. If imaging is negative and the cause of the vertigo has not been established then both the head impulse test (vestibular neuritis) and positional maneouvres (benign paroxysmal positional vertigo) should be carried out.[3]

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Competing interests: None declared.

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PRESSURE ON HOSPITALS

Self referral to hospital may be fuelled by desperation

A report by the Royal College of Physicians identified a 37% increase in emergency hospital admissions in the past decade.[1]

The report suggests several contributing factors, including changing demographics. However, such a large increase cannot be accounted for solely by increased numbers of older people. It might, however, be related to an increase in self referral by older people. Chronic disorders, which particularly affect older people, now receive less ongoing specialist treatment. Some hospital clinics are currently funded only to diagnose, start treatment, and refer back to primary care rather than provide follow-up. For example, a decade ago mental health services

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offered specialist community follow-up to patients with dementia and their carers to help them to manage symptoms. A "psychoeducational" approach was used, which built on carers' practical and emotional abilities, so that they could manage emergencies without resorting to the emergency department. Fewer resources are now available for this type of follow-up. Self referral may not be caused by "increased public expectation" but by desperation and inability to manage chronic illnesses and their minor complications. This trend to reduce follow-up is affecting paediatric services too.

The economic and human impact of reducing support for chronic illnesses is difficult to measure. Interventions are often low cost, valued by patients and carers, undervalued by health authorities, and not seen as a priority relative to acute secondary care. The reduction in specialist chronic illness management needs to be evaluated in the context of the pressure on hospitals.

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Competing interests: None declared.

1 Hawkes N. Pressure on hospitals has led to worse care for older patients. *BMJ* 2012;345:e6137. (12 September.)

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IS BIOETHICS A BULLY?

"Ethics Man" misses mark: most bioethicists are not thugs

Although Sokol never explicitly says that bioethicists (clinical ethics consultants) are bullies, his anthropomorphism of bioethics insinuates this.[1] It would be a tragedy for readers to believe that Sokol accurately portrays the entire field.

Clinical ethics straddles theoretical inquiry and practical application, but theoretical inquiry is not responsible for "bullying" clinicians. Sokol portrays clinical ethicists as malevolent academics—masters of intellectual sleight of hand who use magical words and abstract concepts to amaze and befuddle clinicians. This is simply not the case. Although clinical ethics has a technical language and clinical ethicists often engage in theoretical inquiry, clinical ethics was born out of modern medicine and clinical

ethicists tackle problems arising therein—a pragmatic discipline if ever there was one.

Furthermore, telling clinicians what to do in an authoritative way is anathema to the goal of clinical ethics. For more than a decade, the flagship professional organization for bioethics in the US, the American Society for Bioethics and Humanities (ASBH), has promulgated an "ethics facilitation approach," whereby consultants clarify issues, facilitate open conversation, and resolve value conflicts. This model is described in "Core competencies"—the definitive guide for consultants.[2] ASBH eschews any model where the consultant is the primary moral decision maker to avoid the sort of bullying Sokol describes.

Some clinicians may now be cynical about "bullying bioethicists." But they should realise that Sokol's perspective is missing key relevant data and misrepresents the work of most clinical ethicists.

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Competing interests: None declared.

1 Sokol DK. Is bioethics a bully? *BMJ* 2012;345:e5802. (3 September.)
2 American Society for Bioethics and Humanities. Core competencies for healthcare ethics consultation. 2nd ed. ASBH, 2011.

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Bioethicists do participate in everyday practice

Sokol claims that bioethics "adopts a paternalistic attitude towards clinicians" yet states that "clinicians are easy targets and, without a command of the fancy theories and language of the accusers, possess few means to respond formally."[1] This itself infantilises clinicians, while adopting a collaborative stance towards our colleagues.

If Sokol really wants bioethics to be more constructive, he should have provided some characterization of the "myriad voices within the broad church of bioethicists that do not fall foul of the criticism above."

Sokol seems to think that the clinical bioethicist is a straw general who avoids the "trenches" in favour of university lecture theatres, traditional ethics scholarship, and clinical ethics committees. We spend a small part of our time in university lecture theatres—most is divided between bedside consultation, policy development to enable preventive ethics, and education of clinicians on the units. We also collaborate with clinicians on research to establish responsible boundaries for new clinical innovations. This is far from being "removed from the pressures of everyday practice."

He rightly believes that healthcare ethicists should "take an inward look at their practice," particularly with regard to standard exams and curriculums. The main bioethics associations in North America are already taking steps toward setting the standards Sokol calls for.

Exams and curriculums cannot address Sokol's call for "some immersion in the relevant setting." However, many healthcare bioethicists have clinical backgrounds. For those who do not, clinical exposure is available through well established postgraduate programs that place trainees in hospitals and community access care centres.

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1 Sokol DK. Is bioethics a bully? *BMJ* 2012;345:e5802. (3 September.)

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STATINS FOR ALL?

If facts do not fit theory, the theory is wrong

I am amused that I first heard of the *Daily Mail*'s recent report on statin research in the *BMJ*,[1] not least because that newspaper published my personal view on statins and their side effects in 2009.[2] Afterwards I had a deluge of letters describing similar experiences and all described the difficulty of getting their doctor to listen and understand the problem.

Commentary on the risk-benefit analysis of statins still (usually) fails to explain the difference between absolute and relative risk, as McCartney points out. This has been alluded to for years; Ravnskov wrote, "Tell a patient that his chance not to die in five years without statin treatment is 85.4% and that simvastatin treatment can increase this to 87.1%. With these figures in hand I doubt that anyone should accept a treatment whose long term effects are unknown."[3] Goldacre, in *Bad Science*, underlines this.[4] It is careless at best, and deceitful at worst, to suggest that the risk of a heart attack may be reduced by 50% when it is 50% of 4%. I also know from my own experience that statin myopathy (and myolysis) is far from benign.

Neither is it clear whether the cholesterol lowering effect of statins is itself beneficial, or whether it represents an epiphenomenon perhaps related to C reactive protein (CRP). We know, for example, that in active rheumatoid arthritis (where CRP can be high and the risk of coronary artery disease is substantially increased) effective disease control not only lowers CRP and cardiac risk but results in a rise in serum cholesterol. If facts do not fit theory, it is never the facts that are wrong.

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Competing interests: I have suffered serious side effects from statins.

1 McCartney M. Statins for all? *BMJ* 2012;345:e6044. (12 September.)
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Cite this as: *BMJ* 2012;345:e6584

SAMPLE SIZE CALCULATIONS

An unorthodox approach

Norman and colleagues raise an important issue—sample size calculations are at best an educated guess.[1] While their suggestion might be helpful when an idea of sample size can be gleaned, in a recent study we had very little information at all.

The study was a primary care inception cohort of a rare and little researched condition. Initially, we tried to conduct a formal sample size calculation. We adopted standard values for α and β, but then we were truly making up the values to put into the formula. We had multiple research questions (this is a cohort not a trial) and there was no agreed definition of outcome. This was a primary care study, and virtually all research in this condition had been in secondary care, so we had no best guess of potential rates of any outcome.

We did however have an idea of the sample size we might be able to recruit. By combining the estimated incidence rate from database studies with a feasible number of practices and the time allotted to us by the funders with our experience response rates, we estimated that we could have a reasonable number of people to attempt to answer the questions.

We were therefore honest with the ethics committee. We submitted our calculation of the number we might sensibly hope to recruit and an explanation of the lack of formal sample size calculation. The committee questioned us on the lack of "statistics," but when we reiterated the lack of information, it granted approval.

Our approach was not perfect, and raises issues about the statistical power we have to

answer our research questions. But we hope that our success might encourage others to consider something similar if necessary.

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Competing interests: None declared.

1 Norman G, Monteiro S, Salama S. Sample size calculations: should the emperor's clothes be off the peg or made to measure? *BMJ* 2012;345:e5278. (23 August.)

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Not fit for purpose

Norman and colleagues criticise "conventional sample size calculations, based on guesses about statistical parameters" because they "are subject to large uncertainties." They then propose that normative ranges of sample sizes for common research designs would be more sensible.[1]

To support this they provide a table with sample sizes for various combinations of relative risk reduction and base rate. The sample sizes vary by a factor of 1000. So, based on guesses about likely relative risk and base rate, the normative approach to sample size estimation is subject to large uncertainty.

Whether off the peg or made to measure, the emperor's new clothes seem not to be fit for purpose.

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Competing interests: None declared.

1 Norman G, Monteiro S, Salama S. Sample size calculations: should the emperor's clothes be off the peg or made to measure? *BMJ* 2012;345:e5278. (23 August.)

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UK OFFICE DERMATOLOGISTS

"If everybody's somebody, then no one's anybody"

Ross's proposal that GPs give up their role in caring for skin disorders to "office dermatologists" is undermined by his statistics.[1] He reports that a quarter of the population goes to a GP with a skin problem each year. Even if each attends only once, this accounts for 15 million consultations. He also states that there are 900 000 referrals to dermatology. This implies that 14.1 million extra dermatological specialist consultations would need to be provided.

Most NHS dermatologists are not so underemployed that they could see 15 times more patients than they do now, so his proposal would require the training of a vast army of dermatologists, most of whom would be dealing with straightforward diagnostic and management problems currently managed in general practice. Their clinical experience would also be so diluted that they would never gain sufficient specialist experience to provide a high quality service for challenging problems. It would be necessary to create another layer of senior dermatologists to do this; let's call them consultant dermatologists. We would then have an army of primary care dermatologists who lack the skills to deal with the holistic problems that are the bread and butter of primary care and a few really specialist dermatologists. We will not have improved dermatology services, but will have de-skilled most GPs in dermatological diagnosis and treatment.

Ross needs to recognise that the quality of the UK consultant service depends on experience being focused on patients who really need specialist expertise. "If everybody's somebody, then no one's anybody" (WS Gilbert; *The Gondoliers*).

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Competing interests: None declared.

1 Ross J. The UK needs office dermatologists. *BMJ* 2012;345:e6006. (10 September.)

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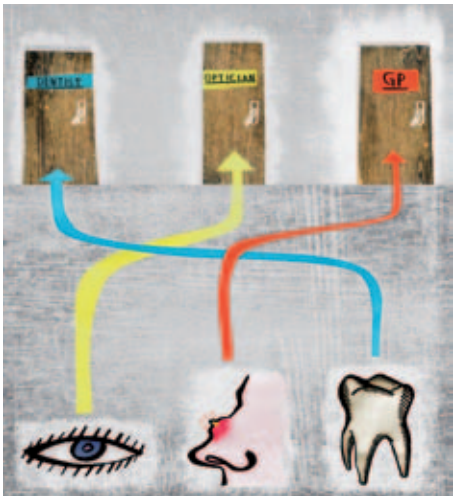
Teledermatology is the answer

Rees has raised an important issue.[1] Skin problems constitute a large proportion of general practice consultations, yet few GPs have any worthwhile training in dermatology. No one would contemplate offering GP obstetric care without further qualification, but this is considered acceptable for skin care (perhaps because the risk of causing harm is less). However, on economic grounds alone, this is not a good use of NHS funds.

Some GPs have studied one of the postgraduate diplomas—such as the Cardiff Diploma in Practical Dermatology—so have excellent skills, but not all GPs have the time to do this. In Cardiff we provide a teledermatology service, which focuses on giving timely advice (within 48 hours) to GPs on the diagnosis and management of their patients with skin problems. This form of consultant supervision and support is very popular with GPs, and 80% of referred patients are managed entirely in primary care. In the modern digital age, this is one way that consultant dermatologists can support GPs, who see most patients with skin problems, and it is a relatively simple method of supporting dermatology services in primary care.



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Competing interests: None declared.

1 Ross J. The UK needs office dermatologists. *BMJ* 2012;345:e6006. (10 September.)

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LANSLEY'S LEGACY

Keep general practice and secondary care separate

I was dismayed by Walshe's phrase "improving the organisation of primary care and its integration with secondary care."[1]

My surgery (six full time equivalent partners, 12 500 patients) has as much wish or need to be integrated with any of our district general hospitals as my local garage needs to be integrated with the specialist Audi garage in Northampton.

From a business point of view (and from my years of experience of fund holding in the 1990s), clear clinical, financial, and legal boundaries are needed between what GPs do and what specialists do. The recent blurring of this fundamental NHS idea has been the cause of much unproductive internecine debate and budgetary confusion. The argument for even more "integration" is often made by those who are unfamiliar with the business of "coalface" practice or those who wish to destroy what most patients seem to value—the family doctor in a surgery near their home.

By any international comparison our system of distinct general practice and specialist services is still the most cost effective way of providing a health service. This is despite recent developments having belittled the GP's gatekeeping and loss adjustor role in what is essentially an insurance based organisation, which—like motor insurance—everyone realises is necessary but few wish to pay much for.

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Competing interests: None declared.

1 Walshe K. Lansley's legacy. *BMJ* 2012;345:e6109. (12 September.)

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