Letters

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Two week rule for cancer referrals

Reducing waiting times from diagnosis to treatment might be more effective

EDITOR—In their editorial on the two week rule for cancer referrals Jones et al discuss the fact that steps to meet the target for "urgent" referrals have led to a doubling of waiting time for "routine" cases.[1] This is exactly the result we would expect from our calculations modelling waiting times with a Monte Carlo model based on Poisson fluctuations in demand.[2]

To sustain a waiting time below two weeks, capacity needs to exceed mean demand by approximately two patients a week for a wide range of values of mean demand. This applies to any appointment, including those for diagnostic and staging procedures, as well as for treatment. Applying this excess capacity to a subgroup of urgent referrals is inherently less efficient than applying it to reduce the waits for all patients. If a fast track for urgent referrals is created by transferring resources from routine cases, this is likely to lead to demand exceeding capacity for routine cases and hence to ever increasing waiting times.

These calculations assume that variations are due to random fluctuations in a constant demand, which is an effective model for oncology referrals.[2] There is some evidence from dermatology that reductions in waiting times lead to increase in demand, negating the benefit of increased resources.[3]

It might also apply to referrals for suspected cancer, in which case the extra capacity required will exceed our calculations. This effect should not apply to the number of cases of diagnosed cancer, which will be limited by the incidence of the disease. This suggests that resources may be more effectively targeted at reducing the waiting times from diagnosis to treatment than on reducing the time from referral by a general practitioner to diagnosis.

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All stages of care pathway need speeding up

EDITOR—I and a colleague from East Yorkshire spoke against the two week rule for cancer referrals[1] a few years ago at the local medical committee conference. We thought that the deadline was a diversion from the important point: that what mattered in cancer care was not the delay at one point at the start of the path but total delay.

I was reminded of this recently when I saw one of my patients, who has just been diagnosed with probable colorectal cancer 15 months after a referral with rectal bleeding and iron deficiency anaemia. In this case the wait for colonoscopy dwarfed any delay in the initial appointment. All stages of the care pathway need speeding up: anything else is window dressing.

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Specialists, not GPs, may be best qualified to assess urgency

EDITOR—In their editorial on the two week rule for cancer referrals Jones et al cite evidence that the standard is only being met for colorectal cancer at the expense of routine referrals.[1] The breast group of the British Association of Surgical Oncology undertook a prospective study last year, with participating breast units auditing all breast referrals from general practitioners over a minimum of three months. Units recorded the number of referrals, the degree of urgency stated by the referring doctor, and the number of cancers subsequently diagnosed. Referrals were also graded according to how they complied with the published guidelines for general practitioners for referral of patients with breast problems.[2]

Numbers (percentages) of breast cancers diagnosed by urgency of referral

Unit	Total referrals	Urgent referrals	Referrals outside guidelines	Total cancers diagnosed	Cancers diagnosed after non-urgent referral	Cancers per 100 referrals
1	115	34 (30)	24 (21)	11	3 (27)	9.6
2	428	210 (49)	64 (15)	33	2 (6)	7.7
3	445	139 (31)	71 (16)	28	3 (11)	6.3
4	455	111 (24)	36 (8)	34	5 (15)	7.5
5	341	43 (15)	55 (16)	28	15 (54)	8.2
6	958	211 (22)		62	19 (30)	6.5
7	845	566 (67)		60	15 (25)	7.1
8	321	112 (35)	119 (37)	32	10 (31)	10.0
9	1680	215 (13)		164	99 (60)	9.8
10	1310	460 (35)		126	34 (27)	9.6
11	406	260 (64)	207 (51)	19		4.7
12	253	80 (32)		36	8 (22)	14.2
13	2522	749 (30)		285	98 (34)	11.3
14	1103	208 (19)		88	34 (39)	8.0
15	1176	54 (21)		115	61 (53)	9.8
Total	12358	3452 (28)	576 (23)	1121	406 (36)	9.1

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Altogether 12 358 referrals were received by 15 breast units, of which 3452 were graded as urgent by the general practitioner. A total of 1121 cancers were diagnosed, but 406 of these were not referred urgently (table). The numbers of both urgent referrals and patients with cancer who were not referred urgently varied widely among units. In seven units that were able to assess referrals almost a quarter (576 of 2511) did not comply with the agreed national guidelines. Most breast units were not able to see all breast referrals within two weeks, and the delay in seeing the non-urgent cancers ranged from 2 to 14 weeks.

These results, and other studies, show that general practitioners may not suspect breast cancer in many cases. The diagnosis may be delayed in women referred to breast units non-urgently, particularly in those units that cannot recruit specialist staff. These problems need urgent attention. Only 1% of breast cancers are found in women under 30, and breast cancer charities have a responsibility to ensure that breast awareness is focused on an appropriate age group without causing distress to younger women.

Evidence based guidelines must be agreed with general practitioners, who need to be reassured that they are unlikely to miss breast cancers and will not face unfair criticism. Until additional resources are in place breast units should be given authority to defer urgent referrals that do not comply with agreed guidelines to enable them to expedite non-urgent referrals for women who seem to be at greater risk.

There is no evidence that a 14 day delay influences survival. All patients with suspected cancer are entitled to a minimum delay, but evidence suggests that the specialist, and not the family doctor, may be best qualified to assess the degree of urgency.[3]

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The following surgeons at breast units participated in this study or made available data from their own audits: R M Watkins, C Teasdale, L Campbell (Derriford Hospital, Plymouth); G T Layer (St Peter's Hospital, Chertsey); N Rothnie (Southend Hospital, Southend); P Cant (Rotherham General Hospital, Rotherham); I Reid, D C Smith (Victoria Infirmary, Glasgow); M Lee (City Hospital, Birmingham); M Perry (Queen Alexandra Hospital, Portsmouth); B Isgar (New Cross Hospital, Wolverhampton); E J Duggan (Royal Victoria Infirmary, Newcastle upon Tyne); M J Higgs (Queen Elizabeth Hospital, Gateshead); T Archer, C Mortimer (Ipswich Hospital, Ipswich); P Armitstead (Kidderminster General Hospital, Kidderminster); R D Leach (Kingston Hospital, Kingston upon Thames); and T Bates (William Harvey Hospital, Ashford).

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Requests for EEG services in a district general hospital

Distinction needs to be made between audit and value judgment

Editor—Audits of investigations are complex, as their value to the physician depends on numerous factors, not least confidence in their own clinical diagnosis and the report. Many different specialties use electroencephalography (EEG) services. This audit imposes the values of an individual without references to practice guidelines and requires critical appraisal.

Smith et al suggest that the unrestricted access and non-specialist reporting in their district general hospital in north Wales is typical, but they do not mention that these practices are contrary to the regional guidelines that their trusts helped to formulate.[1 2] All seven EEG departments in southeast Wales comply.

One author (DS) is credited with grouping EEG requests into "influenced management," "justifiable," and "inappropriate." Requests were considered inappropriate when a diagnosis (epilepsy) had been made on clinical grounds or an unsatisfactory attempt had been made to achieve a clinical diagnosis, usually failure to obtain an eyewitness account of the attack.

No rationale is given. At the time of audit six leading epileptologists in the United Kingdom, including a senior colleague of Smith et al, outlined best practice as every newly diagnosed case will require at least one standard EEG and up to 50% a second.[3] The confidence that Smith et al have in their own clinical judgment is admirable, but is it reasonable to expect less expert users of the EEG service to ignore such advice? The very personal and subjective nature of the audit is highlighted by the 24% of requests by peers at the neuroscience centre that were also considered inappropriate.

Epilepsy is difficult to diagnose clinically; 20% of patients referred with intractable epilepsy prove to have pseudoseizures.[3] The false positive rates of properly reported EEG is 0.5%.[4 5] A diagnosis supported by EEG is far more robust. Smith et al make several false assertions, most remarkably that a single EEG cannot diagnose epilepsy. Spike and wave activity is diagnostic of epilepsy, as has been recognised by the Driver and Vehicle Licensing Agency (DVLA). Furthermore, Smith et al themselves diagnosed epilepsy on this basis in three children presenting with "funny turns," in their retrospective audit. Ironically, as this was not considered a valid reason for referral, it seems that such cases in children will in future remain undiagnosed.

The results of diagnostic tests are by definition unpredictable, and access guidelines will inevitably fail some patients, often those who cannot articulate a good history. The financial savings identified in this audit are likely to be trivial in comparison to social and medicolegal costs associated with misdiagnosis.

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Authors' reply

Editor—Existing guidelines on requesting electroencephalography (EEG) services focus on the use of the technique in epilepsy. These are of limited value in routine practice when there is (*a*) widespread misconception about the role and limitations of EEG and (*b*) a lack of trained expertise in its reporting. We considered EEG requesting in real practice, and retrospective audit showed that diagnosed epilepsy accounted for only 13% of all requests while "funny turns," usually faints, was the commonest reason for request.

In their third paragraph Heath and Thomas misquote us by adding the word epilepsy in parentheses, which explains their misinterpretation of the main theme of our paper. We wrote: "We considered requests were inappropriate when a diagnosis had been made on clinical grounds and the subsequent ordering of an EEG could not have produced useful information." The diagnosis, drawn directly from casenotes, was usually syncope. Request forms read "syncope—exclude epilepsy." Changing this practice was the purpose of the audit.

We agree that EEG is often helpful in classifying epilepsy and occasionally useful in supporting the diagnosis when clinical suspicion is high, but it is rarely the sole determinant of the diagnosis. The exception, clearly stated in our paper, is a generalised spike and wave of 3 cycles/s in an inattentive child. However, this happened in only 3 out of 156 EEGs in patients with funny turns.

Heath and Thomas overestimate the specificity of EEG. That spike and wave occurs in up to 0.5% of people with no history of epilepsy is not the same as the false positive rate of EEG reports. Inappropriate emphasis of minor, non-specific abnormalities often results in false positive interpretation. In our study 25% of patients with funny turns had features on EEG that could be misinterpreted.

EEG is not a useful diagnostic tool when used indiscriminately in patients with funny turns. This was a central feature of the guidelines and was presented in an educative way, implemented immediately, and reinforced in a new request form reminding

clinicians to think about the reason for request.

The main change in practice was a reduction in requests for EEG in people with faints. The proportion of requests in patients with epilepsy increased and, consequently, the overall usefulness of the test increased.

A reduction of 400 or more unnecessary tests each year in one district general hospital is not trivial. Systematic reproduction of this audit project, entailing randomisation of EEG departments to intervention or no intervention using specified outcomes, is recommended.

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Eligibility criteria for home treatment of DVT vary

Editor—Schwarz et al showed that most outpatients (92/117; 79%) with acute deep vein thrombosis do not require hospital admission.[1] A colleague and I found a similar proportion eligible for outpatient treatment among adults attending an emergency department who were diagnosed ultrasonographically as having deep vein thrombosis (178/219; 81%).[2] We showed equal effectiveness and safety compared with outcomes in preceding years. Tillman et al have reported comparable eligibility figures for avoiding admission to hospital in adults with deep vein thrombosis (330/428; 77%).[3]

Schwarz et al assert that "the proportion that do require admission depends mainly on factors to do with infrastructure rather than medical reasons." Fewer of their patients were excluded for medical than logistical reasons (3 *v* 22). Their infrastructural reasons were twofold: inadequate home situations (11 patients) and inability to enrol in the programme, which did not function after 5 pm or at weekends (11). We also found that 16 patients were ineligible for enrolment for non-clinical reasons: living outside the geographical region serviced by home health care (7), inability or unwillingness to comply with the protocol (6), and restrictions on having a ventilation-perfusion scan out of hours (3).

Unlike in Schwarz et al's study, however, our reasons for ineligibility were not predominantly logistical. A greater proportion of our patients required admission for clinical rather than infrastructural reasons (7% *v* 3%): comorbidities (5); high risk of haemorrhage (pre-existing thrombocytopenia or coagulopathy) (3); symptomatic pulmonary embolism (4); and massive leg swelling and severe pain (3). Similarly, Wells et al excluded a higher proportion of patients for medical than logistical reasons (14% *v* 3%): concomitant medical illness (20), massive pulmonary embolism (6), active bleeding (4), and phlegmasia cerulea dolens (3).[4] Few patients (6) were not enrolled in their outpatient protocol because of non-clinical factors (refusal to pay for low molecular weight heparin).

Eligibility criteria for initial outpatient treatment of deep vein thrombosis are being re-evaluated[4] and have expanded as evidence from new studies becomes available.[5] In time, the reasons for medical ineligibility will become more standardised. Logistical factors—for example, an inadequate home situation, the unavailability of medical services out of hours, geographical location of residence, willingness to pay for drugs not covered by insurance—seem to differ among areas, as the data from these three studies indicate. Although Schwarz et al may have admitted more patients to the hospital for factors non-medical than medical, similar proportions are not shared by all facilities.

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Drug laws

War on drugs does more harm than good

Editor—It is 30 years since the then president of the United States, Richard Nixon, declared a war against drugs. But global drug prohibition had its beginnings as far back as 1909. In 1988 the United States Congress passed legislation requiring that country to become drug free by 1995. This denial of reality is global. In 1998 the international community committed itself at the United Nations to eradicate illicit cultivation of coca plants and opium poppies by 2008. By any measure, this is an international crusade and one that has been expensive, ineffective, and often counterproductive. The dictum "first, do no harm" has not applied to drug policy for the last century.

It is disappointing that Drummond's comments repeat so many old myths.[1] Assumptions are presented as unarguable fact. The claim that heroin is inherently dangerous is false. Heroin is rapidly metabolised to morphine, which is used safely by the healthcare system in large quantities throughout the world. In the Swiss heroin prescription trial (1994-7), there were no deaths from overdose in almost 1500 patients followed up for 18 months.[2]

Drummond may believe that legalisation will increase addiction, but this should not be presented as an established fact. What does he mean by legalisation? There is no evidence that heroin prescription to about 1000 patients in Switzerland who were refractory to treatment has increased addiction, but there was enough evidence of benefit to convince 71% of voters to support continuation of this option in a 1997 national referendum.

Calls for more research are simply not enough. The rapid increase in deaths from drug overdose in many countries (including the United Kingdom and Australia) is a scandal. The experiment of treating drug use as a law enforcement issue has shown this to be a resounding failure. Drug use should be regarded as primarily a health and social issue, with funding raised for these measures to the level of drug law enforcement. Research will improve outcomes only if carried out without blinkers. The time has come to think outside the box, even though many, like Drummond, beckon us to stay inside.

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Article drifted into counterpropaganda

Editor—Drummond is quite right to criticise a "documentary" that attributes the damage done by injecting to adulteration by unscrupulous dealers.[1] Why would dealers damage their client base? Injecting itself carries a risk of damage, and the legal benzodiazepines, especially temazepam in gel form, seem to cause the most damage.

He also is quite right to point out that tobacco and alcohol kill more people than illicit drugs. We should not let governments gloss over this inconvenient fact, nor their dependence on the income derived from sale of these dangerous drugs. But I fear Drummond drifts into counterpropaganda when he claims that legalisation would actually lead to an increase of addiction, when no one has that crystal ball. The Netherlands, with a more open and logical approach to cannabis, has the lowest rate of use in the Organisation for Economic Cooperation and Development, for example.[2] The assertion that the governments of the Netherlands and Switzerland are considering a reversal of policy is just untrue. On the contrary, many European countries have already followed suit, or are preparing to do so.

"Legalisation" is also an emotive but unhelpful term here. It is not legal to use cannabis in the Netherlands, but the police overlook minor use, for example. There are

many steps between rigid prohibition and open slather, and only those afraid of change seek to terrify others by using the term legalisation. Why not different strategies for different drugs, just like we have today for tobacco, coffee, paracetamol, insulin, and morphine?

There are other misleading statements. Britain is, in most people's terms, engaged in a war on drugs, no less so than the United States or Australia. Although some may agree that even poor treatment is to be preferred over good incarceration, others may ask why we need to treat a problem created, in the main, by our own laws. And heroin prescribing is vastly more effective at recruiting and retaining people who have failed repeated attempts at methadone, and at improving their health and social functioning.[3] We surely do not wish to promote the "one size fits all" approach of the past?

As for any changes flooding our streets with yet more drugs, most clinical workers think that the place is going under already. More availability, lower prices, and higher purity of illicit drugs throughout the world suggest that a plentiful supply exists. When current strategies do not work, should we redouble our efforts, like the United States, or consider the possibility that the whole strategy is flawed?

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Adoption

Skills of voluntary adoption agencies should be exploited

Editor—The government's white paper on adoption is ambitious indeed[1] and addresses some of the problems highlighted in Mather's editorial.[2]

Some voluntary agencies in the United Kingdom specialise in adoption work. In 1999 an inspection of voluntary adoption agencies showed that local authorities often lacked any strategic planning links with them and rarely used the specialist skills of the social workers.[3] Establishing early links and working in partnership with the voluntary agencies can help in finding adoptive parents for "hard to place" children. The agencies' skill in recruiting and supporting adoptive parents should be exploited. The report found that local authorities often made ad hoc decisions about purchasing or providing services from these agencies, and few monitored the cost and quality of adoption services in their areas.

Adoption gives a child a second chance at acquiring a functional family and provides satisfaction to both parents and children in most cases. Although some politicians argue that adoption work should be wholly given over to voluntary organisations, a recent report from the Performance and Innovation Unit of the Cabinet Office highlighted that not only would it be expensive to reorganise the system but important links with other children's services would be lost.[4]

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Women must be helped to consider all their options

Editor—One aspect of adoption that medical practitioners may forget concerns patients with an unplanned or crisis pregnancy. Only about 600 babies are adopted each year now, but, as Mather pointed out, many thousands of couples long to adopt a baby.[1]

For a woman with an unplanned pregnancy, adoption is a difficult option but should be seriously considered, particularly if she is ambivalent about or morally uncomfortable with the idea of abortion. Abortion can seem like the only option that "puts things back to how they were," but this belief can turn out to be an illusion when the grief and loss set in. Both abortion and adoption entail loss, but, particularly for women who are unhappy about abortion, adoption can be a more "positive loss" (quote from a client).

Many people do not realise how much adoption has changed from the images of babies being forcibly removed from unmarried mothers in the 1950s. The following quote is from www.pregnancy.org.uk, a website devoted to helping women think through their options in an unplanned pregnancy.

"Many women say that they could never go through pregnancy and labour and then 'give up' their baby for adoption. This is often an instinctive feeling, because it means experiencing a loss. A mother never forgets her baby.

"But the process of adoption is not like it used to be . . .. Children are not whisked away secretly any more. Mothers are much more involved. You can say what sort of family you want. You can know as little or as much about the adoptive family as you wish. The adoptive parents can keep a 'lifebook,' which tells the child all about you so that s/he grows up with a sense of where s/he comes from. You can keep in touch via the adoption agency or social services. You will have time to change your mind if necessary because formal consent to adoption cannot take place until at least six weeks after the baby is born."

Women need to be helped to consider all the options open to them—parenting and adoption as well as abortion—and by being allowed time to consider their feelings and to find out what adoption actually entails.

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Reducing sexually transmitted infections among gay men

No doubt should be cast on efficacy of cognitive behavioural interventions

Editor—We applaud Imrie et al for conducting a rigorous, randomised clinical trial to reduce sexually transmitted infections in gay men.[1] We have, however, concerns about the conclusions drawn from this comparatively small scale study to all cognitive behavioural interventions.

Firstly, to see changes in sexually transmitted infections as a result of an intervention, we need to see changes in safer sexual behaviours, such as increased use of condoms. The trials reported by Imrie et al did apparently not produce significant changes in safer sexual behaviour. Therefore, it was to be expected that no changes in the incidence of sexually transmitted infections were seen either.

Secondly, the fact that this trial was apparently not successful should not cast any doubt on the efficacy of cognitive behavioural interventions. Other, much larger, cognitive behavioural trials carried out with high risk populations in the United States and Thailand have been effective.[2–4] Effectiveness has been shown not only by increases in use of condoms, but by decreases in sexually transmitted infections and incidence of HIV in some trials.[2 4]

Thirdly, it is not yet known what smallest "dose" of an intervention of this type will produce sustained effects. But the likelihood that an intervention of one session would be successful is quite small. Although brief interventions have been successful in other areas, they have not been successful in changing sexual behaviour.[5] Furthermore, at least one study has shown a dose-response relation between number of sessions and change in behaviour, indicating that more sessions are required to change a complex behaviour such as using condoms.[2]

To see changes in sexually transmitted infections we need interventions to change sexual behaviours, such as use of condoms. To increase the use of condoms, we need longer, more intensive interventions such as those that have already shown effects.[2–4]

Finally, we suggest that a next question for the field not be "do cognitive behavioural interventions for HIV prevention work?" The answer to this is, yes. We believe the question should be "how, and under what circumstances, can we produce the greatest sustainable intervention effects

through the use of cognitive behavioural interventions?"

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Social and behavioural interventions are effective in preventing HIV transmission

EDITOR—We were disappointed to see the paragraph in This week in the *BMJ* for the paper by Imrie et al conclude that behavioural interventions are ineffective in reducing the risk of HIV among gay men.[1] Imrie et al reported a rigorously conducted evaluation of a one day groupwork intervention targeting gay men attending a genitourinary medicine clinic. Informed by cognitive behavioural theory, the intervention aimed to help these men assess their current risk taking and act to reduce this. The intervention was not effective with regard to either behavioural or biological outcomes.

Our disappointment is not the shock of health promoters suddenly discovering that our work is not achieving its aims. Our centre has pioneered the development of rigorous methods of evaluating social and behavioural interventions. We have sometimes been labelled arch-sceptics concerning the effectiveness of behavioural interventions.[2] Our disappointment results from the manner in which a very general conclusion is drawn from a very specific study. The intervention by Imrie et al was not representative of all behavioural interventions to prevent transmission of HIV, which vary in terms of approach, location, and target group. We should not generalise its results to conclude, say, that outreach work with gay men in Amsterdam or Sydney is ineffective. We should not even automatically generalise its conclusions to other group work interventions for gay men that are based on cognitive behaviour, many of which are delivered over longer periods and are based on different theories.[3]

We wonder whether a similarly general conclusion would have been drawn on the basis of a clinical trial. Would, for example, a study reporting the ineffectiveness of antidepressants in treating post-traumatic stress disorder be accompanied by a paragraph in This week in the *BMJ* announcing that pharmacological interventions are ineffective in treating mental ill health? We presume not. We suggest that the *BMJ* adopts the same caution in reviewing trials as that of the Cochrane Collaboration.[4] One trial is seldom sufficient to make conclusions about effectiveness, especially where the intervention in question is atypical of the interventions under consideration.

More thorough reviews of the effectiveness of behavioural interventions in HIV prevention reveal that while some have been ineffective, many others have been effective.[4 5] In the absence of effective HIV vaccines, behavioural interventions remain one of our only options for preventing HIV transmission. Comment such as the paragraphs in This week in the *BMJ* contribute little to an informed debate, either in drawing conclusions from trials of behavioural interventions or in establishing how best to prevent new HIV infections.

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Authors' reply

EDITOR—Noar and Zimmerman are correct that behavioural change is a precondition to reducing the incidence of sexually transmitted infections. But which behaviours are most important is not always clear; the causal pathway between increased use of condoms and reduced infections proposed is not that simple. Use of condoms is not a single behaviour, nor is it certain to provide protection against infection.[1] Our findings show a non-significant reduction in the highest risk sexual behaviours throughout the follow up, particularly at six months, but without a corresponding reduction in new infections.

Other studies have shown that the incidence of new infections may be influenced by a range of factors—for example, demographic characteristics, doubt on the efficacy of cognitive behavioural interventions, choice of partner, and consistent and correct use of condoms.[2] This makes it difficult to predict the efficacy of an intervention in preventing a disease when the intervention is based on observed behaviour change or use of condoms alone.[2] We know of only one study that has been able to show a causal pathway relation between adopting new behaviours and reduced incidence of sexually transmitted infections—condom use was only part of the explanation.[3 4] As public health researchers, the effectiveness of our interventions is ultimately assessed by their impact on morbidity in the population. Two of the much larger trials that Noar and Zimmerman refer to were not randomised controlled trials, and the trial by Nelson et al did not entail a specifically described cognitive behavioural intervention.

We agree that our study should not cast doubt on the efficacy of cognitive behavioural interventions themselves. But it does raise important questions about the optimal dose and formulation of intervention that is able to produce sustained change of behaviour and can feasibly be delivered within routine care. Limited resources preclude providing long term one on one interventions for every patient at risk. So far there is limited indication that there is a uniform dose of intervention that can achieve sustained change in sexual behaviour.[5]

The question of how different therapeutic approaches and theoretically derived interventions can be optimally deployed in the different HIV prevention settings, including sexual health clinics is still largely unanswered. As Bonell and Strange point out, this was a trial of a highly specific intervention delivered within a particular context. We agreed with them that it may be hard to make major policy generalisations from it. Its greatest value is to remind us to think carefully about the potential impact of our interventions and consider, equally carefully, how best these effects can be measured.

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Universities and tobacco money

Universities must be seen to be truthful

EDITOR—Cohen's editorial misses the most important reason why universities should not associate with tobacco companies.[1] Her argument, based on tobacco's harm to health, implies that universities have a special duty to protect health. It is not obvious that this is so. If universities are to play their allotted social role, however, they need above all to show respect for truthfulness. It is the fact that tobacco cannot be sold without systematic and sustained lying and deception that makes its purveyors unsuitable partners for universities.

Society is impoverished when its universities associate with organisations that treat the truth with contempt. Other arguments distract from this central point.

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Japan has laundered tobacco money

EDITOR—I agree that some universities are accomplices in the tobacco epidemic.[1] In Japan the government helps tobacco companies to promote cigarettes.[2] Although Japan Tobacco, Japan's former monopoly, was privatised in 1985, the ministry of finance still owns two thirds of the company's stock. The Smoking Research Foundation was established in 1986. In 10 years more than 100 universities and institutes received research funds from the foundation—that is, from Japan Tobacco. Tobacco money has been laundered through this process.

I belong to Japan Medical-Dental Association for Tobacco Control, which was formed on 31 May (World No Tobacco Day) 1992 and now has a membership of 1260. One of the regulations of the association is not to accept money from the tobacco industry, directly or indirectly.

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MMR immunisation

True anaphylaxis to MMR vaccine is extremely rare

EDITOR—In their concise review of the common issues surrounding MMR (measles, mumps, and rubella) immunisation Harnden and Shakespeare mentioned that "special vaccination precautions need to be taken … in children with known anaphylactic reactions to egg or coexisting chronic severe asthma."[1] It is important that this statement be clarified.

True anaphylaxis to MMR vaccine is extremely rare, and most cases have occurred in children not allergic to eggs. In a study at our hospital over 400 children with documented egg allergy received the vaccine; minor reactions (not requiring treatment) occurred in four, and no major reactions occurred.[2] Since that time we have immunised hundreds more children with known or suspected egg allergy at our immunisation clinic and have not seen any severe reactions. We do not routinely carry out skin tests on these children for reaction to either egg protein or components of the MMR vaccine.

Children with egg allergy can safely be given MMR vaccine in a centre where resuscitation facilities (including adrenaline) are available. These facilities are required to be present for any immunisation, not just when MMR vaccine is given.

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Health professionals should strongly recommend this immunisation

EDITOR—Many parents have already acquired a lot of (mis)information about measles, mumps, and rubella (MMR) vaccine and autism, particularly from the internet, by the time we see them. What is needed is for health professionals to provide them with information that is supported by hard data so they can check it for themselves. For this reason references to medical literature must be provided. Parents are not going to accept what they are told on the telephone by NHS Direct; directing people to the Health Promotion England website (www.hpe.org.uk) would be much more helpful as the information there is well referenced.

We were surprised that the only study that Harnden and Shakespeare mentioned[1] in relation to MMR (measles, mumps, and rubella) immunisation and autism was a recently reported work from Finland. This is probably the least robust; it would have been much better to quote the study by Taylor et al in London.[2] Much more powerful might have been to point out what the researchers from the Inflammatory Bowel Disease Study Group themselves stated in their original study: "We did not prove an association between measles, mumps, and rubella vaccine and the syndrome described."[3] Later three of the group emphasised, "We emphatically endorsed current vaccination policy until further data are available."[4]

Harnden and Shakespeare set out the reasons behind current policy, but, unfortunately, some inaccuracies crept in. The first dose of the vaccine should be given any time after the child's first birthday; there is no need to wait until 13 months. The reason for the second dose is that the vaccine has an efficacy of only 85-90% for mumps and 90-95% for measles, whereas 99% of recipients will be protected after two doses.

There is little evidence of waning immunity.[5] Although measles is highly infectious, a child will only infect 15 others if they are susceptible, which is now unlikely in most settings. We would have listed convulsions, rather than deafness, among the complications of measles disease.

Although we agree that the decision whether to have a child vaccinated is ultimately the parents', the evidence is so conclusive that health professionals should make it clear that they strongly recommend MMR immunisation. Anything else is second best for the child and the wider community.

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Healthcare professionals must be perceived as caring

EDITOR—Kelley and Tucci outline several simple, well thought out, aspects to improving the experience of quality of care for patients in the light of a North American report.[1]

What is crucial to a perception of improved quality in the NHS is reinforcement of the perception by patients that healthcare professionals at all levels actually "care" for them individually. This can engender forgiveness for slight delays or minor discomforts and appreciably aid the healing process. It is not a substitute for quality, but it is a very important addition. All the mechanistic changes necessary to ensure a robust clinical governance process in NHS trusts must be seen to complement the best human attributes of all staff that work in the NHS, not demoralise them. To care is human.

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Neurosis may be increasing

EDITOR—Ferriman reported that levels of neurosis remained static in the 1990s.[1] Having been extensively involved in ensuring the accuracy of data in my large paperless practice, I am suspicious of all data as I know how hard it is to validate them. We have been paperless for three years, and, with a practice population of 14 000, I am fascinated how Read code systems can be used as social documents. As we have a default record and a small number of codes for neurotic type illness it is easy to look at trends and be reasonably sure that they show something which may be true.

I took three minutes to perform a Read code hierarchy search on depressive disorder for the three 12 month periods from 1998 to 2001. For 1998-9 there were 687 patients; for 1999-2000, 819; and for 2000-1, 902.

Thus these codes increased in our practice by 31%. A more recent search showed a year on year rise in the use of antidepressants every year, with a 97% rise in the number of prescriptions and a 56% rise in the number of patients receiving antidepressants in each 12 month period over the past four years.

I find these data worrying. General practitioners are increasingly picking up the tab for a stressed and unhappy society. The aetiology of this unhappiness is beyond the scope of this letter, but my data suggest a profound problem in my practice population

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1 Ferriman A. Levels of neurosis remained static in the 1990s. *BMJ* 2001;323:130. (21 July.)

Royal Medical Benevolent Fund's Christmas appeal

EDITOR—Readers of the *BMJ* in recent years have been generous in their response to my Christmas appeal on behalf of the Royal Medical Benevolent Fund.

Those of us involved in the work of the fund are constantly made aware of colleagues or their dependants whose lives have been torn asunder by unexpected tragedy. Throughout the year the fund provides support where it is needed. Last year, in financial terms, this amounted to a commitment of just over £1m.

It has become a tradition that at Christmas time we provide extra help—perhaps a gift, or more usually, a little more money to buy presents for the children concerned. Once again, however, we need your continuing kindness and generosity to enable us to give this additional seasonal cheer.

At this time last year we received over £73 000—a second record year. Please help once again in the hope that we can make Christmas for those less fortunate than ourselves approach their memory of happier times past.

Contributions marked Christmas appeal may be sent to the chief executive officer of the fund at the address below or to the treasurer of your local guild of the fund. Thank you.

I also thank everyone who has already contributed.

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Withdrawal of baclofen may cause acute confusion in elderly patients

EDITOR—Ratnayaka et al have reported neonatal convulsions after withdrawal of baclofen.[1] To their piece we add our own experience of the difficulties of withdrawing baclofen at the opposite extreme of life.

An 82 year old man with left ventricular dysfunction and gout was admitted for deteriorating renal function. On admission he was taking lisinopril and frusemide, which were reduced; naproxen, which was stopped; allopurinol; and baclofen 20 mg three times daily. As no reason could be found for his baclofen treatment the dose was halved, and then stopped 10 days later.

Next day the patient had visual hallucinations with confusion and agitation requiring sedation with diazepam. He was afebrile with normal inflammatory markers. Computed tomography showed only cerebral atrophy. Before a lumbar puncture could be performed to exclude encephalitis, baclofen was reintroduced, with complete resolution of neuropsychiatric symptoms within 48 hours.

Baclofen is a derivative of γ-aminobutyric acid, exerting an inhibitory effect on spinal reflexes and reducing excessive tone. Oral baclofen is commonly used to treat spasticity of spinal origin, but 25-35% of cases are refractory to treatment or have considerable depression of the central nervous system, so that intrathecal administration is necessary. Baclofen is also commonly used to treat spasticity occurring as a result of stroke.

Baclofen has a half life of 3-4 hours, with 85% being renally excreted within 24 hours. Thus symptoms of withdrawal tend to occur rapidly. Withdrawal of oral baclofen results in neuropsychiatric symptoms as described above (anxiety, delusions, auditory and visual hallucinations) and new onset seizure activity.[2] Withdrawal of intrathecal baclofen, however, causes more serious systemic side effects (increased spasticity, hyperthermia, rhabdomyolysis, renal failure, and disseminated intravascular coagulopathy).[3 4] This resulted in death in one report.[4] Treatment is supportive, with reintroduction of baclofen often leading to the resolution of symptoms within 24-48 hours. Dantrolene has been used successfully to treat one resistant case.[5]

Caution should be exercised when reducing or stopping long term baclofen treatment. The Committee on Safety of Medicines recommends tapering the dose over 1-2 weeks, or more slowly if symptoms occur.

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GPs need guidance on protecting their computers from viruses

EDITOR—Doctors' surgeries have been encouraged to computerise and connect to NHS online services to give them access to the internet and email. Although the NHS services are (I would hope) well protected against computer viruses, responsibility for protecting surgery systems sits with individual surgeries. So it is up to surgeries to install antivirus software on their computers and keep it up to date. Many of these viruses can wipe all records or send confidential data out in open emails.

I suspect that many doctors are unaware of the risks. They are unaware too that when they signed up for the NHS connection they became wholly responsible for protecting their surgery computers. Many doctors do not know what they should be doing, but I have been shocked at the lack of guidance available to those who ask for help.

Most doctors are already struggling to treat patients in between dealing with the piles of paper generated by NHS bureaucrats who need to justify their jobs. So few doctors have time to become computer experts. And not all surgeries can afford the luxury of a full time expert in information technology who really understands computers.

I would be interested to hear from anyone who shares my concerns, disagrees with them, or can point me to clear practical guidance from the authorities. I can be reached by email.

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