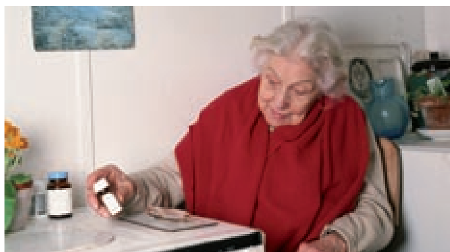
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

BMJ: first published as 10.1136/bmj.39164.411400.1F on 29 March 2007. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

CARING FOR THE OLDEST OLD

Oldest old are not just passive recipients of care



Although Robine et al raise serious points about future trends in ageing, dependency, and care provision in later life,[1] it is also worth noting that older people are not just passive recipients of care. Of particular importance is the contribution that they themselves bring to their own care. A longitudinal study of ageing in Ireland found a marked increase in the amount that older people spend on provision of health and social care[2] over a four year sampling period, despite increases in access to services such as free general practitioner care. Over 8% of older people in this study were themselves the primary carer for another family member.

Therefore, even in advanced old age, a sense of partnership between services and all older people needs to be developed. Enabling this partnership, and responding to the changing demands of health and social care services, will require increased emphasis on effective care for older people, whether through acute geriatric medicine (which can reduce death and disability by 25%)[3] or by improved chronic disease management.[4] It will also require some thought to ensuring that the societal structures, such as housing and transport,[5] do not hinder participation of the oldest old in sharing in their own care.

Desmond O'Neill associate professor, Department of Medical Gerontology, Adelaide and Meath Hospital, Dublin 24, Republic of Ireland arhc@amnch.ie

Hannah McGee professor, Department of Health Services Research, Royal College of Surgeons in Ireland, Dublin 2

Competing interests: None declared.

1 Robine JM, Michel JP, Herrmann FR. Who will care for the oldest people in our ageing society? *BMJ* 2007;334:570-1. (17 March.)
2 O'Hanlon A, McGee A, Barker M, Garavan R, Hickey A, Conroy R, et al. *Health and social services for older people II (HeSSOP II): changing profiles from 2000 to 2004*. Dublin: National Council on Ageing and Older People, 2005.
3 Ellis G, Langhorne P. Comprehensive geriatric assessment for older hospital patients. *Br Med Bull* 2005;71:45-59.
4 Lorig KR, Ritter PL, Laurent DD, Plant K. Internet-based chronic disease self-management: a randomized trial. *Med Care* 2006;44:964-71.
5 O'Neill D, Dobbs B. Age-related disease, mobility and driving. In: Transportation in an aging society, a decade of experience. Washington, DC: *Transportation Research Board*, 2004:56-68.

CORD CLAMPING

NICE is encouraging artificial intervention

As well as seeming to discourage the detection of postpartum depression,[1] the National Institute for Health and Clinical Excellence (NICE) is also encouraging the artificial intervention of immediate cord clamping.[2]

The NICE guideline for caesarean section includes a section on cord clamping. It states a number of "suggested" benefits and a number of "possible" harms. The reference is a review paper in a midwifery journal.[3] This review clearly provides evidence for the benefits, not simply a "suggestion," and clearly disputes any evidence of harm from polycythemia, hyperviscosity, or hyperbilirubinaemia.

The NICE draft guideline on intrapartum care never mentions cord clamping (www.nice.org.uk/page.aspx?o=334322). The authors recognise that the major rapid physiological changes that take place enable the baby to adapt to life outside the womb. How rapidly should we expect these changes to take place? Is it reasonable to expect these physiological changes to occur within a few seconds and at the whim of a bystander? Active management of the third stage is considered to be an established part of good intrapartum care, and early cord clamping an integral part of it.[4]

How precise does the practice need to be? The timing of the oxytocic agent varies among the studies and in different parts of the world. There is no real logic for incorporating early cord clamping in a strategy to reduce postpartum haemorrhage. Removing the clamp and draining the residual placental blood seems to shorten the third stage.[3] This is recommended practice in rhesus negative women, in an effort to reduce the risk of fetomaternal haemorrhage.[5] It is therefore totally illogical to recommend immediate cord clamping and cutting, followed by drainage of the residual placental blood. This is blood that is physiologically required by the newborn baby. It would be better to "drain the placenta" into the newborn baby or at least provide the baby with the amount of blood that it requires. Any residual blood at that stage can be allowed to drain away.

David J R Hutchon consultant, Darlington Memorial Hospital, Darlington DL3 6HX obstetrician
djrhutchon@postmaster.co.uk

Competing interests: None declared.

1 Coyne JC, Mitchell AJ. NICE may be discouraging detection of postpartum depression. *BMJ* 2007;334:550-a. (17 March.) doi:10.1136/bmj.39150.424896.BE.
2 Kent A. What's new in the other journals? *BJOG* 2007 114:379-80.
3 Mercer JS. Current best evidence: a review of the literature on umbilical cord clamping. *J Midwifery Women's Health* 2001;46:402–14.
4 Soltani H, Dickinson F, Symonds I. Placental cord drainage after spontaneous vaginal delivery as part of the management of the third stage of labour. *Cochrane Database Syst Rev* 2005 (4): CD004665.
5 Prendiville W, Elbourne D. Care during the third stage of labour. In: Chalmers I, Enkin M, Keirse MJNC, eds. *Effective care in pregnancy and childbirth.* Oxford: Oxford University Press, 1989:1145-69.

PERINATAL DEATH IN TWINS

Absolute risk: better basis for decision making

Smith et al's conclusion of threefold to fourfold increased mortality in a second twin when born vaginally at term is a relative rather than an absolute risk.[1] There was an excess second twin all cause mortality of 73 infants, and an excess second twin anoxic mortality of 60 infants. Altogether there were nearly 100 000 births, but the preterm rate (higher in twin births) was not stated, so there might have been 90 000 full term confinements. This gives an increased mortality for the second twin of 0.8 per 1000 births, and an increased anoxic mortality for the second twin of 0.67 per 1000 births. If caesarean section successfully avoided all the second twin mortality, 1250 caesarean sections would be needed to save one infant. If caesarean section were only successful in preventing anoxic deaths, 1500 caesarean sections would be needed to save one infant. Although this large number of extra sections might be justifiable, the low possible statistical benefit might persuade some mothers or their obstetricians that a vaginal delivery is a

reasonable option for full term confinements. The absolute rather than the relative risk is the correct guide to decision making.

The figures do not prove that caesarean sections would prevent deaths in the second twin.[2] Fetal behaviour may affect birth order in twin deliveries, and the more vulnerable infant may be delivered second in vaginal but not in caesarean deliveries. The benefit of caesarean section can be proved only by a comparison of total fetal mortality in vaginal and caesarean deliveries.

Christopher Cheetham consultant paediatrician (retired), High Wycombe HP13 6QW
kimcheetham@btopenworld.com

Competing interests: None declared.

1 Smith GCS, Fleming KM, White IR. Birth order of twins and risk of perinatal death related to delivery in England, Northern Ireland, and Wales, 1994-2003: retrospective cohort study. *BMJ* 2007;334:576-8. (17 March.)
2 Steer P. Perinatal death in twins. *BMJ* 2007;334;545-6. (17 March.)

ASTHMA IN PREGNANCY

Attacks seem rare in labour

I was concerned to read that 10-20% of women experience an exacerbation of asthma during labour.[1] In 40 years' practice as an obstetric physician, I never saw an attack of asthma in labour; and nor have other obstetricians and respiratory physicians that I have questioned at conferences. I wonder if any of the *BMJ's* readers have personal experience of managing asthma attacks in labour? This is important because women with asthma are very frightened of not being able to cope with asthma at delivery. Up to now I have reassured patients that this is very unlikely to be a problem.

Michael de Swiet emeritus professor of obstetric medicine, London N6 5LU m.deswiet@imperial.ac.uk

Competing interests: None declared.

1 Rey E, Boulet L-P. Asthma in pregnancy. *BMJ* 2007;334:582-5. (17 March.)

A GOOD DEATH

Dying on the acute take can be improved

Numerous patients with chronic illnesses in whom death may be expected or patients with severe and significant comorbidites will be admitted to acute medicine.[1] We recently performed a retrospective audit of patients admitted through the medical admissions unit who subsequently died. Death did not come as a surprise in 21/23 patients; seven of the 21 patients had terminal cancer, and nine had severe infection with severe comorbidities. An average delay of 11 hours occurred from recognition that the patient was dying to institution of any palliative measures. Of the terminally ill patients, six were judged to have had adequate palliation, 10 received no palliative drugs, and five received minimal palliation. The commonest reason for withholding palliative drugs seemed to be a trial of active treatment in the first instance.

Care of dying patients in acute medicine may not always be seen as a priority. However, these patients should be recognised early—so that symptomatic treatment can be used to ensure a comfortable death and enable the patient and family to prepare for death.[2] These measures can be instituted alongside active management in these patients who are sick enough to die.

Suzie Gillon senior house officer, general medicine, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP suziegillon@doctors.org.uk
Kathryn Mannix consultant in palliative care
David A Price consultant in acute medicine (and infectious diseases)

Competing interests: None declared.

1 Dy S, Lynn J. Getting services right for those sick enough to die. *BMJ* 2007;334:511-3. (10 March.)
2 Ellershaw J, Ward C. Care of the dying patient: the last hours or days of life. *BMJ* 2003;326:30-4.

MTAS

New system threatens UK clinical research

We are committed to the development of a professional medical workforce, able to contribute to national health, wealth, and knowledge creation. To achieve this we must identify and nurture a strong cadre of clinical academics for the future, building on the opportunities afforded by the recent UK funding schemes. It has therefore been particularly disappointing that the new system of application to specialist medical training (MTAS) has paid scant regard to the determinants of academic potential.[1]

Academic trainees—those doctors wishing to pursue careers that encompass research as well as patient care—have been particularly badly affected by the decision to anonymise applications and deprive the assessors of details of previous clinical and research experience. These trainees, who are among the brightest of their generation, are a precious commodity.

Without a scientifically informed and research oriented medical workforce throughout the country, the government's vision of the UK as a world class centre for biomedical research and health care, cannot be realised.

J Bell president, Academy of Medical Sciences, London SW1Y 5AH nick.hillier@acmedsci.ac.uk
John Tooke chair, Council of Heads of Medical Schools, London WC1H 9HD

Competing interests: None declared.

1 Brown MJ, et al. Raging against MTAS. *BMJ* 2007 Mar7. www.bmj.com/cgi/eletters/333/7579/0-f#161670.

PUBLISHER BOYCOTT

Editorial misses the point

Clearly there is an unsavoury and unethical aspect to the sale of weapons,[1] but there is a legitimate trade as well. Few would doubt that there are benefits from various "peacekeeping" forces in the world, though obviously there are controversial invasions. Only the most naive would argue that our own democracy was not protected during the cold war by our weaponry. We can pretend it is not happening and let other countries dominate the arms trade, but we will still buy weapons for our armies. If my son is to be sent to an area of conflict, I don't want him being armed with inferior weaponry because a non-combatant thought it unethical to seek the best technology.

Unpalatable as it is, there will always be an arms trade and dissociating ourselves from it will merely remove any possibility of influencing control. Landmines would not disappear if Reed Elsevier stopped organising exhibitions.

Laurie R Davis general practitioner, South Hermitage Surgery, Shrewsbury SY3 7JS lauriedavis@doctors.org.uk

Competing interests: LRD owns shares in Qinetic, a British defence company.

1 Young C, Godlee F. Reed Elsevier's arms trade. *BMJ* 2007;334:547-8. (17 March.)

It's a hatchet job

Young and Godlee write: "The *BMJ* has no wish to see the *Lancet* diminished."[1] Well, you could have fooled me. Calling for contributors to boycott the *Lancet* will lead to its closure, which would almost certainly benefit the *BMJ*. Is there a hint of self interest dressed up as moral outrage in this article?

Does anyone believe that boycotting Reed Elsevier will make the slightest difference to the international arms trade? It is a sad fact of human existence that the sophistication of a society is often measured in its weaponry. The arms trade is loathsome but at least Reed Elsevier is conducting its business in plain view. It's when it goes underground that you need to worry. I think it would be better if they weren't involved, and I'm sure the board of the *Lancet* does too. But boycotting a journal that has no control over another part of its parent company is not the way to go.

Christopher E Nancollas general practitioner, Newnham GL14 1BE ChrisNanco@aol.com

Competing interests: None declared.

1 Young C, Godlee F. Reed Elsevier's arms trade. *BMJ* 2007;334:547-8. (17 March.)

BMJ: first published as 10.1136/bmj.39164.411400.1F on 29 March 2007. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.