

LETTERS

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EMERGENCY DEPARTMENT PRESSURES

Elephants and scapegoats in emergency departments



Curiously, elephants in small rooms often escape detection even by experts. Ham's editorial reviewed pressures on English emergency departments.¹⁻² Yet he avoided explaining that while the NHS runs at white heat, hospital bed numbers are still being cut. This is despite the UK having the second lowest per capita ratio in the European Union,³ the population having risen by 10%, and 8% of major emergency departments having been closed over the past decade (although an increase of 25 major departments was needed to maintain equivalent levels of occupancy).⁴ Moreover, Ham is surely aware that high emergency department occupancy, like high bed occupancy, is associated with poorer patient outcomes, and that patients in England have poor outcomes for many major conditions, with absurdly delayed investigation and treatment standards.

Financial and clinical failure of the NHS is a political choice that creates useful leverage to introduce politically unacceptable policies. Analysis of falling performance in the four hour emergency department target shows that only 11% of the decline is caused by a rise in the number of elderly people seen.⁴ Yet, the continued political and Department of Health misattribution of emergency department pressures to elderly people, and of bed pressures to elderly “bedblockers,” suggests an ageist agenda.

Blaming older people for the NHS crisis creates a specious excuse to introduce policies that exclude an increasing proportion of them from acute secondary care in favour of default “palliative care” (perhaps the true reason for the marked rise in elderly deaths noted in 2012 and expected again this year).⁵⁻⁶ Recklessly slashing emergency admissions by 15% over the next two years, claiming a (non-existent) capacity to offer appropriate diagnostic and clinical care in the community, and the proposed 168 hour working week for doctors are further examples. Sadly, Ham fails to challenge the party line.

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1 Ham C. Emergency department pressures need to be tackled through integrated urgent and emergency care. *BMJ* 2015;350:h322. (20 January)

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LYMPH NODES IN BREAST CANCER

In defence of one step nucleic acid amplification

Dixon and colleagues made several damning comments about one step nucleic acid amplification (OSNA), which is used intraoperatively to assess whether sentinel lymph nodes contain metastases.¹ These are based on one seriously flawed meta-analysis.²

Firstly, it stated that many published papers on OSNA were financed by the manufacturer (Sysmex, Japan), which is untrue.

Secondly, it quoted a positive predictive value of OSNA for axillary lymph node metastasis of only 0.79 when it should have been 0.86 on the basis of the data presented in the paper. The mistake was due to tissue allocation bias—different parts of the lymph node were sampled when comparing OSNA with histology.

Thirdly, the wrong mathematical model was used to translate tumour volume into a diameter for distinguishing between micrometastasis and macrometastasis.

Dixon and colleagues then made several false statements.

Firstly, they say that OSNA is the most common method of intraoperative assessment of sentinel lymph nodes. Only 26 centres in the country use this technique, so this is unlikely.

Secondly, they quote 4700 copy numbers as the lower limit for the diagnosis of a macrometastasis when all units use 5000 as the lower limit. Most patients diagnosed with a macrometastasis have copy numbers well in excess of this value. This is important because tumour burden in the sentinel lymph node is the most powerful predictor of non-sentinel node positivity³⁻⁴ and of those patients who have four or more positive lymph nodes.⁵ Such patients have significantly worse prognosis, require additional radiotherapy, and make up 8-13% of the patients in the Z0011⁶ and AMAROS⁷ studies. Incorporation of copy number into a predictive nomogram for non-sentinel node positivity greatly improves its predictive ability.⁸

Finally, the National Institute for Health and Care Excellence (NICE) guidance on OSNA was published in 2013, not 2011.

As the invited clinical lead for the NICE guidelines, I can confirm that all the published evidence was carefully evaluated. The authors note that axillary recurrence is remarkably low in these patients and that routine axillary clearance can be safely omitted in those with low tumour burden. I agree that patients should be involved in discussions about their care, including whether to test sentinel lymph nodes intraoperatively. Sentinel node surgery is the accepted gold standard in clinically node negative breast cancer even though it misses 7% of patients with a positive axillary lymph node, so it seems strange that OSNA is so heavily criticised by the authors, who have not used it in routine clinical practice.

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Full response at: www.bmj.com/content/349/bmj.g6803/rr.

1 Dixon JM, Rutgers E, Hunt KK. Intraoperative assessment of axillary lymph nodes in patients with breast cancer. *BMJ* 2014;349:g6803. (25 November)

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Authors' reply

Rayter raises concerns about our editorial on intraoperative assessment of axillary nodes.¹⁻² He believes that the meta-analysis of one step nucleic acid amplification (OSNA) is seriously flawed, that it contains a mathematical error, and that the positive predictive value (PPV) should be 0.86 not 0.79.³ The PPV of 0.79 is statistically correct. When calculating the PPV of a relatively rare event its prevalence must be taken into account.⁴ He has not done this. The PPV of OSNA was even lower in a paper by Rayter's group. Of 30 nodes classified by OSNA as positive, just 13 had histological evidence of macrometastases.⁵ Rayter argues that the meta-analysis used the wrong mathematical model to translate tumour volume into a diameter,³ but the authors confirmed that they modelled using both a sphere and a cube.

Rayter argues that only 26 UK centres use OSNA, so it may not be the most widely used technique. A survey of surgeons at the 2014 Association of Breast Surgeons meeting identified OSNA as the only technique in routine use. Rayter asserts that we quoted 4700 copy numbers as the lower limit for the diagnosis of macrometastasis. We did not; we said that it varied between 4700 and 140 000. Rayter is

correct that the National Institute for Health and Care Excellence (NICE) approved OSNA in 2013 not 2011: our reference was dated 2013.²

Rayter justifies the 21% false positive rate of OSNA by citing the 7% false negative rate for sentinel node biopsy. In a study of 2001 women with a negative sentinel node biopsy, only nine (0.45%) had developed axillary recurrence by 10 years.⁶ These and other results fully justify the incorporation of sentinel node biopsy into routine clinical practice. By contrast, OSNA exposes up to 21% of women with axillary node involvement to surgery that may not be beneficial, a 50% rate of damage to the intercostobrachial nerve, and a 40% rate of lymphoedema at one year.⁷

Rayter accepts that routine axillary clearance can be omitted safely in patients with a low tumour burden. Randomised trials show that patients with micrometastasis do not benefit from axillary dissection,^{6, 8} but OSNA cannot accurately differentiate micrometastasis from macrometastasis.^{3, 4} As the invited clinical lead for the NICE guidelines, Rayter should encourage NICE to re-evaluate its guidelines on OSNA urgently. None of Rayter's criticisms makes us doubt our conclusion that routine intraoperative sentinel lymph node assessment should be abandoned forthwith.

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Full response at: www.bmj.com/content/349/bmj.g6803/rr-0.

With collaboration from Jim Tiernan, Eldo Verghese, and Andrew Hanby—authors of the meta-analysis.³

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NICE GUIDANCE ON PLACE OF BIRTH

NICE on claim that its place of birth guidance lacks neutrality

We wish to correct O'Brien and colleagues' misapprehensions about a *BMJ* headline that they misquote,^{1, 2} which was not derived from the National Institute for Health and Care Excellence (NICE) intrapartum care guideline or press release. They are also mistaken about the meta-analysis (and its published erratum),³ which was considered and excluded, while its individual studies were appraised individually for inclusion. They quote selectively rather than present the whole picture, as NICE recommends. Further detailed rebuttal can be found online.

NICE guideline development groups (GDGs) are multidisciplinary (and include lay members), constituted after competitive appointment, and tasked with developing recommendations based on prespecified review questions and the best available evidence. GDGs' considered

consensus judgments are laid out transparently in "linking evidence to recommendations" sections. Recommendations are published only after internal quality control procedures, expert peer review, and widespread external consultation with a large range of stakeholders, in this case generating amendments and responses to more than 1200 comments.

The GDG was extremely conscientious about informing women of the evidence (tables 1-9, NICE guideline).⁴ Strong key recommendations were made for health professionals to share these figures with pregnant women at low risk. The outcomes for mothers and babies are immediately obvious and can be found with one mouse click. The best available evidence based information can now be widely accessed and should form part of the literature and decision support tools for everyday conversations that any midwife, GP, obstetrician, maternal-fetal medicine subspecialist, or member of the general public can use to support informed decision making.

NICE recommends respect and support of women's informed decisions. The Royal College of Obstetricians and Gynaecologists agrees.⁵ As competent adults, women weigh evidence alongside their values and preferences. This is not merely a matter of trust but also their legal, ethical, and human right.

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Full response at: www.bmj.com/content/349/bmj.g7776/rr-1.

1 O'Brien AL, Chandiramani, Lees CC, on behalf of Teoh T, Bourne T, Jones B, et al. NICE guidance on place of birth falls short of neutrality. *BMJ* 2014;349:g7776. (31 December).

Cite this as: *BMJ* 2015;350:h621

PREDATORY JOURNALS

Predatory journals are only part of the problem

Clark and colleagues discuss an important problem affecting research publication in many emerging low and middle income countries. But predatory journals and publishers are only part of the problem.¹ The main problem is the low quality of research being done in these countries for various reasons, including lack of support for research, substandard infrastructure, and lack of incentives.²

Good quality research done anywhere in the world can be published in high quality journals without much difficulty and does not need to be published in predatory journals.



MALCOLM WILLET

But for poorer quality research researchers turn towards predatory journals, which provide easy publication at some cost. Moreover, many of these predatory journals are searchable on Google Scholar, which has gained popularity among researchers in the past decade.³

To solve the problem, many good institutes in low and middle income countries now encourage researchers to publish in reputable indexed journals and take into account the impact factor (Thomson Reuters), H index, and other matrices when recruiting and promoting researchers. But as well as optimising publication literacy and enforcing publication guidelines, research in low and middle income countries needs to be improved by enhancing resources and providing a supportive environment for research. Until that happens there will always be a market for predatory journals.

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1 Clark J, Smith R. Firm action needed on predatory journals. *BMJ* 2015;350:h210. (17 January)

Cite this as: *BMJ* 2015;350:h707

Reputable publishers and transparency about profits

Although I welcome the editorial on predatory journals,¹ I was concerned about the lack of information on "reputable publishers." Predatory journals are accused of having financial gain as their motive and lacking transparency. The same could be said of reputable publishers, who have been accused of making colossal profits—Reed Elsevier's profits are in the billions.^{2, 3} Most publishers charge fees for open access publishing that ensure they still make huge profits, rather than just cover costs. I suggest that reputable publishers should agree to publish their annual profits in their journals or on their websites. Also, a standard universal open access fee should be introduced. This should be set by non-profit making institutions such as PLoS.

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