Letters

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Chronic aspirin is effective—if data are massaged sufficiently

Editor—Baigent et al argue passionately for the effectiveness of aspirin but also warn against the power of prejudice.[1] Perhaps there is more than one reasonable perspective on the aspirin meta-analyses, which they should have the courage to admit.

So to arithmetic—250 patients were reported lost to follow up on aspirin in the original ISIS-2 report, more than the 216 deaths' difference between aspirin and placebo.[2] This was subsequently revised.[3] Which figure should we believe? However, my real concern is about the long term efficacy and risks of aspirin. Should aspirin be a short term intervention after a vascular event or a long term agent for cardiovascular prophylaxis?

Baigent et al have trouble in accepting the fact that the long term post-infarction studies failed to show a reduction in mortality, individually or overall.[4] The reason the meta-analysis shows any reduction in long term mortality with anti-platelet agents after myocardial infarction is due to retrospective, unblinded, re-analyses of studies long completed.[4] This exercise identified new deaths and also resurrections. We know neither how bias during this exercise was prevented nor why these newly acquired data were much more in favour of anti-platelet agents. Publication bias in favour of aspirin also exists.[5] Considering the small treatment effect, bias could easily explain all the purported long term effects of aspirin. With enough post hoc revision many other failed medicines might also be shown to be effective.

All cause mortality tells us if treatment is effective; mode of death helps explain why a treatment is or is not effective. An increase in sudden death with aspirin was reported in the original post-infarction trials. It is curious that this fact "disappeared" in the meta-reanalyses. Baigent et al suggest that a modest concealment of non-fatal infarction could not account for the effects of aspirin. Perhaps such an effect is not subtle? Perhaps aspirin reduces the chance of a non-fatal myocardial infarction being reported from 75% to 50%? This could explain the results of the US Physicians' trial, in which a 39% reduction in non-fatal myocardial infarction was observed but no reduction in mortality or stroke and a trend to excess sudden deaths.[6]

The validity of recommendations based on meta-analysis alone is questionable because it is difficult to ensure freedom from bias and because it has frequently been misleading when supported only by individually inconclusive trials. At least one guideline group has decided that meta-analysis should be used as a method for deciding whether the mass of data is consistent with the outcome of a positive trial rather than taken as sufficient evidence by itself.[7] Since the original reports of the best trials on aspirin failed to show a reduction in mortality, guideline recommendations may now have to be revised.

The authors conclude that it were better that my article had not been published. I am thankful that powerful people have a limited ability to censor the medical press. We need to be sure that long term aspirin is effective. The consequences of not doing so would be disastrous, for patients and future therapeutic developments.

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Revalidating retired doctors

Revalidation is essential for retired doctors who continue to practise

Editor—The concerns expressed by Vickers over the revalidation of retired doctors are worrying if they really represent those of "the most distinguished and longserving members of our honourable profession."[1] The purpose of revalidation is to provide a mechanism for self regulation to ensure that doctors are fully competent to practise in their specified field. Doctors who are retired rapidly get out of touch, and their skills therefore become rusty.

To pretend that one is retired while continuing to practise, examine patients, prescribe for them, and accept fees is both disingenuous and dishonest. Furthermore, prescribing for one's relatives and friends is both unsafe and unprofessional. This is not a "field" of medicine; it is general medicine practised on a restricted group of patients, most probably without the knowledge or consent of the general practitioners with whom they are registered.

Self prescription must, strictly speaking, fall into the same category. If doctors are no longer deemed fully competent to prescribe drugs for patients why on earth should they be thought fit to do so for themselves? There would be no good reason to make an exception to public policy on the grounds of expediency. And there is every good reason why, even though the doctors risk injuring themselves, they should not be allowed to kill their relatives.

The right to validate passport applications is a red herring—an old tradition stemming from the general belief that a doctor's word, like that of any professional, can be taken on trust. It has no bearing on revalidation.

Of course, Vickers can offer advice if it is asked for, but if he is really retired it is not

strictly professional advice and it should be unattributed and given free of charge.

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1 Vickers M. Revalidating retired doctors. *BMJ* 2001;323:701. (22 September.)

Retired doctors' skills would be invaluable in a crisis

Editor—I retired from full time anaesthetic practice at the age of 63 but continued occasional locum duties until just past my 70th birthday. Early in 1996, at the age of 74, I spent a couple of months in Kurdistan, north Iraq; I was helping Emergency, an Italian based medical charity, set up a surgical hospital for the war wounded.

Fortunately, my skills and knowledge had not deserted me. When I returned in the summer hostilities broke out between the two main Kurdish political parties. We were the only hospital open, as the general, teaching, and maternity hospitals all closed temporarily. For a short time I was the only anaesthetist in a city of nearly three quarters of a million people. I returned to Kurdistan briefly in 1997 and 1998.

I am not unique. There is a large pool of medical knowledge and skills among retired doctors, which could be invaluable in a crisis. I assume that Vickers's article was written before the terrorist attacks in the United States on 11 September.[1] It would be disastrous if the skills of retired doctors were no longer available owing to our removal from the medical register through lack of a suitable revalidation process.

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Transplant patients need to be made aware of skin cancer risk

Editor—Harden et al in their survey of skin cancer surveillance in recipients of renal transplants have highlighted the fact that monitoring of these patients is inadequate.[1] They say that patient information does not necessarily correspond to patient awareness. Despite being given information on skin cancer, many patients remain unaware of the risks of ultraviolet radiation and do not adopt long term sun protection measures.[2]

The risk of non-melanoma skin cancer in renal transplant patients increases steadily with length of time since transplantation.[3] In this group skin cancer presents earlier and is more aggressive. It is therefore important to target the paediatric transplant population. We performed a questionnaire survey of the cohort of 39 Scottish paediatric patients who received kidneys between 1987 and 2000.[4] We aimed to assess parents' awareness of the need for sun protection, the sun protection measures used, and their children's attitudes to the sun. We sent a questionnaire to each child and parent.

Twenty six of the 39 (67%) questionnaires were returned. The patients were aged 6-17 years, and time since transplant varied from 6 months to 13 years. Whereas 24 of the 26 parents were aware that their child needed sun protection, only six were aware of their child's specific increased skin cancer risk as a result of immune suppression. Twenty four of the 26 children had sunscreen applied to exposed areas when on holiday. Far fewer used the more effective measures of wearing protective clothing (11) or avoiding the midday sun (4). Only a small proportion (6) used these measures daily during the British summer. Not surprisingly, most children (25/26) liked the sun. It is worrying that seven of them actively sought the sun to get a tan and that seven recalled having had sunburn. Only 13 of the children knew that there was a risk of their skin being damaged by the sun. The problem of non-melanoma skin cancer in transplant recipients needs to be highlighted.

Children with renal transplants are a particularly vulnerable group. The need for adequate and appropriate sun protection in this group needs to be emphasised by all professionals participating in their care.

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1 Harden PN, Reece SM, Fryer AA, Smith AG, Ramsay HM. Skin cancer surveillance in renal transplant recipients: a questionnaire survey of current UK practice. *BMJ* 2001;323:600-1. (15 September.)
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Any changes in prevalence of autism must be determined

Editor—Because of the current concern over the rising incidence of autism the *BMJ* owes its readers better information than a letter based on comments by a focus group of interested parties.[1] Would the journal have published a letter from a focus group of parents who believed that MMR vaccine (measles, mumps, and rubella vaccine) had caused their child's autism? I doubt it.

Rigorous methods are especially important because of a controversial current hypothesis.[2] Fombonne has argued that despite reported increases in the prevalence of autism in many countries, the true incidence has remained constant. The impression of an increase, he argues, arises only because of increased rates of detection.

There is no hard evidence to support this hypothesis. The only studies that have explored the question have failed to find a "hidden horde" of autistic children. Burd et al conducted a prevalence study of autism in North Dakota.[3] They found a prevalence of 3.26 per 10 000 among a cohort of children born between 1967 and 1983. A 12 year follow up survey of the same cohort showed that the original prevalence study had found 98% of the autistic children in the area; only one child had been overlooked.[4]

Nylander and Gillberg screened adult psychiatric outpatients for evidence of undiagnosed autistic spectrum disorders.[5] This population had not been screened for autism previously. The authors hypothesised that they would find high rates of undiagnosed autism. The screening procedure located 19 adults with autistic spectrum disorders who had not received a prior diagnosis. However, the prevalence in this group was only 2.7 per 10 000, a finding that provides little support for a hidden horde hypothesis. The authors note this point reluctantly, claiming that the observed prevalences "should be regarded as an absolute minimum."

Many scientists and health professionals are uncomfortable about the data regarding recent increases in rates of autism. A few have developed extravagant theories as an expression of their discomfort. Nevertheless, the simplest interpretation of the record supports the conclusion that the incidence of autism has increased.

To avoid the consequences of complacency the burden of proof should lie with those who seek to dismiss decades of epidemiological research as flawed. Yet we are now offered focus groups as a new research tool. I am surprised that the *BMJ* would dignify such efforts. Good science demands that we face the real data, no matter how inconvenient the implications may be.

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1 Heussler H, Polnay L, Marder E, Standen P, Chin Lyn U, Butler N. Prevalence of autism in early 1970s may have been underestimated. *BMJ* 2001;323:633. (15 September.)
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Use of interactive multimedia decision aids

Alternative explanation for results may exist

Editor—The results of Murray et al's two studies on interactive multimedia decision aids are compatible with the conclusions that both they[1 2] and the author of the accompanying editorial[3] draw: that such products are generally acceptable; that they lead to a substantial decrease in patients' decisional conflict; that the interactive

nature of the software allows information to be personalised; that high technology decision aids, though expensive now, are likely to cost less per case in the future; that it does not much matter that the technology was obsolete and the evidence had moved on by the time the papers were published; and that such technologies should be introduced more widely.

However, the results are also compatible with the opposite conclusion: that most patients prefer not to use (or even try out) multimedia decision support aids (hence the disappointingly low recruitment); that the absolute difference made to decisional conflict and to the actual decision made was small; that the interactivity provided only limited personalisation of the information for variables such as age and could not mirror the complexity of real life decision making; that the apparent acceptability and usefulness of multimedia decision aids might be explained by the Hawthorne effect of new technologies in educational contexts; and that the favourable economic evaluations presented failed to take into account the massive cost and lengthy time course of developing the technology in the first place.

Murray et al's results show that both high technology software and the information it contains have a high chance of being obsolete by the time they are used. An emerging social science of information technology warns against extrapolating from resource rich, quantitative, and highly contextual research studies to the messy and under-resourced reality of real life.[4] The introduction of high tech interactive decision aids is complex[5]; the next phase of research trials must surely include in-depth qualitative studies on precisely how and why patients and health professionals use (or choose not to use) these products.

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1 Murray E, Davis H, See Tai S, Coulter A, Gray A, Haines A. Randomised controlled trial of an interactive multimedia decision aid on benign prostatic hypertrophy in primary care. *BMJ* 2001;323:493-6. (1 September.)
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Discrepancy may exist between GPs and their patients about who is making the decisions

Editor—In her response on bmj.com (www.bmj.com/cgi/eletters/323/7311/493#responses) (published here as the letter above) Greenhalgh suggests alternative interpretations of the studies reported by Murray et al,[1 2] but there seem to be confounding factors associated with the intervention. In both studies, patients who viewed the multimedia program were also given a booklet and a printed summary. Yet the authors attribute all the observed effects to the multimedia program. Is there evidence that the printed materials had no effect? If they contributed greatly to the effectiveness of the intervention this would raise questions about the economic analysis—was the computer needed?

The comments made by Dixon-Woods and Thornton in their letter on written information for treating minor illness—about the need to specify not just the content but the quality of the information provided to patients, and the need for quality to be evaluated from a patient's perspective—would seem as relevant to videos and interactive programs as they are to printed materials.[3] If the decision aid adopted a style of speech that seemed American, did this influence viewers? Murray et al report that "the information comprised quantified probabilities of the risks and benefits," but such probabilities have little meaning for some people.[4]

Murray et al mention evidence that having more information about hormone replacement therapy leads to greater uptake, but they do not discuss why they found no such effect. Perhaps some aspects of the quality of the material—for example, its emotive tone or perceived agenda—contributed to this lack of change. Providing too few details about the design features of decision aids undermines the value of subsequent meta-analyses—a point that applies to all studies of patient information no matter what the medium of communication.

For their control groups Murray et al report that general practitioners' perceptions of patient involvement in decision making were closely similar in both studies, with almost two thirds of the decisions being seen as made jointly by the general practitioner and patient (table). In contrast, patients' perceptions of being the decision maker differed considerably between the studies (56% in the hormone replacement therapy study and 4% in the benign prostatic hypertrophy study). Even without information on whether this is a gender effect or relates to the perceived severity of the medical condition or its treatment, the data show (with replication) the discrepancy that can exist between general practitioners and their patients about who is doing the decision making.

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Summary of perceptions of who made decision about treatment in control groups in studies by Murray et al (values are percentages of patients).[1 2] For clarity, small frequencies when decision maker was thought to be mainly general practitioner have not been included

	GP's perception		Patient's perception	
Who decided	Prostate	HRT	Prostate	HRT
GP and patient	65	66	88	38
Patient alone	25	31	4	56

GP=general practitioner. HRT=hormone replacement therapy.

2 Murray E, Davis H, See Tai S, Coulter A, Gray A, Haines A. Randomised controlled trial of an interactive multimedia decision aid on benign prostatic hypertrophy in primary care. *BMJ* 2001;323:493-6. (1 September.)
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Authors' reply

Editor—Greenhalgh calls for more in-depth qualitative studies on precisely how and why patients use multimedia decision aids. We are well aware of the issues concerning the design of trials of complex interventions[1]—indeed, our initial protocol included such a qualitative component, but this part was not funded. We disagree with her, however, when she says that most patients prefer not to use (or even try out) such decision aids, and we contend that patients should be offered the best available evidence in an appropriate format to assist their decision making.

Greenhalgh is wrong to state that the economic evaluation failed to take into account the development costs of the technology: we reported that the substantial hardware and software costs were fully allocated to the small numbers of patients in these trials. Hence the results were unfavourable using that technology but would be much more favourable using internet based methods.

. We strongly endorse Wright's comments on the importance of the quality and content of such decision aids for patients. We contend that where possible such aids should be developed from the Cochrane Collaboration's syntheses of evidence of effectiveness.[2] Because much of the expense of developing decision aids is in reviewing and updating the evidence base, such a linkage would simultaneously ensure quality content and keep costs down. The use of written materials alone is unlikely to have influenced decision making.[3]

Wright questions the reasons for our finding that there was no greater uptake of hormone replacement therapy in the intervention than in the control group. The trial was not designed to determine how participants reached specific decisions; this is one question that a qualitative component could have addressed. Possibly the information in the decision aid allowed women who did not want to take hormone replacement therapy to feel comfortable with that decision, and make it positively rather than by default. The content of the aid was well balanced and had been extensively field tested in the United States before our trial began.

We agree with Wright that our data confirm the discrepancy that may exist between

general practitioners and patients about decision making; in our view this provides further argument for ensuring that patients have direct access to information.

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1 Campbell M, Fitzpatrick R, Haines A, Kinmonth A-L, Sandercock P, Spiegelhalter D, et al. A framework for the design and execution of complex interventions to improve health. *BMJ* 2000;320:694-6.
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Public views of UK Population Biomedical Collection are being taken into account

Editor—We think it important to respond to Kaye's letter concerning the proposed UK Population Biomedical Collection, a project sponsored by the Wellcome Trust, the Medical Research Council, and the Department of Health.[1] Kaye suggests that the collection will be a test run for the establishment of a national population collection, but this may mislead readers.

The proposed collection will include DNA samples from roughly half a million adult volunteers, together with data on environmental and lifestyle risk factors and (in due course) health outcomes. Central to the proposal are requirements that informed consent must be obtained from all volunteers and that all information would be stored and analysed in a form that would not allow individuals to be identified by those conducting the research.

An independent body would oversee the collection and would be accountable to the public for ensuring that the data are used responsibly and within the terms of the consent obtained from the volunteers. It will be a collection held in public ownership for public benefit. We intend that methodology for obtaining reliable information on health outcomes from NHS electronic records will be piloted as part of the proposed study, but this is an independent research project and not linked to the establishment of any more extensive national collection.

We agree with Kaye that transparency, public consultation, and debate are vital to the success of this project. We have commissioned a series of public consultations to ensure that public attitudes towards the collection are clearly understood and taken into account during its development.[2–4] In April two regional workshops were held with key opinion formers at local and regional levels in the NHS; a short report will follow.

Finally, Kaye rightly mentions "public consultation, consent, data security, access, and oversight mechanisms" as issues that need to be addressed in the establishment of a population collection. All these issues have been and will continue to be considered in the development of the collection, and we intend that the collection will be seen as an exemplar for future projects of this nature.

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1 Kaye J. Report may lead to population collection by the back door. *BMJ* 2001;323:632. (15 September.)
2 Public perceptions of the collection of human biological samples (www.wellcome.ac.uk/en/1/biovenpopcol.html or www.mrc.ac.uk/publicperceptions.htm).
3 Consultation with primary care health professionals on the proposed UK Population Biomedical Collection (www.wellcome.ac.uk/en/1/biovenpopfoc.html).
4 Use of biological sample collections and personal medical information in human genetics research (www.wellcome.ac.uk/en/1/biovenpop.html).

Independent review of Worcester PFI is needed

Editor—We at Worcestershire Local Medical Committee wish to refute McCloskey's assertions on the cost of the private finance initiative (PFI) hospital scheme in Worcester.[1] We have had major anxieties about the strategic review of health care in Worcestershire and the Worcester PFI project. We have been unable to obtain the clarification we seek from the health authority and have welcomed expert independent assessment of the issues.

Last summer the local medical committee asked for an independent review, a request that was rejected by the Department of Health and Worcestershire Health Authority. An adjournment debate was held in Parliament on 25 July 2000, at which serious concerns were raised and important questions asked that were never satisfactorily answered. A review has now taken place as part of the national bed inquiry, whose findings confirmed our fears that there would be too few beds in Worcestershire in the short, medium, and long term. The report produced by McCloskey himself states that there will be a deficiency of 90 beds when the new Worcester PFI hospital opens. It should be noted that even this figure is disputed and could be as high as 200, according to some senior managers in the acute trust.

In this era of supposed open government it should be of great concern that major decisions on healthcare provision are made in such a way that even local general practitioners are not fully informed, which results in them being misled. We need more independent review and analysis. Pollock et al in their electronic response should be commended for raising important issues and bringing the debate into the public arena. There are serious concerns regarding PFI that need to be debated. We at Worcestershire Local Medical Committee do not wish to see other areas of the county left in a similar state to ours. The wider NHS must learn from our experiences

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1 McCloskey B. Letter should show balance, not bias, when reporting on PFI. *BMJ* 2001;323:753. (29 September.)

**Professors McCloskey and Pollock continue their debate on numbers of beds and sums of money at www.bmj.com/cgi/content/full/323/7315/753#responses.

Variation in rates of oestrogen receptor positivity in breast cancer again

Editor—Mayor reports the findings of a postal survey showing an alarming wide variation in rates of oestrogen receptor positivity in women with breast cancer.[1] The results of this questionnaire showed that the rate of breast tumours positive for oestrogen receptor that were detected at different breast cancer centres varied from as low as 5% to around the expected 80%.

For several years the UK National External Quality Assessment Scheme for Immunocytochemistry has been regularly assessing the quality of oestrogen receptor staining, but only recently has the number of laboratories participating in this module reached 173. Currently we have identified 24 of these as having difficulty with their oestrogen receptor assays. These laboratories will be offered an opportunity to visit the scheme's centre at University College London and given help. Those who fail to improve will be referred to the national quality assessment advisory panel for remedial action.

Clinical Pathology Accreditation will be asked to ensure that those laboratories that are performing oestrogen receptor testing but are not currently participating in the oestrogen receptor module do so with immediate effect.

A further study, based on the returns obtained from 48 laboratories registered with the UK National External Quality Assessment Scheme for Immunocytochemistry and covering oestrogen receptor analysis of over 7000 breast carcinomas, also recorded a variation in rates of oestrogen receptor positivity.[2] These rates fell within a more acceptable range of 44-90%, with the expected mean of 75% (95% confidence interval 73% to 78%).

Scrutiny of the methodologies used by the participants in the UK National External Quality Assessment Scheme for Immunocytochemistry showed that the lower positivity rate was largely due to the lower sensitivity of the assay used. This lower sensitivity in turn was principally due to a lower power of

the antigen retrieval method applied. Adjustment of this factor conducted under the guidance given by the quality assessment scheme significantly improved the sensitivity of the assays performed by centres getting the poorer results.[3]

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1 Mayor S. bmj.com news roundup: UK survey finds variation in oestrogen receptor testing. *BMJ* 2001;323:713. (29 September.)
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Canadian Medicare needs choice

Editor—Lewis et al accurately describe the intent of Medicare in Canada, but this does not represent the reality of day to day practice.[1] Nor do they discuss the economic reality. In practice, the system is not portable. For example, Quebec does not pay physicians in Ontario their proper fees, and, as a result, many patients from Quebec have to pay the doctors they visit in Ontario with cash and then collect whatever portion of the fee they can from the Regis (the Quebec plan).

The system is not accessible. Hundreds of thousands of residents of Ontario do not have a primary care physician to manage their long term and continuing care. Such patients often get piecemeal care in walk-in clinics or emergency departments. At best, this is mediocre medicine. The delays in elective surgery, cancer care, acute psychiatric care (especially for children and adolescents), and even emergency care are scandalous. If a patient needs to be admitted to hospital (assuming there is an available bed) he or she is well advised to bring along a private nurse, such is the shortage of nurses on the ward. Many newer treatments are not made available simply because they are too expensive. Thus only the well off can afford these newer medications or vaccines—so much for "single tier" Medicare.

Physicians and nurses are working under duress. Professional morale is shockingly low. Many practitioners would like to quit but cannot afford to. Numerous specialties are in short supply, and the training programmes are fiscally restrained from keeping up. The system is bankrupt as it has been financed entirely with borrowed monies and has never been funded on an actuarially sound basis. From a macroeconomic point of view, Canada would be free of debt were it not for its "investment" in Medicare. Moreover, the fact that there are no copayments or user fees invites abuse, an issue that health economists refuse to address.

There is an urgent need to overhaul this system and offer Canadians their right to choose between private and public medicine—a right that citizens in most democracies take for granted.

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Competing interests: None declared.

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New method to monitor drugs at dance venues

Perhaps results of testing tablets should be made public

Editor—Ramsey et al report the analyses of illegally purchased controlled drugs that had been surrendered in a nightclub.[1] They argue that monitoring such samples would provide important information to healthcare professionals, which they could use to "formulate better advice on avoiding injury through drug use and to design the most appropriate campaigns against drug use."

Yet no indication is given of how this would be done, other than by increased use of the TICTAC database, which is edited by Ramsey.[2] As this database is presumably already used by people reading this paper, its ability to fulfil this purpose is questionable. No evidence is presented that any evidence based harm reduction strategy uses these data or that an outcome evaluation has been conducted on them.

Two major problems arise with ecstasy tablets: the unknown amount of 3,4-methylenedioxymethamphetamine (MDMA) present, if at all, and other drugs being sold as 3,4-methylenedioxymethamphetamine, such as 4-methylthioamphetamine (4-MTA). Adverse reactions to 3,4-methylenedioxymethamphetamine seem to be both idiosyncratic and rare. Perhaps the information about tablet contents should be made available to people who are deciding whether or not to use the tablets, so that they can avoid ingesting tablets of unknown content.

On-site facilities for tablet testing in the Netherlands reduce the drug use of people attending organised dance parties.[3] Information on tablets in circulation at the venue is immediately available to both the users and medical support staff. The TICTAC database, on the other hand, would not be able to provide this information without confirmatory analysis.

No controlled study has ever been conducted to evaluate whether the availability of information about the contents of ecstasy tablets either increases or decreases the harm associated with their use. What is evident is that restricted access to this information is not preventing adverse reactions and is having no effect on the drug use of young people.

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Authors' reply

Editor—Cole is correct that we presented no evidence of harm reduction, but this was an unfunded pilot study. Our intention was to propose a protocol for monitoring drugs on the dance scene. The findings are communicated to healthcare and law enforcement professionals without encouraging or condoning drug misuse.

TICTAC is a quarterly CD Rom with interim updates on the internet, to which data from our study were added as soon as they became available. There is public access through the national drugs helpline and, indirectly, through community pharmacists. Healthcare professionals have access through the National Poisons Information Service, regional medicines information centres, and the Royal Pharmaceutical Society; and the law enforcement community also uses TICTAC.

Cole suggests that a major problem with ecstasy tablets is the unknown amount of 3,4-methylenedioxymethamphetamine (MDMA) that they contain. In our view this is less important than the fact that a recent survey of clubbers found that the number of tablets taken averages 2.8 and may be as high as 15 per session.[1]

In the Dutch ecstasy testing model (DIMS) tablets are collected from several sites and sent to a central laboratory for analysis.[2] The results are made available to the public at dance venues the next weekend, or an alert is issued if particularly hazardous substances are discovered. At dance venues the testers note the physical appearance of tablets handed to them and match them to laboratory findings. A simple colour test (Marquis reagent) is then applied, but its value is limited because it does not react with many of the most toxic substances found in ecstasy tablets–for example, 4-methylthioamphetamine (4-MTA).

At best, therefore, on-site testing indicates that a tablet contains 3,4-methylenedioxymethamphetamine. The tester is, in effect, providing limited quality control for a toxic and illegal substance and may be giving users a false sense of safety.[3] The proponents of this scheme believe that it reduces the number of tablets in circulation that do not contain 3,4-methylenedioxymethamphetamine and that it initiates a dialogue between users and drug workers that enables a harm reduction message to be imparted. This process would

almost certainly contravene the Misuse of Drugs Act if applied in the United Kingdom.

Our approach would fulfil similar aims to the Dutch ecstasy testing model, without imparting the unfounded imprimatur of quality that on-site tablet testing may provide.[3]

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Widespread body pain and mortality

Theories that psychological states cause cancer should be rejected

Editor—In attempting to explain the finding that bodily pain is associated with excess mortality from cancer Macfarlane et al make reference to psychological theories of the aetiology of cancer.[1] They claim that "the inability to release emotion" may "predispose people to the development of cancer." So why doesn't everyone in the United Kingdom have cancer? Why does Spain have higher rates of cancer than Japan? Why do Chileans have a comparable risk of cancer to the Chinese?

In support of their claim the authors cite a 20 year old review, as well as the work of Spiegel et al, whose randomised trial suggesting that psychological treatment aids survival from cancer[2] has been repeated with negative findings.[3 4] More recent studies casting doubt on the links between psychological state and cancer are not cited.[5] Simplistic theories suggesting that psychological states cause cancer are out of date and should be rejected.

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Diagnosing fibromyalgia stops doctors from thinking

Editor—Macfarlane et al report an increased mortality, particularly from cancer, in people with widespread pain.[1] They say that widespread body pain is a cardinal feature of fibromyalgia.

Fibromyalgia is such a dubious condition that many rheumatologists dispute its existence as a clinical diagnosis.[2] People with so called fibromyalgia complain repeatedly and often frustrate their medical attendants. One possible reason for the increased mortality is that they are regarded as "heartsink" patients, so their complaints become less worthy of attention. The early symptoms of malignancy are therefore ignored, leading to late diagnosis. It would be interesting to know whether cancer was more common in this group, or simply death from cancer was.

Fibromyalgia is a dangerous diagnosis. It stops the doctor thinking.

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Evaluation is essential for all types of intervention

Editor—Clark's plea for home visits by health visitors to be excluded from evaluation by randomised controlled trials cannot be accepted.[1] His objections—the limitations of meta-analyses, the problems of confounding particularly where complex social factors are involved, and the selection of outcome measures—apply to many other interventions. The acceptance of randomised controlled trials does not preclude other methods of evaluation.

Complex social interventions can be and have been evaluated despite the difficulties as Oakley described in her review of the rise and fall of evaluation of social interventions.[2] She noted that one of the main reasons for the decline in evaluation was the apparent ineffectiveness (and in some cases adverse effects) of some of the favoured interventions, and concluded that experts in the social domain, like those in medicine, have resisted the notion that rigorous evaluation of their work is more likely to give reliable answers than their own individual preferences. When randomised controlled trials find that new "treatments" are no better than old ones, a retreat to other methods of evaluation is particularly likely, as though the prime task is not to identify whether anything works but to prove that something does.

It would not be right to discontinue every intervention for which evidence of effectiveness is lacking. If, as Clark says, however, home visits to elderly people have almost disappeared by default, then it is reasonable to ask for evidence—from randomised controlled trials or otherwise—before reintroducing them.

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Cover picture highlighted what is wrong with approach to managing chronic disease

Editor—As a respiratory physician I should be pleased to see that in your issue on managing chronic diseases the cover picture showed respiratory disease, but I am wondering if was this intended to be ironic.[1] The picture highlights much of what is wrong in our approach to managing chronic disease. It shows a man, presumably with chronic obstructive pulmonary disease, desperately using a device and drug that are at best of limited value to him. These were designed and developed primarily for the treatment of an acute or relapsing condition, asthma. Chronic disease requires proper assessment and the development of coping strategies to which medicines may make only marginal contributions.

Chronic obstructive pulmonary disease is often diagnosed and managed without proper assessment. This results in underestimation of the severity of the condition in those with severe disease, but—at least as important in chronic obstructive pulmonary disease—of overassessment of severity in those with mild disease. Both result in unnecessary suffering. An exercise class would far better have illustrated the correct approach, where patients learn to cope with their principal symptom of breathlessness, which often occurs before physiological limitation of exercise. A spirometer in the background might have shown the need for confirming the diagnosis and assessing the severity.

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1 Front cover. *BMJ* 2001;323. (27 October.)

Emergency departments are well placed to identify alcohol misuse problems

Editor—We agree with Foster that greater attention must be paid to alcohol use disorders if national and international targets for suicide reduction are to be met.[1] Accident and emergency departments have a central part to play in tackling the link between alcohol misuse and suicidal behaviour as most patients with deliberate self harm present there.

Research has indicated that over half of men who present to hospital after deliberate self harm have consumed alcohol in the few hours preceding the attempt, half regularly drink excessive amounts of alcohol, and 23% are alcohol dependent.[2] Despite this strong association many patients who present to hospital after deliberate self harm do not have their alcohol use assessed.[3]

At the accident and emergency department at St Mary's Hospital, in inner London, the proportion of patients whose alcohol consumption is assessed has been greatly increased by the introduction of the Paddington alcohol test.[4] This test takes less than a minute to complete and provides a reliable indication of the presence of alcohol use disorders. Those with positive scores are offered brief intervention from staff working in the department, which may include literature about safer drinking or an appointment with an alcohol health worker.

Providing assessment and treatment for people who attend accident and emergency departments after deliberate self harm is complicated because many people are reluctant to take up offers of help.[5] A recent audit of the management of alcohol problems in St Mary's accident and emergency department showed that of 34 patients who presented after deliberate self harm and yielded positive scores on testing, 24 were prepared to take up an offer of further advice about their alcohol consumption. We are currently examining the effects that this advice has on the likelihood of further suicidal behaviour.

This evidence suggests that people who present to accident and emergency departments after deliberate self harm and who drink excessively are willing to accept offers of help. It emphasises the importance of identifying alcohol misuse problems in patients in accident and emergency departments.

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Reducing health risks to British Muslim pilgrims

EDITOR—Each year around 40 000 Britons make the pilgrimage to Mecca in Saudi Arabia, most travelling during the Hajj season, which this year will fall later this month. The extreme overcrowding (numbers for the Hajj are estimated at around three million) and oppressive climate pose considerable health risks to pilgrims. The most significant is the risk of meningitis.

Although the risk of infection with meningitis A and C is well recognised, the Hajj of 2000 heralded the introduction of W135 meningococcal disease. During the past two years 79 cases of W135 meningococcal disease have occurred in returning pilgrims, of whom 18 died. The government of Saudi Arabia has now made quadrivalent meningococcal vaccination (ACWY Vac) a visa requirement for pilgrims.[1]

The Department of Health, working in conjunction with the Muslim Council of Britain, has distributed appropriate advice to general practitioners and travel clinics. Public information leaflets, available in six languages, have also been distributed to those preparing to perform the pilgrimage through mosques and Muslim community organisations throughout Britain.[2] In addition, the Department of Health has provided important support to the work of the newly formed British Hajj Delegation in providing much needed health and consular expertise to British pilgrims during their stay in Saudi Arabia.[3]

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Hand-arm vibration syndrome may be associated with prolonged use of vibrating computer games

EDITOR—We report the development of the hand-arm vibration syndrome in a 15 year old boy who presented with a two year history of painful hands. His hands became white and swollen when exposed to the cold and subsequently red and painful on warming. He had no clinical or laboratory features of an underlying connective tissue disorder.

The onset of his symptoms was preceded by the prolonged use of a widely available domestic computer game (Sony Playstation). He spent up to seven hours a day playing this game. He particularly enjoyed driving games using the vibration mode on the hand held control device ("rumble board"). He described the sensation of realism associated with the device vibrating when the on screen vehicle came "off road."

His presentation is typical of the hand-arm vibration syndrome—vibration white finger as it was previously known—described in association with occupational exposure to vibration. This syndrome came into force as an industrial disease in April 1985.[1] As a result sufferers were able to claim compensation and disability benefit. The prolonged use of hand held vibratory tools such as gas powered chain saws and pneumatic tools has been implicated in the aetiology of this syndrome. The increasing recognition of the problem and the subsequent lawsuits that have arisen have led to the use of antivibratory tools and changes in working practice aimed at prevention.

To our knowledge, there are no published references on the hand-arm vibration syndrome in children. Injuries associated with the use of computers or their accessories, however, have been described, including joystick digit, mouse elbow, and a central palmar blister following rotation of the central console joystick of a Nintendo game in the palm of the hand.[2–4] No cases of the hand-arm vibration syndrome have previously been reported in association with prolonged use of vibrating hand held computer devices.

Children spend long periods playing domestic computer games. The seven hours a day that our patient reported is excessive and exceeds the manufacturer's recommendation, but we must assume that this is not an uncommon occurrence. We believe that, with increasing numbers of children playing these devices, there should be consideration for statutory health warnings to advise users and parents. The potential for developing the hand-arm vibration syndrome should be considered, although more evidence of its occurrence in this context is required. We encourage paediatricians encountering health related effects of using these devices to report their findings.

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