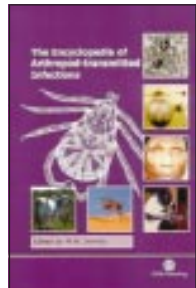


reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS

The Encyclopedia of Arthropod-Transmitted Infections

Ed M W Service



CABI Publishing,
£99.50/\$185, pp 608
ISBN 0 85199 473 3

Rating: ★★★

What do doctors working in the United Kingdom need to know about arthropod transmitted infections? Only two are endemic in the British Isles.

A febrile patient who has recently been rolling in the heather in the Scottish Highlands may be suffering from louping ill, a tick borne virus endemic in sheep and red grouse; but this is unlikely, as only 40 human cases have been reported.

A patient who has been walking in the New Forest, presenting with a localised, spreading skin lesion, accompanied by headache, myalgia, arthralgia, or neurological symptoms, may be suffering from Lyme disease, caused by *Borrelia burgdorferi*. This tick borne spirochaete normally infects birds, small rodents, and red deer. It has become endemic in the leafy suburbs of the eastern United States, where about 15 000 human cases are reported annually.

Imported arthropod transmitted infections are increasingly important. Travellers to Africa are at risk of malaria (more than 2000 cases are reported every year in England and Wales), African tick typhus, trypanosomiasis, and many other diseases. Travellers to North America and continental Europe may also be at risk. A number of arthropod transmitted infections are endemic in the US, including Rocky Mountain spotted fever, first described in settlers of the Bitterroot Valley in Montana in the 1890s. Howard Ricketts discovered the causative organism, named *Rickettsia rickettsii* in his honour, and showed that it was transmitted to humans by ticks from its usual reservoir in small rodents. Ricketts was unlucky enough to die of the infection that bears his name. It is a disease not to miss, as

it has a high mortality, but can be cured with a single dose of doxycycline.

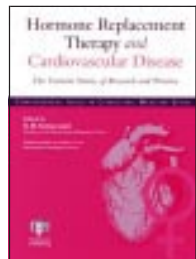
Continental Europe also has its share of endemic arthropod borne infections, from leishmaniasis and Mediterranean spotted fever in southern France, Italy, and Spain, to tick borne encephalitis in the Baltic states. But before we feel too smug about living on an island, we should reflect on the outbreak of West Nile encephalitis that occurred in 1999 in New York. This virus, first isolated in Uganda in the 1930s, had never before been seen in the West; it is transmitted by mosquitoes, but endemic in birds, including several migratory species, and was presumably taken to the Americas by an infected bird. Can we be sure that we would have recognised an outbreak in this country?

This scholarly encyclopaedia covers arthropod transmitted diseases of both animals and humans, from African horse sickness to Zika virus. It is a mine of interesting and recondite information, written by the leading authorities in their fields. It is intended more for the natural historian than the clinician. But it is a useful reference work for those interested in infectious diseases, and fascinating to dip into.

David Mabey professor of communicable diseases,
London School of Hygiene and Tropical Medicine

Hormone Replacement Therapy and Cardiovascular Disease: The Current Status of Research and Practice

Ed A R Genazzani



Parthenon, £51.99/\$77.95,
pp 200
ISBN 1 84214 038 8

Rating: ★★★

Some years ago I listened to a lecture in which the speaker vigorously defended her hypothesis that oestrogen deficiency was no more acceptable than insulin or thyroid hormone deficiency. This

was in the heady days when we believed, or wished to believe, that the use of female hormone replacement therapy (HRT) would confer major benefits, with limited risks. Over the past four or five years, however, we have been forced to re-examine the potential benefits of HRT. We now realise that some assumed benefits have not been proven and need to weigh this against risks that were previously discounted.

Symptom relief remains the prime indication for HRT. Also, the observation that the progression of cardiovascular disease in women is more rapid after the menopause led to the hypothesis that maintaining oestrogen levels with HRT could prevent this. Observational studies in the 1980s confirmed this hypothesis—impressive risk reductions were reported, with a halving of the risk of cardiovascular events and cardiovascular mortality.

However, women who choose to use HRT frequently have a different risk profile for cardiovascular disease than non-users, and selection bias may have influenced the outcome of these early observational studies. Indeed, the results have not been borne out in more recent randomised controlled trials. In the Heart Estrogen/progestin

Replacement Study (HERS), a secondary prevention trial in which women were randomised to receive HRT or placebo, no overall benefit with regard to arterial disease could be demonstrated. Furthermore in the first two years of a large placebo-controlled primary prevention trial (Women's Health Initiative), an excess of myocardial infarction was reported in the treatment group.

To add to these disappointments, although early studies failed to demonstrate an association between HRT use and venous thromboembolism (VTE), a number of recent observational studies have quite clearly shown that there is an increased risk. Randomised placebo controlled studies have also confirmed that the relative risk of VTE associated with HRT use is similar to the relative risk of VTE associated with the use of combined oral contraceptives.

This compilation of papers presented by world renowned authors provides both the specialist and non-specialist with relevant and up to date scientific and clinical information on which to base discussions with patients.

Isobel D Walker consultant haematologist,
Glasgow Royal Infirmary

Items reviewed are rated on a 4 star scale
(4=excellent)



A Beautiful Mind

Directed by Ron Howard

A film from Dreamworks Pictures/Universal Pictures/
Image Entertainment

UK release date: West End cinemas from 22 February,
nationwide from 1 March

Rating: ★★★

This film, “inspired by events in the life of John Forbes Nash,” is a true life fantasy. Nash is a lucky man. Firstly, he overcomes schizophrenia. Then he wins the Nobel prize for economics. And then he finds himself portrayed by Hollywood’s hottest heartthrob, Russell Crowe.

The setting is the Ivy League universities on the east coast of the United States in the 1950s and 1960s, a time when science and mathematics were sexy. Einstein was the campus idol. The US psyche was, however, troubled. Lurking behind the optimism was the H bomb and the cold war. America’s predominant mental state was one of anticommunist paranoia.

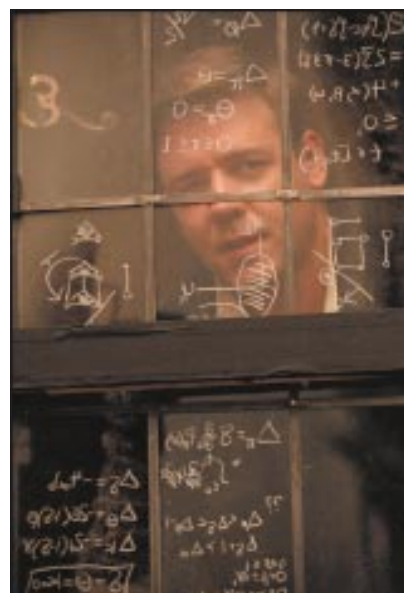
In such a mad world, the awkward, gauche maths prodigy from West Virginia, John Nash, found his niche. For someone who could produce mathematical formulae to explain apparently random behaviour and who could reduce human interaction to the rules of a game, it was a small step to seeing meaningful patterns in the random outpourings of newspapers and magazines—hidden messages from Soviet spies, warnings of Armageddon. Years of partially successful psychiatric treatment followed.

This, combined with Nash’s own brand of do it yourself cognitive therapy, led not so much to a cure but to a useful recovery. His early intellectual contributions took on contemporary relevance and the plaudits followed.

The film lures us unsuspectingly into an elaborately constructed, impressively realised, three dimensional psychotic world. Fortunately, I have never viewed psychosis from the inside but judging from the hundreds of accounts I have been given and hear every day, it is not like this. The hallucinations of schizophrenia are fragmented and disembodied, as are the delusions that sustain them. On the other hand, seeing significance in the mundane and the struggle to find order amid chaos are common enough. The film does convey the palpably real pain of family and loved ones and how the loss of potential and opportunity follows invariably in the wake of this terrible illness. Psychiatry, in the end, is not portrayed unsympathetically. The drugs do work—albeit with side effects—and they are getting better.

A Beautiful Mind is an engaging and compassionate film. It nevertheless manages to reinforce most of the enduring myths about severe mental illness, not least the link between genius and madness, the healing properties of the love of a good woman, and the brutality of some psychiatric treatments. Enduring because all, save perhaps the first, have some basis in reality. Furthermore, you can’t really blame the screenwriter and director. Imagine trying to pitch a more realistic tale to the studios: “There’s this average guy, well, a bit below average actually, who doesn’t really achieve anything special and then he gets schizophrenia. He recovers a bit but then gets ill again. Things go up and down, then he dies.” Would you go and see it?

Those who have read Sylvia Nasar’s scholarly biography of Nash (Faber and



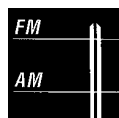
© 2001 UNIVERSAL STUDIOS AND DREAMWORK LUELI REED

Winning formula? Russell Crowe as John Nash

Faber, 1999) will miss the attempt to demystify some of his mathematics, whose origins remain as spooky and ineffable as his madness in the film. They may also note the odd discrepancy between book and film. No mention is made of the fact that Nash’s son, also a talented mathematician, also had schizophrenia.

The confusion between fantasy and reality is at the heart of this film and John Nash’s amazing story. It is both its subject and object. But the inescapable fact is that it’s about a guy with schizophrenia and it has a happy ending.

Anthony David professor of cognitive neuropsychiatry, Institute of Psychiatry, London



28 Minutes to Save the NHS

BBC Radio 4, Wednesdays at 11 pm,
6 to 27 February 2002

The quality of health care is causing a major crisis throughout the Western world. In the United Kingdom we love to bash the NHS, but have little to compare it with, in the way that Americans can compare managed care with fee-for-service. They moan about the evils of managed care, but are gradually realising, in the words of quality expert Bob Brook from US think tank RAND, that “managed care is not the problem, quality is.”

In Australia, New Zealand, and the United Kingdom, the quality of health care in general practice has almost never been

found to meet acceptable standards. Even France and Germany have huge variations in quality, as the fearless travelling NHS overflow patients may be discovering.

What can we do about this terrible state of affairs? New Labour has spawned a host of new agencies with Orwellian names—from the Commission for Health Improvement to the NHS Modernisation Agency—to solve the problem, all so far to no avail. But now the BBC has unleashed its secret weapon in the national drive to improve the NHS—Phil Hammond, David Spicer, Bob Baker, and Pete Hambly’s new satirical series, *28 Minutes to Save the NHS*.

The central idea is the uncomfortable but essentially plausible one that doctors are human. Not only do they inevitably make mistakes, they may not worry that much about them. “Lighten up about death,” we are urged—the responsibility for medical cock ups lies with the patient who does not ask for enough information, or perhaps the system that allows doctors to practise in such a variable way.

The second episode tells us that the NHS was designed to deliver four treat-

ments: fresh air, Ovaltine, an extra potato, and a sharp tap from sister’s pencil. The RAWP (resource allocation working party) formula finally became clear to me: it’s tied to the price of pencils and potatoes. We also hear an interview with an alarmingly realistic secretary of state for health, who is unable to say “rationing,” and discover that the next medical scandal after Alder Hey (“pathologists collect pathology specimens”) will be: “surgeons cut you up with knives.”

This series has the potential to achieve more than a host of government agencies can, and may well evolve into the Commission for Health Care Satire, with an official brief to inform an unwilling public that medicine is riddled with uncertainty. I recommend catching the final episode next Wednesday. Be prepared to feel uncomfortable, whether you are a doctor who has ever performed a TUBE (“totally unnecessary breast examination”) or patient who has never inquired about their doctor’s competence (“Are you mad?”).

Nick Steel Institute of Public Health, Cambridge



How parents decide on MMR

A radio journalist describes giving one family a unique perspective on the triple vaccine story

Early in the new year I was asked to work on an in-depth piece about MMR. I “adopted” the Warburton family, who had emailed the BBC saying that they were in a quandary over whether or not to vaccinate their 14 month old first-born, Phillip. It seemed the simplest way to illustrate how parents are thinking, and the effect that the polarised arguments for and against MMR are having on them.

I took the Warburtons to see some of the people who have had a role in the debate: Dr Peter Mansfield, who was referred to the General Medical Council for offering single vaccines and whose case was dropped; Dr Elizabeth Miller at the Public Health Laboratory Service; and the charity Sense, which represents people who are deaf and blind, which is often the result of rubella. They spoke to the deputy chief medical officer, Dr Pat Troop; and they conducted the only interview with Dr Andrew Wakefield during the week of his most recently published material.

Darren and Carol Warburton had read on the internet about possible links with autism and bowel disorders and they were hungry for as much information as they could get. They were ready to be convinced either way, but the BSE (bovine spongiform encephalopathy) scandal had left them distrustful of government policy. Perhaps most interesting was the fact that they really couldn't decide where to draw the lines between government and medical professionals' advice. They wanted to trust their doctor and health visitor, but they felt they were being spun a political line.

I'd love to say the journey—which was broadcast on BBC Radio Five Live every morning from 4 to 8 February—helped them, but it pulled them from pillar to post. Dr Mansfield told them that most advisers sang from an official hymn sheet and that healthy children had nothing to fear from the three viruses. Dr Miller took them through the scientific evidence and the potentially horrible consequences of measles. The director of Sense said he felt that MMR was the best option but that if they were really opposed to it they should at least have single vaccinations. Dr Troop assured them that the government's scientists knew best. And Dr Wakefield said that he would need some time yet to prove any links, but he admitted it was theoretically possible that the measles in a single vaccine might have affected the intestines of children just as he believes that measles in MMR might have done.

What really swayed the Warburtons the most was the personal touch. When Peter Mansfield said that they were right to



BBC RADIO FIVE LIVE

The Warburtons: swayed by the personal touch

question the official line, they felt vindicated. Elizabeth Miller's science talk impressed them, but it was when she talked of her own children that they warmed to her advice the most. Pat Troop's comments about truly wanting what was best for Phillip stuck in the mind. And it was the conviction in Andrew Wakefield's voice when he talked about listening to parents' worst fears that impressed Darren and Carol, and not the results of his research.

The Warburtons have decided to opt for single vaccines, after toying with the idea of no vaccine at all. If single vaccines had been available on the NHS, I don't think they would have thought twice—it would have endorsed their concerns over MMR.

I've not publicly said whether my children have had the vaccine because I have a responsibility not to influence listeners' medical decisions. I'm a journalist, not a doctor. But I've watched the Department of Health box itself into a corner over this vaccine. It has huge amounts of scientific evidence to back up its policy. Anyone who cares to read it all can see that it is overwhelming. Parents know that. They've been told. But the decisions we make about our children's health are, in the end, a lot to do with individual emotions—confidence, trust, fear. If Tony Blair had been able to talk personally of his and Cherie's dilemmas over vaccination, it probably would have held much more sway with undecided parents than any medical research.

Halfway through their journey, Darren and Carol said that the more insistent the government became, the more they distrusted its advice. So when Professor Liam Donaldson called a press conference to endorse MMR, flanked by the great and the good of the medical world, it was the last straw. If more measles outbreaks are to be avoided, parents have to feel as though the medical profession isn't pulling rank and dismissing their concerns.

Sharon Alcock *health specialist, BBC Radio Five Live*

You can hear the Warburtons questioning Andrew Wakefield at www.bbc.co.uk/fivelive/audio/mmr.ram and you can read about the Warburtons' week in full at www.bbc.co.uk/fivelive/breaking_news/20020204_mmr.shtml



WEBSITE OF THE WEEK

Venomous creatures Britain has less than its fair share of venomous creatures.

The only poisonous snake is the adder, and while its bites can cause painful swelling and fever, they are rarely fatal. UK Safari (www.uksafari.com), a site for anyone interested in British wildlife and countryside, says that the last fatal adder bite in Britain was in 1972.

Australia and its waters, on the other hand, are teeming with poisonous reptiles, spiders, arthropods, and marine creatures. Whereas adders are generally shy of humans and will move away if approached (www.uksafari.com/adders.htm), the Sydney funnel web spider is aggressive with large, powerful fangs and mouse spiders, found throughout Australia, “are aggressive, and will adopt an attacking posture when threatened, rearing up on their hind legs.” These descriptions come from the Australian Venom Research Unit (www.avru.unimelb.edu.au/pharmwww/avruweb/index.htm), which was founded by Struan Sutherland, whose obituary appears in this week's *BMJ* (p 488). More than a mere menagerie of nasties, the site offers clear guidance on first aid and treatment to lay and medical surfers alike.

The internet is an ideal place to exchange information about venom, antivenom, and the most effective treatment strategies for potentially lethal bites and stings. There are sites from all over the globe—for example, http://snspkz.lorton.com/vid/index_eng.html from the Toxicology Center of the Republic of Kazakhstan, which has valuable information on the poisonous snakes and spiders of central Asia, and <http://ntri.tamuk.edu/> from the Natural Toxins Research Center at Texas A&M University, Kingsville, which has a serpentarium database with details of snakes from all over the United States. The hard thing at present is how to find exactly what you want. However, there are some excellent links pages, which aim to bring much of the information together—for example, The Arachnology Home Page (www.ufsia.ac.be/Arachnology/Arachnology.html), which describes itself as the arachnological hub of the worldwide web.

Trevor Jackson
BMJ
tjackson@bmj.com

PERSONAL VIEW

A day in the field that changed my methodology

In India, more than 60% of the population use the services of private general practitioners. I had planned a study to assess GPs' knowledge of diabetes using a quantitative questionnaire based on semi-structured interviews. To pilot my questionnaire I went into a densely populated area of north Delhi and noticed how patients could choose a doctor from many on the same street.

I stepped into a private GP's clinic, introduced myself, and explained the purpose of my visit. This clinic was small. It had a desk, an old cabinet, a partition behind which the GP examined the patients, a washbasin, and some chairs and benches for patients to sit on. The paint was peeling off the walls. It was the peak of summer with temperatures reaching 44°C, but the fans were not working because of power cuts. There were no patients. The doctor met my pre-prepared questions with disinterest. "What is the point of asking me all these questions? I don't see such patients. Patients never come back to me for follow up," she said.

A patient came to the gate and asked, "How much do you charge?" The doctor said, "Thirty rupees" (US \$0.80). The patient said in astonishment, "What, 30!" The doctor calmly nodded yes. The patient then inquired, "Medicines?" The doctor said, "You will have to buy them." The patient was further aghast and exclaimed, "What! The other doctors include medicines in that much money." The patient turned and left.

The doctor explained that this was a daily feature. She had qualified at a reputed medical college in Delhi but her 10 years in private practice had left her completely disenchanted. "Non-qualified doctors have ruined the medical practice. They are the ones who get all the patients, not us," she said. Across the road from her a quack, practising as a doctor, was seeing more than 60 patients a day.

I was astonished at the pathetically low consultation fee and how health care was treated like a commodity. I began to wonder what effect this had on the attitudes, behaviour, and practices of GPs?

Soon thereafter, an obese lady in her mid-forties walked in. The doctor examined her and wrote a prescription. The patient left after paying. The doctor said, "She has a urinary tract infection, but I cannot ask for a blood glucose. I can ask only for a urine glucose, as these patients feel that the problem is in the urine. If I insist on a blood glucose she would simply consult another doctor."

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com



Lots of data from lots of people would not get to the root of the problem

The look in the doctor's eyes showed her sense of frustration. The patients' perceived needs, idiosyncrasies, and financial limitations governed her practice. From the GPs' perspective the patients were their providers. The GPs were forced to give in to their perceived needs.

Talking about microalbuminuria, glycosylated haemoglobin, and lipids seemed far fetched when getting simple tests was so difficult. It dawned on me that my carefully planned questions about these things seemed almost irrelevant to the GP's clinical practice. Many factors, other than knowledge, determine how doctors practise.

My quantitative research method seemed inappropriate to understand the root causes of poor management of diabetes mellitus. The questionnaire filled with truthful responses would have had "face validity" but would have lost out on understanding the core issues.

We wanted to acquire meaningful data that helped in giving explanations and in planning and implementing interventions, and therefore decided to amend the research methodology from a quantitative to a qualitative approach. Through the use of ethnographic methods such as direct, non-threatening observation and free-flowing interviews, we were able to discern sensitive key issues that frame the practices of doctors and patients and from it acquired cues for planning interventions.

Shifalika Goenka senior research fellow, department of endocrinology, All India Institute of Medical Sciences

SOUNDINGS

The inaugural

Planning your inaugural lecture? You need to decide what to say, what to wear, and whom to invite.

Anyone who has been on the payroll for more than 40 years gets to come automatically. Their brief is to occupy the front three rows and stare disapprovingly if you say anything controversial.

For the most part they will feign sleep, but on the stroke of six they will make a swift dash for the refectory via a little known passageway. By the time that you arrive with the main cohort of guests, they will have stationed themselves against the bar, lit smelly cigars, and consumed the lion's share of the claret and canapés.

To redress the balance, you need a good showing of youth, gaiety, and intellectual curiosity. Medical students can be hired for the purpose—the going rate is a tenner each (for £15 they will laugh at your jokes on cue).

What to wear? If you are male and under 45, you need a Marks and Spencer sports jacket and a pair of well cut chinos. Older, and you should go for a mid to dark grey suit, off white shirt, and fading alma mater tie. Have your hair cut Albert Einstein style, and hold your head at an angle of 15 degrees to the vertical so as to appear eccentric and quizzical.

If you are female, your outfit must say four words: sod the glass ceiling. Assuming you lack the credentials to don the national costume of an under-represented ethnic minority, you have three choices. The first is unwashed jeans and a stud through your tongue. But unless you have a first degree relative on the throne or a Nobel prize within your grasp, such behaviour is likely to get you branded a silly girl. The second is full academic regalia (check your cv—you will probably find that you are eligible for a red gown with black and gold epaulettes by now). If you carry this off well—with ample bosom and firm jaw—the faculty might commission an oil painting of you to go in the entrance hall.

The safest option is probably a pair of three inch stilettos and a slinky black dress. This will allow the crusty old dons in the front row to fantasise about you draped over the bonnet of a Ferrari once they have ceased to follow your line of argument.

And what to say? Frankly, as long as you don't offer a faultless critique of the dean's latest publication, no one will give a damn.

Trisha Greenhalgh professor of primary health care, University College London