Letters

Fine needle aspiration has its place
EDITOR—Metcalfe et al underline the risks of fine needle aspiration cytology for hepatic colorectal metastases, but their proposed contraindication of fine needle aspiration and the possible diagnostic alternatives for liver lesions without apparent primary malignancy are not evidence based.

In suspected metastases of unknown origin Metcalfe et al recommend that the investigations should be directed to detect the primary lesion, something clearly opposed to current guidelines for the diagnostic work up of unknown primary tumours that limit diagnostic approaches. Routine use of invasive surgery for the diagnosis of liver lesions implies a risk of procedure associated morbidity and morbidity that may be not reasonable in some patients with advanced cancer. Positron emission tomography cannot be considered the gold standard to differentiate between benign and malignant lesions as its sensitivity is not significantly different to that of fine needle aspiration.

We suspect that even Metcalfe et al will not accept for themselves their proposed “natural selection” criterion consisting of a three month delay to confirm that a suspected benign (and resectable) lesion has become unresectable and fatal.

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Competing interests: None declared.

Fine needle aspiration of hepatic colorectal metastases
See editorial by Roskell and Bailey


BMJ enters arena of tabloid journalism
EDITOR—That the BMJ decided to publish the lesson of the week by Metcalfe et al with an eye catching title smacking of tabloid journalism is most surprising. To dismiss outright any suggestion of danger a high procedure of fine needle aspiration of suspected colorectal metastases will raise serious doubts in the minds of many clinicians of the safety of this procedure, not only in colorectal metastases but in any form of image guidance certainly has medicolegal implications for people who perform fine needle aspiration of any malignant lesion.

There have been recent examples of chaos and confusion caused in the minds of the public and the medical profession resulting from publications based on inadequate, inaccurate, or biased data. Many in this country have performed several hundreds of fine needle aspirations and percutaneous biopsies without such a high rate of tumour seeding, allowing for the fact that we may not be aware of all such complications.

Some of the current practices adopted are likely to give rise to a higher incidence of seeding. Use of serrated needle tips, which enhances visibility of the needle, may trap tumour cells and deposit them along the route. Multiple passes, especially if performed with the same needle, could be blamed. I have always encouraged the use of a generously wide port for the entry site to prevent the cells being “wiped” off the needle when the needle is withdrawn. Penetration deep into the tumour may contaminate a longer length of the needle. The needle calibre may have a bearing.

Oncologists are highly unlikely to treat on the basis of diagnosis based on imaging alone. Few radiologists would claim a high degree of accuracy except in a few tumours. May I therefore suggest that guidelines for best practice be formulated for reducing this and other complications encountered with fine needle aspiration and biopsies by using any form of image guidance.

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Competing interests: AEJ has recently been granted patents in the United States and Europe for enhanced visualisation of devices for ultrasound guided interventional work and this invention is now in the commercialisation phase.

Damage is done now
EDITOR—Well, the damage is done now.1 Thank you, BMJ.

No amount of evidence based, reasoned debate is likely to undo the damage that your Grub Street one liner has caused to an inexpensive, comparatively non-invasive, and often very useful technique. The only thing that is useless and dangerous here is an inappropriate title attached to a rather slight case report.

If the title is the author’s (it does sound a bit surgical) then you should have changed it. If it is yours then you should be ashamed. An exchange of correspondence buried in a subsequent edition of your tabloid will not fix this one. A reflective editorial on the importance of maintaining standards in medical journalism might, Useless and dangerous? I should say so.

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Competing interests: SK is a cytopathologist.

Authors’ reply
EDITOR—We are delighted to have provoked such a lively debate with our article. The only weakness anticipated in advance of publication was that it perhaps represented rather “old news.” It is gratifying then to find that its message merited vigorous reiteration.

In response to the specific points of Sanz and del Valle, laparoscopic biopsy is minimally invasive and reduces the risks of both sample error and tract metastases. Positron emission spectroscopy is of similar sensitivity to fine needle aspiration cytology, we agree, and not attended by the risk of seeding metastases.

Joseph describes reducing the risk of tract metastases by modifications of technique, although no evidence is presented for this. This implies an acknowledgment of the risk itself. He seems to be arguing for risk...
reduction rather than elimination. We disagree. However, Joseph is quite correct to acknowledge that he may be unaware of the rate of this complication in his hands, as it is likely to present elsewhere for management. The authors look forward to Joseph publishing his series of several hundred liver biopsies through fine needle aspiration cytology with the associated complication rates. He is also correct to declare his commercial conflict of interest.

We are pleased to acknowledge responsibility for the title and thank the BMJ for allowing it to stand. Naturally, an impassioned, non-committal heading could have been concocted, perhaps in the style that one might find in some radiology or cytopathology reports, for example. However, this would seem to defeat the object of publishing a “Lesson of the week.”

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Competing interests: None declared.

Social class and elective caesareans in the NHS

<table>
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<td>0.9</td>
<td>1.0</td>
<td>1.1</td>
<td>1.2</td>
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Adjusted odds of elective caesarean section compared with most affluent fifth of population

Analysis is not really about social class

Editor—Although purporting to investigate social class differences, Dr Foster in his article on social class and elective caesareans in the English NHS actually analysed differences according to area deprivation score.1 It cannot be assumed that residents of all geographical areas are socially homogeneous. As analyses of differences in low birthweight show inequalities both within and between areas with similar deprivation scores,2 it would not be surprising if the same applied to rates of caesarean section.

Although there is nothing new in the observation that caesarean section rates are higher among older mothers, the fact that women in professional occupations are more likely than others to have babies at older ages may or may not add to the differences, which are likely to be related to maternal complications among older women. Dr Foster has not allowed for the possibility of systematic differences between maternity units. An analysis of Maternity Health Episode Statistics data for earlier years, which adjusted for available data about factors associated with caesarean section, found that they accounted very little of the difference between units’ caesarean section rates.3 This implied strongly that differences between units’ and consultants’ policies are likely to play an important part.

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Competing interests: None declared.

3 Alves B. Risk factors and variation in caesarean section delivery rates in England in the late 1990s. MSc dissertation. London: London School of Hygiene and Tropical Medicine, 2002.

Dr Foster is cheap and offensive

Editor—Dr Foster shows its ignorance of obstetrics in the article on social class and elective caesareans in the NHS. The authors imply that an “elective” caesarean section is performed solely at the request of the pregnant woman.

Traditionally an elective caesarean section is one carried out in the absence of labour. Many caesarean sections are performed to save the life of the woman and her infant—for example, because of severe pre-eclampsia or placenta praevia. Because they are carried out in the absence of labour they are often labelled “elective” in case notes. Women who have had a previous caesarean section after a long labour may wish to avoid the uncertain hazards of another labour and prefer to have an elective caesarean section. Very few women actually have a caesarean section performed solely at their request. In a recent survey of caesarean section 31 out of 3150 (1%) elective caesarean sections were performed solely at the request of the woman.

Dr Foster shows only a weak relation between elective caesarean section and social deprivation but also an overwhelming relation between elective caesarean section and maternal age. It is the relation with maternal age that deserves further study. The authors could have made this important point in their paper; instead they have made an irrelevant one, by focusing on social deprivation.

Incidentally, the slogan “too proletarian for a caesarean” is cheap and offensive.

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Competing interests: None declared.


Treatment of minor burns

Dressings do not need to stick

Editor—Hudspith and Rayatt discussed the treatment of minor burns.1

Firstly, nobody’s burn dressing now needs to become painfully adherent. Mepitel (silicone impregnated gauze) is expensive, but this should not be a reason for confining its use to children.

Secondly, not all facial burns need to be referred to a burns unit, and this is just as
well for those of us whose nearest such unit is 60 km down a congested motorway. Most superficial facial burns heal well with watchful neglect, and particularly in elderly patients.

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Competing interests: None declared.


Treatments of burns is controversial

Editor—Dressing burns represents one of the most controversial topics in the area of cutaneous wounds. Hudspith and Rayatt suggest using a simple paraffin gauze;

but this type of dressing is easily briddled with a burn’s exudate when it dries up, tending to cause pain and difficulty in movement.

Cole suggests using up to four overlapped layers of paraffin gauze to obviate this drawback. Silver sulfadiazine ointment is widely used in treating burns. In the few randomised controlled trials on the use of silver sulfadiazine in the treatment of burns, silver sulfadiazine has always shown worse results than biosynthetic dressings and particularly in elderly patients.

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Is road of initiative paved with good intentions?

Editor—The grandiose scale of George W Bush’s mental health initiative makes it difficult to comment on the “road” it wishes to take, or to relate this American proposal to the recent British report on mental health and social exclusion.1

The devil is in the detail. Because of the longstanding mutual interests of the pharmaceutical industry and this presidency, the remorseless pressure of Big Pharma on doctors and patients spreads far beyond the United States to policy and planning across the world’s health economies.1

None the less, the United Kingdom can learn from the American population perspective that schools “are in a key position” to screen the 52 million students.2 Big Pharma has an interest in screening to label more mental illness that can introduce millions of new child “consumers” to maintenance psychotropic treatment. But schools can also provide promising opportunities for promoting mental health across the entire school age population.

That really could “change their trajectory” to the benefit of a whole society. In Britain there are several educational trials aiming to help children develop self awareness, motivation, and empathy and deal with feelings and social situations. These do not aim to make more children into long term consumers of drugs. One critical step is missing in the United Kingdom. To tackle the huge inequalities present in public mental health, the government must first amend this: “There is no requirement for schools to include learning about mental health”.2

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Competing interests: WK is past chair of the School Health Research Group and current member of the mental health promotion forum for London.


Mental health and social exclusion

Summary of responses

The responses sparked by Lenzer’s news item on US president George W Bush’s plans to screen the whole US population for mental illness overwhelmingly opposes such plans.3 Some correspondents, however, see some positive elements in the plans as an attempt to improve the United States “very diseased” mental health system, or as ambitious yet commendable. Under different labelling such a programme could even be a valid public health measure designed to prevent or delay the onset of acquired neurodegenerative disorders or diseases of ageing.

Letters

Bush plans to screen whole US population for mental illness

Editor—The news that Bush plans to screen the whole US population for mental illness is widely used in treating burns. In the few randomised controlled trials on the use of silver sulfadiazine in the treatment of burns, silver sulfadiazine has always shown worse results than biosynthetic dressings and particularly in elderly patients.

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Competing interests: None declared.


Bush’s sanity test is revealed

Editor—Q: Do you agree with Bush’s policies?
A1: Yes. (Then you are sane.)
A2: No. (Then you are insane.)

Next!

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Competing interests: None declared.


Summary of responses

The responses sparked by Lenzer’s news item on US president George W Bush’s plans to screen the whole US population for mental illness overwhelmingly opposes such plans.3 Some correspondents, however, see some positive elements in the plans as an attempt to improve the United States “very diseased” mental health system, or as ambitious yet commendable. Under different labelling such a programme could even be a valid public health measure designed to prevent or delay the onset of acquired neurodegenerative disorders or diseases of ageing.
Several correspondents write from their own experience with mental illness in the shape of depression or autism. Acknowledging that mental illness is like any other disease may be a good thing. Equally, so is taking an active part in conveying the needs of people who have a mental illness but cannot express themselves. Many correspondents, on either side of the argument, seem to think that if this happens in the United States, the United Kingdom will follow suit.

On the contra side, correspondents recommend that any such screening programme has to start at the very top of public service (and not all of them are joking) and warn that the president may be perceived as pushing drugs. While screening and the treatment of mentally ill people can certainly be improved, attention has to be paid to a possible hidden agenda, when “unpatriotic” means “mentally ill” or when the goals of such a programme are not entirely clear. Comparisons with totalitarian regimes with fascist agendas are inevitable.

The dangers of denying people, especially children, their emotional experience by giving drugs to control them is highlighted by several correspondents. The role that other factors, such as homelessness, poverty, violence, unemployment, etc., play in children’s mental problems or behaviours is being ignored. So is the child’s own viewpoint. The question is what the US government’s priorities are, and why other ways of treating children’s behavioural problems are not being considered. Urgency because of the forthcoming US elections is suggested as a possible motive for the one-sidedness of the proposal.

Much worry is expressed about the erosion of personal freedoms, not only in the United States, and about the fact that the current US government has done more to restrict the rights of disabled and mentally ill people than any in recent history. Furthermore, such a screening programme could be entirely subjective and reduce people’s mental health to a mere number.

The warning that we could become a second rate profession, which results in the aggregation of all the data shows a significant difference in delivery outcome, but aggregation of all the data shows a significant effect. By contrast, one out of six comparisons of low (usually 0.0625%) bupivacaine and high concentration infusions showed a difference in delivery type, despite randomising over 800 women. Had any randomised trials compared low dose bupivacaine epidurals with systemic opioid analgesia, they might have found no significant effect on instrumental vaginal delivery.

The authors say that neonatal outcomes may be better with epidural analgesia. Since 1974 many studies showed improved neonatal status and protection from the adverse effects of a prolonged second stage of labour with epidural analgesia, and meta-analysis has shown a significant benefit to the newborn in Apgar score and acid base status with epidural analgesia of all types, compared with systemic opioids. Such good news is disregarded by many groups, who still consider epidural analgesia an undesirable interference. Let us hope that this latest evidence will receive better attention.

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Competing interests: None declared.

Birte Twisselmann technical editor
BMJ

Good news is often ignored

Entire—In their systematic review Liu et al show that epidural analgesia does not increase the caesarean section rate, which is welcome.1 Unlike previous meta-analyses, this one included only studies of nulliparous women receiving low concentration epidural infusions, in order to re-examine their effect on instrumental vaginal delivery, in the belief that low concentration infusions of local anaesthetic are associated with fewer abnormal deliveries than higher concentrations.

They cite the COMET trial, which could compare only high and high dose bupivacaine administration.2 There have been at least five other randomised comparisons of low and high dose bupivacaine, three showing no significant difference in delivery outcome, but aggregation of all the data shows a significant effect. By contrast, one out of six comparisons of low (usually 0.0625%) bupivacaine and high concentration infusions showed a difference in delivery type, despite randomising over 800 women. Had any randomised trials compared low dose bupivacaine epidurals with systemic opioid analgesia, they might have found no significant effect on instrumental vaginal delivery.

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Competing interests: None declared.

Birte Twisselmann technical editor
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Competing interests: None declared.

1 Liu EHC, Sia ATH. Rates of caesarean section and instrumental vaginal delivery in nulliparous women after low concentration epidural infusions or opioid analgesia: systematic review. BMJ 2004;329:4140-2. [12 June.]

Hope of prevention training in South Asia

EDITOR—The theme issue on Health in South Asia in April addressed problems and hopes for health but neglected prevention. South Asia has a quarter of the world’s population. The optimal means to improve health is public health, which means that new public health workers need to be recruited and educated. The global 25 year increase in life expectancy is almost all due to prevention, not clinical medicine. In South Asia, Sri Lanka shows the importance of public health and prevention with impressive achievements at low cost.1

In South Asia the epidemiological transition has resulted in a twin disease burden. Cardiovascular disease is a potent cause of death, with only 0.1% of $2.9 billion being allocated to it in 2003.2

The neglect is apparent in training: around 200 medical schools produce 7000 graduates annually but there are only 23 public health centres and no schools of public health in South Asia (www.cscasnet.iscse.unimi.it/ClinDams/numbervsprevntionsists by 10-20 times. Public health has been neglected. Some of the resources targeted at clinical training should be re-allocated to public health.

Public health is considered to be a second rate profession, which results in most resources being allocated to clinical medicine. To change this inexpensively, public health education in medical students can be improved by using an internet based supercourse (www.pitt.edu/~super1). It can enrich medical curriculums with over 1800 PowerPoint prevention lectures. A mission of the 15 500 faculty (900 from South Asia) is to connect people working in prevention worldwide and provide better teaching material.3 A proposed model of a school of public health in Pakistan on the website can be used as a template (www.pitt.edu/~super1/lecture/lec11921/index.htm).

Brick and mortar schools such as Harvard are needed for high end training. World class schools can be built in developing countries for a fraction of the cost of a hospital or medical school. Such schools should be accredited to become world class.

The costs would be small, but the impact on health, immense.

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On behalf of the South Asian Health Preventionists Association (SAHPA)
SD is also assistant professor at the Department of Family Medicine, Aga Khan University, Karachi, Pakistan.
Is the bubble due to burst for medical research funding?

Editor—The campaign to revitalise academic medicine may well demand radical thinking.1 Many expect or hope for a continuation of the long expansion of medical research funding, but consider the fate of physics.

Physics was once the richest, most self-confident, and most prestigious science. The first half of the 20th century was a golden age for its science, the time after the second world war a golden age for funding. Achievements did not match the hype, and support for physics has collapsed, fundamental physics research now being pursued in only a few universities in the United Kingdom.

Similarly, the middle of the 20th century was the golden age for clinical break-throughs and biological science, which was followed by massive expansion in research funding. But the rate of major clinical advances has not lived up to the spin. The Human Genome Project was the costliest scientific venture in history but the promised major clinical benefits now recede ever further into the future. A continual enhancement in the internal “performance indicators” of medical science, such as grant income and refereed publications, has not been matched by the kind of outputs that are valued by people external to the system. Effectively new treatments for serious diseases are progressively drying up, perhaps because of fundamental flaws in the “basic to applied” model that is the focus of funding.1

A cult of medical research will therefore probably be a good thing—signs of an imminent modernisation of European science are apparent.2 We predict that, like physics, in a decade or two funding of medical research will be much less, fundamental medical science will be pursued at only a few research centres, and most medical schools and universities will concentrate on training doctors and performing “applied” medical research and development.

Separation of clinical practice and medical research systems will probably be more efficient and effective, but the transition will be painful.

Bruce G Charlton

Competing interests: None declared.

Doctors are not scientists but we still need science

Editor—It takes guts for a medical editor to disburse his readers of their most cherished assumption that doctors are scientists, but it is true that they are not.1

We doctors like people to think we know what we’re talking about, and may be so convincing that we convince ourselves too. Because other people’s lives depend on it, we have a big emotional need to be right and to be seen, with the thought that none of us really knows enough to be a good doctor. Even if we know everything that is known, we still don’t know that which is yet unknown.

Scientists, on the other hand, are very comfortable with the unknown; it is their bread and butter. When scientists disagree there is no more at stake than the scientists’ amour propre, whereas medical disputes get rancorous because forever in the background is the thought that none of us really knows enough to be a good doctor.

Science does not in itself make its practitioners haughty (the contrary, if done honestly), whereas medicine does. The main reason for that, I think, is because doctors get used to seeing other people undressed—meaning unreasonably, whereas medicine does. The main reason for that, I think, is because doctors get used to seeing other people undressed whereas medical disputes get rancorous because forever in the background is the thought that none of us really knows enough to be a good doctor.

Takken together it becomes ever so easy for us doctors to start believing that we know everything, and that makes us unreasonably un receptive to new ideas. That is the reason why medical journals must continue force-feeding original scientific studies to their unwilling readers.

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Competing interests: None declared.

Letters

Campaign to revitalise academic medicine

See also pp 241 and 277-89

Don’t believe us

Editor—Rather than add my advice to the deluge that met the magnificent, international group of young people who came together last month to propose improvements for the academic medicine of tomorrow, I pose a question to them: “Why, on earth, should you accept our advice?”

We have rejected the provision of continuous, comprehensive care and middling incomes in favour of huge waiting lists, unethical self referral for costly diagnostic tests, and industry-consultantships that pervert our science as profoundly as they line our pockets.

We continue to apply curriculums that value memory above thought, promote study by fear rather than reason, and sentence postgraduates to years of servitude in the educationally “lost generation.”

We value the study of adenine, thymine, cytosine, and guanine far above the study of external to the system. Effective new research policies that place greater value in continual enhancement in the internal “performance indicators” of medical science, such as grant income and refereed publications, has not been matched by the kind of outputs that are valued by people external to the system. Effectively new treatments for serious diseases are progressively drying up, perhaps because of fundamental flaws in the “basic to applied” model that is the focus of funding.1

A cult of medical research will therefore probably be a good thing—signs of an imminent modernisation of European science are apparent.2 We predict that, like physics, in a decade or two funding of medical research will be much less, fundamental medical science will be pursued at only a few research centres, and most medical schools and universities will concentrate on training doctors and performing “applied” medical research and development.

Separation of clinical practice and medical research systems will probably be more effective and efficient, but the transition will be painful.

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Competing interests: None declared.

1 Kienzlecz W. Campaign to revitalise academic medicine calls for radical thinking. BMJ 2004;328:1454. (19 June.)


