Points

Self referral to consultants

Dr PETER ARNOLD (Vaucluse, NSW 2030, Australia) writes: Dr Gerald Michael and colleagues (27 February, p 640) lament self referral by middle class patients and suggest that provident organisations insist on a signature from a referring general practitioner. Sir Richard Bayliss (19 March, p 808) endorses this suggestion. Would that it were that simple. In fee for service systems, such as those in Australia, in America, and in British private practice, consultants are tempted to accept any patient seeking their services. Busy general practitioners resent writing mundane letters for middle class patients whose personal specialists already know them and their problems, but we cannot refuse to refer them. In Australia neither our medical association nor our equivalents of the General Medical Council have found a solution. I doubt whether the problem in Britain can be solved except by ethical consultants themselves. They must instruct their secretaries to refuse an appointment unless the patient already possesses a letter of referral and to return the patient to the general practitioner for attention or follow up which does not require consultant expertise. But with consultants being paid on a fee for service basis, will they?

Passive smoking

Mr W A PRIDMORE (Cottingham, North Humberside HU16 4HG) writes: Patients with social consciences are alarmed by environmental tobacco smoke (ETS), and the dangers were discussed by Mr John Warden when he assessed the Froggatt report (2 April, p 1012). Froggatt says that the 10-30% increased risk suggested by Wald *et al*[1] is now official. He states that "it is unwise to express ETS uptake in terms of an equivalent number of cigarettes actively smoked despite its undoubted convenience." Wald *et al* do just that when proving that environmental tobacco smoke kills.

Wald *et al* combined smoking studies from England, Scotland, the United States, Hong Kong, Greece, Japan, and Sweden published since 1981 (but collected years before). He said that, while most (but not all) were positive, when added appropriately they gave a positive result. When questioned about their own smoking some people in the United Kingdom give inconsistent answers (no one knows about their statements concerning other people). Wald *et al* think that this brings a 35% risk down to 30; others say to lower or even zero, according to Froggatt. If Froggatt backs Wald *et al*'s figures he must think that this inconsistency is true and identical for the United States, Hong Kong, Greece, Japan, and Sweden. Only then can we accept 30% as it stands. If my medical advisers believe that they will believe anything (including Mrs Currie).

1 Wald *et al* NJ, Nanchahal K, Thompson SG, Cuckle HS. Does breathing other people's tobacco smoke cause lung cancer? *Br Med J* 1986;**293**:1217-22.

Passive smoking and lung cancer

Dr G WYNNE GRIFFITH (Beaumaris, Gwynedd LL58 8BU) writes: The analysis by Dr A Judson Wells (16 April, p 1128) prompts me to refer to what was probably the earliest observation of the association between passive smoking and lung cancer. In his investigation of cancer in north Wales and the Liverpool region the late Percy Stocks noted a statistical association between lung cancer and drinking beer.[1] He thought it likely that heavy cigarette smoking tended "to go with frequent beer drinking" and that this could account for the association. He therefore examined the strength of the association among different categories of smokers. Among the heaviest smokers there was no association but in the combined group of light cigarette smokers, pipe smokers, and non-smokers there was a positive association ($p=0{\cdot}002$). Men who did not smoke heavily were at higher risk of lung cancer the more frequently they drank beer. He offered the explanation that "most daily beer drinkers spend much time in an atmosphere laden with tobacco smoke even though they smoke few or no cigarettes themselves."

1 Cancer Campaign. *Thirty-fifth annual report. Supplement*. London: British Empire Cancer Campaign, 1953.

Osteoporosis in elderly Chinese

Drs S T LEE, K O LEE, and K BOSE (Departments of Orthopaedic Surgery and Medicine, National University of Singapore, Singapore 0511) write: Dr Tessa Richards (5 March, p 659) perpetuates the myth that osteoporosis is rare among elderly Chinese women. We have studied the incidence of hip fractures in elderly Chinese women in Singapore and the changes in bone mass with aging using bone densitometry. In 1980 the incidence of hip fractures in women aged 60 and above was 1·5 per 1000, which is about half that in the United Kingdom.[1] This high incidence occurred despite our year round sunshine and absence of icy pavements. One of the reasons for thinking that hip fractures were rare in elderly Chinese women was the underrepresentation of this group in a previous study.[2] But with increasing longevity hip fractures have become an important problem in the past few years. Bone densitometry studies show that Chinese women in Singapore have a similar profile to caucasian women[3] and a similar accelerated bone loss after the menopause. In fact, when absolute densities were compared elderly women in Singapore had 20% less bone mass than caucasian women of the same age.[3]

1 Bose K. Overview of osteoporosis in Singapore. In: *Proceedings of the 1st Asian symposium on osteoporosis*. Singapore: Excerpta Medica (in press).
2 Wong PC. Fracture epidemiology in a mixed South Eastern Asian community (Singapore). *Clin Orthop* 1966;**45**:55.
3 Lee ST. *Bone mineral content of normal adult population in Singapore*. Liverpool: University of Liverpool, 1987. (MCh thesis.)

Procedures in dermatology

Mr RUSSELL HOPKINS (Dental Hospital, Heath Park, Cardiff CF4 4XY) writes: Dr D W S Harris (12 March, p 769) includes a drawing of the skin crease lines of the face but shows incorrect angulation of the crease lines of the neck, where, particularly in the submandibular region, they are not parallel to the lower border of the mandible but lie at an angle. An incision along the line suggested by Dr Harris is likely to produce a stretched and unsightly scar. He also suggests that sutures should be removed from the face four to five days after surgery. By this time epithelium will have begun to grow into the suture wound producing the permanently pitted skin which is so unsightly. Facial sutures, if Steristrips are unsuitable, are best removed on the third day and replaced by Steristrips to avoid scarring. The subcuticular suture, although more difficult to insert, is advised.

Mr P J BILLINGS (St James's Hospital, Balham, London SW12 8HW) writes: Dr D W S Harris (12 March, p 769) rightly advocates that skin incisions should run parallel to the skin wrinkles, or Langer's lines, to produce the best cosmetic scar. Unfortunately, his diagram of Langer's lines is not completely accurate. The lines of cleavage were originally observed by Dupuytren after a stabbing in the Hotel-Dieu in Paris in 1831. He noted that the wounds produced by a circular stiletto were linear. Langer was the first to investigate these lines,[1] but more recently Cox has studied the subject in greater detail with similar conclusions.[2] In the limbs the lines of cleavage run along the axis of the limb except in the areas of the joints, where they run circumferentially. The lines can be determined in an individual patient by pinching up the skin to find the direction in which it is easiest to pick up the skinfold.

1 Langer K. Zür Anatomie und Physiologie der Haut: über die Spaltbarkeit der Cutis. *Sitzungsberichte der Kaiserlichen Akademie der Wissenschaften* 1862;**44**:20.
2 Cox HT. The cleavage lines of the skin. *Br J Surg* 1941;**29**: 234-40.

Benzydamine oral rinse and rash

Dr RICHARD J MOTLEY (University Hospital of Wales, Heath Park, Cardiff CF4 4XW) writes: Cutaneous reactions to benzydamine in its various forms have been described, and the value of patch and photopatch testing has been shown.[1-5] I was disappointed that Mrs M Turner and Dr R Lait (9 April, p 1071) did not refer their patient to a dermatologist for appropriate patch testing. This would have largely eliminated the need for speculation about the aetiology of the rash.

1 Brunynzeel DP. Contact allergy to benzydamine. *Contact Dermatitis* 1986;**14**:313-4.
2 Fernandez De Corres L. Photodermatitis from benzydamine. *Contact Dermatitis* 1980;**6**:285-303.
3 Balato N, Lembo G, Patruno C, Bordone F, Ayala F. Contact dermatitis from benzydamine hydrochloride. *Contact Dermatitis* 1986;**15**:105.
4 Ikemura I. Contact and photocontact dermatitis due to benzydamine hydrochloride. *Jap J Clin Derm* 1971;**25**:129.
5 Motley RJ, Reynolds AJ. Photosensitivity from benzydamine cream. *Contact Dermatitis* (in press).

How informed is signed consent?

Drs L LOVETT and D SEEDHOUSE (Departments of Psychiatry and General Practice, University of Liverpool, Liverpool L69 3BX) write: Dr D J Byrne and others (19 March, p 839) show that signed consent to surgical treatment does not guarantee even the most minimal knowledge about the operation. It is suggested that inadequate information from surgical staff is "unlikely to be a major factor." This must be challenged as the methods chosen were inappropriate to the aim. The survey assessed the recall of facts, but recall is not an issue when one is investigating the question "how informed is signed consent?" The fact that a person may have forgotten information to which she consented does not affect her consent at the time if she was aware of the facts then. If a person signs an agreement to a procedure with no knowledge of what is involved then there is no meaningful consent. Thoughtful and thorough proposals for ensuring better understanding at the time of signing are needed.

Imaging for prostatism

Dr DAVID SOUTHCOTT (Mayday Hospital, Croydon) writes: The suggestions of Dr Gerald de Lacey and colleagues (2 April, p 965) are broadly correct but they have neglected two considerations. Firstly, they undervalue the plain abdominal radiograph, which, in addition to showing the full bladder and radioopaque calculi, would show the skeleton, where the presence of unsuspected metastases from an occult primary would indeed alter management. Secondly, the medicolegal position was discussed at the meeting of the British Association of Urological Surgeons in Torquay several years ago and it was decided that, regrettable as it may seem clinically, a "defensive" intravenous urogram should be obtained. Other imaging techniques (and indeed intravenous urography) have improved since then, but, unhappily, the medicolegal climate has not.

The sickening of medical research

Dr G C SUTTON (Pontefract Health Authority, West Yorkshire WF7 6HT) writes: British medical research will not regain its vitality until the health system it serves adopts healthier ways. A national commitment to do so already exists, and it is disappointing that Dr Richard Smith does not mention it (16 April, p 1079).

The European strategy towards health for all by the year 2000 was adopted by the British government in 1984. Of its 38 targets, 20 are due in 1990 and many will be missed. These include target 32—to formulate a national research strategy in support of health for all—and target 38—to establish a national mechanism to evaluate health technology. Such an approach could promote relevant, low cost research in line with the government's objectives while conceding nothing in intellectual quality or methodological rigour. The government's consistent spurning of its obligations towards "health for all" has been one of the disasters of the late 1980s.