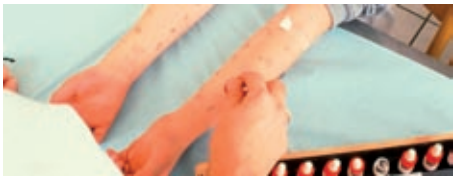
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list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



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ALLERGY AFTER BREAST FEEDING

Study was not designed to test the hypothesis

The PROBIT study is a large randomised controlled study aimed at reducing childhood gastrointestinal infection by promoting breast feeding. Secondary outcomes included atopic eczema and asthma.[1] However, the recent paper was written as if the study's main aim was to test the association between prolonged and exclusive breast feeding and asthma and allergy.[2] When no statistical difference was found, the authors erroneously concluded that breast feeding has no effect on these outcomes.

This conclusion cannot be drawn from this study design and cannot be extended to different populations. The post hoc analysis, with grouped breastfeeding classes, is more suited to the aim of the paper, but it has methodological and interpretative limitations, such as confounding.

The intervention promoted exclusive and prolonged breast feeding in women who wished to breast feed. This approach can test only whether the duration of breast feeding or exclusion of allergens in the first months of life reduces risk of asthma and allergy in the children of mothers who wish to breast feed. It cannot investigate differences in asthma and allergy rates resulting from a mother's decision to breast feed, or the effect of colostrum or immediate skin to skin contact after birth.

The results cannot readily be extrapolated to populations with higher rates of asthma and allergy. The prevalence of allergy was low—family (parental and sibling) history of atopy was <5% compared with >80% (excluding siblings) in New Zealand.[3]

The wide confidence intervals suggest that all important confounding and predictor variables may not have been included in the multivariate model. Major concerns exist about the quality of the skin prick test—the only objective measure of atopy used.

Breast feeding may not protect against asthma and allergy, but this study cannot prove this hypothesis. Rather, it shows that in a Belarusian population, promotion of breast feeding in women who wish to breast feed does not alter the risk of asthma and allergy at 6.5 years.

Karen M Silvers senior research fellow, University of Otago, Christchurch, PO Box 4345, Christchurch, New Zealand
karen.silvers@xtra.co.nz

Michael J Epton senior lecturer in medicine, **Chris M Frampton** associate professor

Competing interests: None declared.

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ABDOMINAL AORTIC ANEURYSM

Screening reduces all cause mortality in men

Greenhalgh and Powell[1] cite a recent Cochrane review, which reported that screening asymptomatic people for abdominal aortic aneurysm (AAA) significantly reduced not all cause but AAA related mortality in men aged 65-79. The review, however, excluded some recent studies with long follow-up.[2-4] Therefore, we performed a meta-analysis of randomised controlled studies with long follow-up of screening for AAA in men (both AAA related and all cause mortality).[5]

Our comprehensive search identified four reports—the Chichester study (over 15 year follow-up),[2] the Viborg country study (median 9.6 year follow-up),[3] the Western Australia study (median 3.6 year follow-up), and the multicentre aneurysm screening study (mean 7.1 year follow-up).[4] Pooled analysis of the four reports showed a statistically significant reduction in AAA related mortality (risk difference –0.25%, 95% confidence interval –0.46% to –0.04%) and all cause mortality (–1.06%, –1.81% to –0.31%) with screening relative to control in a random effects model.[5]

Thus, our meta-analysis,[5] an update of the Cochrane review, showed that screening for AAA significantly reduced not merely AAA related but also all cause mortality in men aged >65 years.

Hisato Takagi consultant cardiovascular surgeon, Shizuoka Medical Centre, Shizuoka 411-8611, Japan
kfgth973@ybb.ne.jp

Norikazu Kawai registrar, **Takuya Umemoto** consultant cardiovascular surgeon

Competing interests: None declared.

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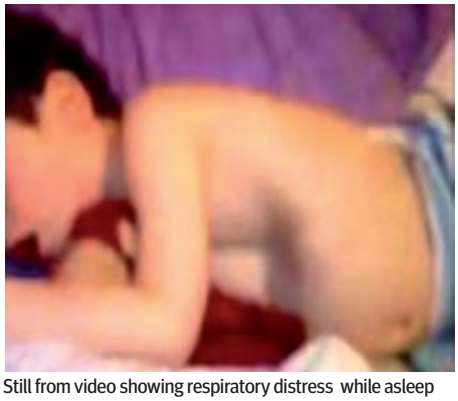
VALUE OF VIDEO CLIPS

Useful in acute upper airway obstruction in children



Still from video showing respiratory distress while asleep

Ashworth argues that mobile phone video footage is useful when treating sick children.[1] We know of two recent cases in which such video footage provided by parents was valuable in the diagnosis and treatment of upper airway obstruction.

A previously healthy 2.5 year old boy was reported by his parents to have

severe respiratory distress at night, which completely resolved during the day. He was seen several times by a family doctor and ear, nose, and throat specialist. No diagnosis was made as he seemed well. Finally, his parents presented a video recording showing him in severe respiratory distress while asleep (figure). Direct laryngoscopy and bronchoscopy were then carried out under general anaesthesia. He needed urgent adenotonsillectomy and made an uneventful and complete recovery.

The second patient was a 13 year old girl with cystic fibrosis who was due to have a scheduled bronchoscopy. She seemed well when she presented for an anaesthesia assessment, with no signs of respiratory distress, but her parents supplied a video recording from a mobile phone that showed her in respiratory distress in the morning or when anxious. She successfully underwent a diagnostic bronchoscopy and postoperative respiratory symptoms were consistent with the mobile phone recordings.

These cases highlight the usefulness of modern technology in the diagnosis of problems of uncertain severity in children and may represent a useful alternative to inpatient admissions.

Graham A M Wilson consultant paediatric anaesthetist, Royal Aberdeen Children's Hospital, Aberdeen AB25 2ZN
graham.wilson@nhs.net

Thomas Engelhardt consultant paediatric anaesthetist, **Bruno Marciniak** staff anaesthetist, Clinique d'Anesthesie Reanimation de l'Hopital Jeanne de Flandre, CHRU Lille, 59037 Lille Cedex, France

Competing interests: None declared.

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HONOURING ADVANCE DECISIONS

You don't in psychiatry

Dyer reports, "A new statutory right for patients to say in advance what treatments they would want to refuse if they later lose the capacity to take decisions came into force this week. Doctors will have to abide by the new advance decisions to refuse treatment (ADRTs) or risk criminal or civil proceedings in the courts."[1] Alas, this is true only for medical patients. It is not true for mental health patients. And it cannot be true so long as we have special laws for such patients.

Dyer adds that "Patients will not be able to . . . require a doctor to do anything unlawful." There is the rub. In psychiatry, procedures that incarcerated mental patients view as protection of their civil rights, psychiatrists regard as interference with their duty to protect patients and the public from the ravages of mental illness, an interpretation the courts uphold.

In short, the perceived moral-psychiatric need to prevent harm to self and others precludes the use of advance directives in psychiatry. Doctors and their patients ought to be aware of this limitation of advance directives.

Thomas Szasz professor emeritus of psychiatry, SUNY Upstate Medical University, Syracuse, New York 13210
tszasz@aol.com

Competing interests: None declared.

1 Dyer C. Patients win right to have their advance decisions honoured by medical staff. *BMJ* 2007;335:688-9. (6 October.)

OBSERVATIONAL STUDIES

More than high standards needed

Von Elm et al provide a welcome set of criteria to judge prospective observational studies.[1] What they do not include is the health warning that should accompany such publications. The accompanying editorial highlights the usefulness of these studies to examine rare diseases,[2] but such studies are often used for common illnesses like cardiovascular disease and cancer. End points are frequent and prevalence high enough to make randomised controlled trials more reliable for assessing these illnesses.

The quoted examples seem to prove the importance of cohorts, but a list from cardiology alone shows that results of observational studies are often seriously flawed. Observational studies of the cardioprotective effects of female sex hormones, the usefulness of antioxidants or homocysteine lowering strategies, and rhythm control for atrial fibrillation suggested a clear treatment effect and greatly influenced practice. But subsequent randomised trials refuted each hypothesis.

The main problem is interacting factors that cannot all be statistically accounted for. For example, in general, overweight people do less exercise, have a high saturated fat intake, smoke, and do not attend to their insulin therapy or take their blood pressure tablets. So, the results of cohort studies are often wrong if cohorts are considered in isolation. This would not be a problem if cohort studies were not acted upon until a randomised trial is conducted. Glasziou et al suggested that a combined rates ratio of at least 10 and a P value of <0.01 should be used to distinguish between a true effect and background population "noise."[3] Few of our current favourite targets—mild obesity, salt intake, or passive smoking—would pass this test. The findings of cohort studies should start rather than close the debate. Experts are too hasty to present a hypothesis as a proven fact, and the medical profession is too willing to accept such findings uncritically.

Guy Lloyd consultant cardiologist, Eastbourne District General Hospital, Eastbourne BN21 2UD
lloyd.cardiol@btopenworld.com

Competing interests: None declared.

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TALK OF PSYCHOSOCIAL FACTORS

Tell the whole story

Goldacre says he sounded like an ass when explaining the complex pathogenesis of back pain on radio, but he is unduly harsh on himself.[1] His message is not wrong, but might have been better gift wrapped.

Western medicine is based on the biomedical model. This model is reductionist—all symptoms can be explained by underlying pathology—and dualist—if there is no pathology, it's all in your head. This model was drilled into us at medical school and is the principal model for the National Health Service.

But it's wrong. For up to 90% of people presenting to their general practitioner with genuine physical symptoms, the symptoms are not explained by pathology. It is also not appropriate to label most of these patients as anxious or depressed. I now explain this to patients, and tell them that the problem lies with the model, not with them. It is normal to have genuine physical symptoms that cannot be explained through radiographs or blood tests.

You can then help the patient understand that extensive research has proved what will help. The psychological yellow flags act as obstacles to recovery and return to work. These include catastrophising, low mood, avoidance behaviour, and having an external locus of control. These all inhibit recovery. Cognitive behaviour therapy is excellent for tackling these obstacles (www.livinglifetothefull.com). When coupled with graded exercise programmes, the outcomes are excellent.

Charles T Vivian consultant occupational physician, Gloucestershire Royal Hospital, Gloucester GL1 3NN
charlie.vivian@glos.nhs.uk

Competing interests: None declared.

1 Goldacre B. Beware of mentioning psychosocial factors. *BMJ* 2007;335:801. (20 October.)