foods that evoke a low postprandial glycaemic response (for example, pasta and rye bread) are encouraged. Root and green leafy vegetables are also regarded as acceptable substitutes for fat. Under these conditions increasing carbohydrates does not produce hypertriglyceridaemia or decrease the concentration of high density lipoprotein cholesterol.¹³

Reaven and Hollenbeck *et al* emphasised the importance of hypertriglyceridaemia and reduced high density lipoprotein in causing coronary heart disease in diabetes.^{5,10} They suggested that the reduction in saturated fatty acids should be compensated for by an increase in monounsaturated fatty acids and polyunsaturated fatty acids, both of which enhance the low density lipoprotein lowering effect of reducing saturated fatty acids. Increasing the intake of monounsaturated fatty acids avoids the hypertriglyceridaemia and reduced high density lipoprotein concentrations seen when unspecified carbohydrate replaces saturated fatty acids, and epidemiological data, the Mediterranean experience in particular, endorse the suggestion that monounsaturated fatty acids may at least be a partially suitable substitute for saturated fatty acids. Nevertheless, studies that have compared diets high in monounsaturated fatty acids and carbohydrate have not taken into account the role of soluble fibre and that some other carbohydrate containing foods may be particularly beneficial.⁴

Hence probably much of the apparent controversy hinges around the different ways of replacing the energy derived from saturated fat. This will be resolved by long term studies, presently under way, comparing the metabolic effects of different dietary manipulations. For the present the European guidelines seem to offer a compromise. They endorse the standard advice concerning energy balance and planning meals, and, in the light of probable benefits of monounsaturated fatty acids, polyunsaturated fatty acids, and carbohydrate rich in soluble fibre, they suggest that the reduction of saturated fatty acids might be compensated for by some increase of each of these. This would seem to be the most practical approach for many countries. In 1987

oral hypoglycaemic agents costing more than £11.5m were dispensed by retail chemists in Britain (Department of Health and Social Security, Statistics and Research Division, personal communication), and undoubtedly this cost to the health service (and that of preparations dispensed in hospital and by dispensing doctors) might be appreciably reduced by adherence to these dietary principles. It would be unfortunate if patients with diabetes were deprived of advice that can profoundly influence the metabolic derangements of diabetes because of the misguided belief that there is more confusion than consensus among "experts" about the optimum diet.¹⁰

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Best documented practice

Time to set down a few benchmarks

Ask different doctors how they would deal with the same clinical problem and you may get many different answers. Managers, if consulted, might come up with a few more alternatives. Everyone will claim that they are doing what is best for the patient. Why is agreement so elusive?

It should be possible to identify how a particular problem could be managed to make the best use of clinical experience and available resources. The decision should take account of a treatment's effectiveness, toxicity, and cost, and, once established, a "best documented practice" might be used as the standard for comparison. To be credible it would need to be reached by consensus. Consensus groups could not be self appointed but would need to be composed of widely acknowledged experts on the topic concerned.

Cancer lends itself well to such a process. Easily definable end points, such as complete remission, disease free survival, and overall survival, have long been criteria for judging the efficacy of treatment for cancer. Although the results of different clinical trials are sometimes difficult to compare—no two institutions seem capable of implementing the same

protocol in an identical fashion—they have furnished useful comparative information on the effects of different treatments on crude measures of outcome, such as rate of complete remission and survival. Why then are different, sometimes profoundly different, treatments in use for identical well defined conditions? Why, for example, is combination chemotherapy still used routinely for advanced ovarian cancer when treatment with a single agent has been shown to be equally effective?¹

Attempts to achieve consensus on managing breast cancer have been made.² The conclusions of the consensus group have generally been regarded as guidelines, but the definition of best documented practice goes beyond this, requiring the identification of a treatment for use as a basis for comparison. To use again the example of ovarian cancer: different histological subtypes, regimens, drug toxicities, and management costs are well documented, and their contribution to treatment of the outcome may be estimated fairly accurately. Treatment with cisplatin or chlorambucil are candidates for the best documented practice of advanced ovarian cancer.

Neither has yet been shown to be appreciably better than the other.

Once established, a best documented practice could be displaced only if rigorous tests showed that a different treatment was better. Information on the effects of a best documented practice on patients could be easily stored on computer, providing a standard for internal audit. Any change in response rates or other outcomes should become apparent early. Questions might be asked close to the source of the information, which would provide substantially more reliable data than are currently available in most hospitals for most patients. To some, such scrutiny may suggest a loss of clinical freedom. As resources are limited and always will be, however, a consensus on best documented practice may help doctors decide how best to use those resources at their disposal.

Several royal colleges have endorsed medical audit, regarding it as an integral part of modern clinical practice.³ The government's new white paper *Working for Patients* supports their view.⁴ To audit satisfactorily an idea is needed not only of outcome but also of the appropriateness of treatment. Audit would be substantially simplified by establishing a best

documented practice for each clinical condition. One problem of recognising a best documented practice would be the legal implications of establishing a standard. The threat is perhaps greatest to the spurious or untested remedy.

Optimum management must always remain under challenge from new developments, and one best documented practice will be replaced when the benefits of another have been shown. Recognising a best documented practice is no substitute for clinical skills—it permits, however, the channelling of those skills for the best advantage of those for whom they are intended: the patient.

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Treatment of shingles and post-herpetic neuralgia

Relieves shingles but does not prevent neuralgia

The annual incidence of herpes zoster in the general population ranges from an estimated 0.8 to 4.8 per thousand.^{1,3} Nevertheless, this increases sharply with age—from two to three cases per 1000 in early adult life to five in the sixth decade, six to seven in the seventh and eighth decades, and 10.1 in those aged 80 and over—corresponding to the natural decline in cell mediated immunity.^{1,2}

Herpes zoster occurs spontaneously in normal people, most cases being self limiting and resolving completely.^{2,4} The pain may be severe but is usually transitory; but increasing age increases both the duration and severity of herpes zoster neuralgia.¹ Complications occur in 15-20% of cases, the most common being post-herpetic neuralgia in 9-14%.⁴ This is pain persisting or occurring at the site of shingles over 30 days after the onset of the acute infection.^{5,6} Its frequency and severity increase with age; it occurs in 16% of patients under 60 and 47% of those over 60.¹ In one study no fewer than three quarters of patients over 70 had post-herpetic neuralgia, and one year after the acute infection it persisted in 42% of those aged under 20 and about half of those over 70.⁷ Herpes zoster of the eye is a complication in 2% of cases, being associated with a high rate of inflammatory and neuropathic ocular complications in half to three quarters of instances; such complications, especially keratitis and uveitis, may become chronic, sometimes causing loss of vision.⁸

The treatment of acute herpes zoster aims at reducing the upset caused by the acute infection as well as preventing complications, especially post-herpetic neuralgia. The results of studies on the efficacy of topical idoxuridine in dimethyl sulphoxide in uncomplicated herpes zoster are difficult to assess because the control groups were not always closely matched.⁹ In one study 40% idoxuridine applied continuously to cover the whole of the dermatome relieved the pain¹⁰; in another study it had no effect on the pain, but the inflammatory response was shortened.¹¹ Neither healing nor

pain were altered in thoracic herpes zoster whereas both were greatly improved in trigeminal infection.¹²

Hence questionable efficacy as well as the side effects and the cost limit the usefulness of idoxuridine. In immunocompetent patients, on the other hand, herpes zoster may be severe enough to warrant antiviral treatment, particularly in the elderly. Acyclovir has largely replaced idoxuridine and older antiviral agents because of its low toxicity and ease of administration.¹³ Oral acyclovir given in high dosage (800 mg five times daily for seven days) early in the illness modifies the rash and reduces pain.¹⁴ It does not, however, diminish the likelihood of neuralgia, either by itself¹⁵ or with prednisolone,¹⁵ though it will lessen the more common ocular complications, including keratitis and uveitis.⁸ Treatment is expensive and thus can be considered only in patients presenting with acutely painful shingles within 48 hours of the onset of the rash, immunocompromised patients, and those with herpes zoster of the eye.

Multiple and repeated sympathetic and somatic nerve blocks relieve the pain of acute shingles and are valuable in preventing subsequent neuralgia. Early treatment of acute shingles at a pain clinic by sympathetic blockage and infiltration of somatic nerve endings with local anaesthetics has been suggested to prevent the development of post-herpetic neuralgia,^{17,18} but in view of the frequency of the condition this can be offered only to those at greatest risk, to the elderly, or to immunocompromised patients with severe acute infection.

Corticosteroids are commonly used to prevent the development of neuralgia despite conflicting results of several studies.^{19,21} Further research is needed before this treatment can be recommended, given its immunosuppressive effects and potential for serious complications. In a small, poorly controlled study amantadine given twice daily to patients with acute herpes zoster had no effect on the acute illness