

Radiation from CT and perfusion scanning in pregnancy

EDITOR—In her news article Eaton notes that most of the rise in medical radiation exposure is due to computed tomography.¹ However, the whole body effective dose given for computed tomography may not reflect the increased risk to individual exposed body areas.

Last year we assessed the risks for pregnant women undergoing investigation for possible pulmonary embolism.² The British Thoracic Society guidelines 2003 recommend computed tomography for pulmonary angiography as the modality of choice for non-massive pulmonary emboli.³ It is also recommended for pregnant women because of the low fetal dose compared with low dose (50 milliBequerel) technetium-99m perfusion lung scans.

According to our local data, the maternal whole body effective dose for computed tomography for pulmonary angiography was 2 milliSievert (mSv) compared with 0.6 mSv for a low dose perfusion scan. The absorbed doses to the fetus were 0.01 milliGray (mGy; risk of fatal cancer to the age of 15 years is <1/1 000 000) for computed tomography for pulmonary angiography and 0.12 mGy (risk of 1/280 000) for the perfusion scan. This shows a distinct advantage to the fetus of performing computed tomography for pulmonary angiography.

However, the absorbed doses to the breast were 10 mGy for computed tomography for pulmonary angiography and 0.28 mGy for a perfusion scan, about 40 times the dose to the breast at a time when proliferating, pregnant breast tissue would be expected to be at greater risk.

When available and appropriate, lung perfusion scans should be considered the investigation of first choice for any young woman. Pregnant women with a family history of breast cancer or who have had previous computed tomography for pulmonary angiography may wish to elect for lung perfusion scans, despite the slightly higher risk to the fetus.

Computed tomography is a valuable, but high dose, investigation. Although the over-

all risk is very small and usually completely outweighed by the benefits of obtaining a prompt diagnosis, it is still important to choose the technique that entails the least risk.

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Model of outcomes of screening mammography

Spontaneous regression of breast cancer may not be uncommon

EDITOR—The model of outcomes of screening mammography by Barratt et al proposes that more breast cancer is diagnosed among screened than unscreened women.¹ The model predicts about 40% higher cumulative incidence in women screened biennially during a 10 year observation period.

Two important underlying assumptions in mammography screening are that the sensitivity at the screening is comparatively high (>75%) and that spontaneous tumour regression is uncommon. From these assumptions, it emerges that most of the difference in the cumulative incidences between screened and unscreened women should disappear if a prevalence screening of previously unscreened women had been done at the end of the observation period.

In particular, the model predicts that if women were followed up from 40 to 69, the cumulative 30 year difference between screened and unscreened per 1000 is $(17.6-13.2)+(28.1-19.8)+(32.5-23.9)=21.3$ invasive breast cancers.¹ To

compensate for this difference, the detection rate at a prevalence screening of previously unscreened women at age 69 should be 21.3 plus the background incidence. However, less than 50% of this difference is compensated for by prevalence screening at age 69.²⁻⁴ Thus, at least one of the two assumptions above should be modified.

Prevalence screening detects most of the slow growing cancers, and the detection rates at the following screenings are stable at a lower level.² This indicates that it is true that the sensitivity is comparatively high. We are therefore left to conclude that for small invasive breast cancers, spontaneous tumour regression is not uncommon.

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Information needs to support informed choices

EDITOR—Barratt et al report that for every 1000 women screened from the age of 50 over 10 years, two fewer will die from breast cancer and 13 more will be diagnosed with breast cancer (corresponding to 63% more cancers, which mostly constitute overdiagnosis).¹ Similarly, we found that for every woman who has her life prolonged, five healthy women, who would not have received a breast cancer diagnosis in their lifetime if there had not been screening, will be converted into cancer patients unnecessarily.²

However, it is important to inform women that the often used estimate of 25-30% for the survival benefit is uncertain and rather optimistic.^{2,3} Barratt et al even used 37% since they adjusted their estimate of 25% for non-compliance. This



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procedure is doubtful since, as noted by two of the investigators in the screening trials, women who refuse to be screened have a worse prognosis, presumably because some of them are afraid of having a suspicion of breast cancer confirmed.⁴

These women also have a much higher death rate from all causes.⁴ We disagree that one can equate two fewer women who will die from breast cancer with two fewer who will die from any cause.¹ An effect of screening on all-cause mortality has not been shown.^{2,3} Breast cancer mortality is an unreliable outcome that is biased in favour of screening⁴; and the extra treatment because of overdiagnosis would be expected to lead to excess mortality in the screened group.⁵

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Women's decisions about screening depend on many factors

EDITOR—All women would like accurate and balanced information to help them decide whether or not to participate in screening programmes. So the question is whether the information presented by Barratt et al in their article actually provides accurate or balanced information.¹ We have our doubts about this.

The article is based on assumptions about the "harms" associated with false positive results from screening. Although we acknowledge these harms, we would argue that the harms associated with false negative results are even greater. False negatives may lead to death. Most women would be prepared to cope with the problems of anxiety, etc, if they understood that there was a trade-off with the possibility of death.

The next issue is how accurate these "estimates" are. We are not in a position to argue this at the present time; the statisticians will need to get to work to be able to determine the answer to this question. But be reminded that they are estimates. If the range of estimates for overdetected ranges from 2% to 30%, just how much value can be placed on this concept? We would argue that overdetected is not the issue; the main problem is the overwhelming desire by clinicians to treat women—that is, overtreatment is more of a problem than overdetected.

Even if these estimates are accurate, will this information actually help women in

making their decisions? These figures are of only partial value to women. Although women will take these estimates into account, they also base decisions on factors such as their own personal value systems, their fears of developing breast cancer, and their personal circumstances. Estimates such as this have a limited role in their decision making.

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Authors' reply

EDITOR—Zahl and Mæhlen and Gøtzsche and Jørgensen cite a variety of evidence, consistent with our model, to propose that overdetected (and potentially overtreatment) may be substantial in breast screening. Furthermore, Zahl and Mæhlen say that the biological mechanisms underlying the observed overdetected may include regression of small cancers, as well as non-progression.

Although the frequency of regression is as yet very unclear, evidence from epidemiology and cancer biology are indeed consistent in pointing towards biological mechanisms that control early cancer.^{1,2} In future, molecular markers may help clarify which screen detected cancers will progress and therefore warrant treatment, and which can be treated minimally or even left alone because they will remain asymptomatic or regress. Evidence already exists that screen detected cancers with certain mammographic features (small, stellate lesions in particular) have an excellent prognosis regardless of treatment regimen.³ Future research findings will provide much needed information on this issue for screening policy, management decisions, and participants in screening programmes.

Our optimistic estimate of the effect of breast cancer screening is plausible and defensible. We probably overestimated the impact on total mortality as there is no allowance for harmful effects of screening, particularly the mortality (and morbidity) from treatment of screen detected disease. As noted above, the extent of this is currently unclear.

We agree with Lockwood et al that these are only estimates. However, potential participants should be aware of the uncertainty surrounding outcomes of breast screening. Decisions still have to be made, and our estimates, although imperfect, represent a realistic general picture.

False negatives may be viewed as an important harm of screening, included under interval cancers in our model. However, overdetected and the potential for overtreatment are important but largely ignored outcomes of screening that warrant

attention. Public views about overtreatment are largely unknown, and it remains to be seen how people view the possibility of receiving cancer treatment unnecessarily. Early evidence suggests women want to be told about it and want to take it into account when considering screening.⁴

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Methods of hysterectomy: should women have a say?

EDITOR—The review by Johnson et al shows that vaginal hysterectomy outperforms (open) abdominal hysterectomy on all outcomes for which there is evidence from randomised controlled trials, and laparoscopic hysterectomy outperforms abdominal hysterectomy on all except injuries to the bladder or ureter.¹ In practice, abdominal hysterectomy dominates, so Edozien in his editorial reasonably advocates more training in vaginal surgery and the development of evidence based guidelines about choice of surgical method.²

Questions must also be asked about how women should be informed about, and enabled to influence, the selection of a method for their hysterectomy.

We recently found that 25% of women surveyed before a hospital admission for hysterectomy had not been told what method they would have.³ Fewer than half had been told about the advantages or disadvantages of different methods. Women knew, or learnt as they discussed their forthcoming hysterectomy with friends, that there are different methods. The women whose gynaecologists had told them that vaginal or keyhole surgery was not feasible because of their particular pathology—for example, large fibroids—apparently accepted this. But some women whose gynaecologists did not discuss alternative methods of hysterectomy wondered whether the selection was made in their interests or their gynaecologists'. None expressed awareness that some gynaecologists only perform certain methods of hysterectomy.

Decisions between hysterectomy methods may be preference sensitive. Although the review team consider laparoscopic surgery preferable to abdominal surgery,¹ some women may be more concerned to avoid higher risks of bladder or ureter injury than to obtain other benefits associated with the laparoscopic method.

Especially in the context of renewed calls for greater choice for patients about type of treatment,⁴ the nature and acceptability of constraints on individual choice between hysterectomy methods need careful consideration, as do the desirability and feasibility of revising consultation and referral procedures to give women more say about their surgical procedures.

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Changes in atopy over 25 years Allergy epidemic has spread to old age

EDITOR—The data presented by Law et al on changes in atopy over 25 years seem to challenge the idea that respiratory allergies affect mainly young people.¹ They present evidence that atopy (detectable serum IgE antibodies against inhalant allergens) has increased in middle aged men over recent decades.

Furthermore, their results support the notion that atopy is a reasonably stable condition, since the prevalence of atopy was similar in two groups of people from the same birth cohort examined at 40-50 and 55-64 years of age. Data from a Danish prospective, population based cohort of 15-69 year olds have shown that hay fever is a stable condition.

The eight year remission rate of hay fever symptoms was 15%.² However, remission of symptoms and sensitisation was only 2%, which underlines the chronic, intermittent nature of hay fever. In this prospective cohort followed up over eight years (1990-8), the prevalence of atopy increased among subjects who were younger than 30 in 1990—those born during the 1960s or later—and remained unchanged among subjects who were older than 30 in 1990.³

These results support the idea that, in Denmark, the increasing prevalence of

atopy is caused by a cohort effect—an increase associated with being born around 1960 or thereafter. These “allergic generations” may have been subjected to a more urban and Western lifestyle than earlier generations, increasing their susceptibility to allergy. Although this cohort effect may point towards early life risk factors, it is increasingly being recognised that adults can also develop atopy if they are exposed to changes in risk (or protective) factors such as migration to more urban areas.⁴ The allergy epidemic may be spreading to old age.

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Atopy now affects wider age range

EDITOR—In the previous letter responding to the paper by Law et al on changes in atopy over time Linneberg asks whether the allergic epidemic has spread to old age.¹ We recently tried to answer a similar question by retrospectively reviewing our patients' records, the results having been presented as an abstract at the last annual meeting of the American Academy of Allergy, Asthma, Immunology.²

In the past five years 956 patients (306 male and 650 female) aged 60 and older (median 76, range 60-93) were referred to our allergy clinic for suspected atopic conditions. All of them underwent skin prick testing with the most common inhalant allergens, and 318 (33%) were found positive with a wheal of at least 3 mm, men being more often positive than women (40% (123/306) v 30% (195/650), $P < 0.005$).

The median age of these subjects was 65 (range 60-86). The allergen profile of skin positivity was similar in men and women and was characterised by a clear prevalence of pollens (78% (96/123) v 75% (147/195)) over dust mites (41% (51/123) v 36% (71/195)), animal danders (18% (22/123) v 16% (32/195)), and moulds (6% (7/123) v 8% (16/195)). Rhinitis (hay fever) was the most common complaint (74% (235/318)), whereas asthma was present in 33% (105/318). In 22% (70/318) the clinical onset of atopy was at or after their 60th birthday.

We conclude that atopy is spreading to old age. We need to be aware of this phenomenon so as not to underestimate the role of atopy in the respiratory conditions affecting elderly people. We will also need to draw specific guidelines for the management (allergen avoidance, pharmacological treatment, immunotherapy) of atopy in such patients, who often have important comorbidities.

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Where next with revalidation?

Smart money is on using new communications technology effectively

EDITOR—I assume that the survivalists of the profession will get into revalidation—better to be reporting on people than being reported on.¹ The authorities need to look at practice in terms of how much daily evidence based peer review is going on in a team.

In our medium sized (non-training) practice journal articles are sent around the email system every day for discussion. Any interesting article results in an email to our audit clerk to search on our patients to see how we are performing with reference to it. The results are circulated and so practice is influenced. The audits are collected and presented at the weekly practice meeting for further action. Many clinical cases and much experience are shared by email to ensure that one doctor's experience is disseminated.

We rarely have set meetings for education and peer review because so much is going on all the time. The authorities must recognise that this patient based education and peer review is far more effective and valid than certificates of meetings attended. It means that I can do a full eight sessions of contact with patients a week and still be home for tea and family, while in many ways being better informed and educated than ever.

It is not rocket science, and it costs nothing. It is a revolutionary way of staying up to date and well informed in a way that directly influences practice. It is worth far more than the cosy confidential chat of reappraisal, where mendacity is always tempting, or an examination, which can be studied for and will never represent patient focused learning.

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- 1 Norcini JJ. Where next with revalidation? *BMJ* 2005;330:1458-9. (25 June.)

Make CME and CPD compulsory with support of audit and mentoring

EDITOR—Walsh and Benson say that changes to UK professional regulation have lacked strategic direction, that the current reviews offer an opportunity for fundamen-

tal reform that can regain public confidence, and that public and political faith in the professions and their regulators is lower than ever before.¹ However, despite a small number of high profile (and very frequently cited) cases, the public continues to give doctors an approval rating of some 90% in the BMA's annual poll. Politicians, lawyers, and journalists tend to receive trust ratings in the order of 20%. It is these latter groups whose voices are loudest in calling for ever increasing regulation of doctors.

The public are wise enough to recognise that the appalling crimes of Shipman were a one off. This evil man would have sailed through any revalidation process, and it is bogus to cite his uniquely evil deeds as an argument to pile yet more costly and time consuming processes on working doctors. His *modus operandi* is blown and cannot be repeated. Dame Janet's view that appraisal and revalidation was about stopping the next Shipman is in my view a big mistake.

The answer to optimising performance is regular compulsory continuing medical education and continuing professional development supported by audit and mentoring, combined with a fair but robust independent inspectorate that can be alerted by safe whistleblowing. Rather than concentrating efforts and resources on stopping the bad doctors, we need to restructure so that every doctor is helped and guided to improve his or her performance.

Appraisal, in which I am involved, is a useful developmental exercise, but this has not been proved to improve performance. The costs locally have been something like £1000 per general practitioner (appraiser fee of £500, £400 for appraisee, plus admin time). This money could have been spent to better effect on providing and supporting education.

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Political will does not exist for radical reform

EDITOR—Walshe and Benson underline the importance of the primary mission to protect the public.¹ But little is written in their article about the inadequate arrangements for managers—deemed to be a group of professionals at the Bristol inquiry—that still exist behind closed doors rather than in the public domain. Just as a list of wayward doctors can be reeled off, it would be possible to reel off a list of managers who have not acted in a way compatible with “professional” codes; unlike doctors, rather than being held to account, the managers are often simply and quietly moved on, sometimes into another healthcare post.

The accusation levelled at doctors and other healthcare professionals by Walshe

and Benson, of blocking or watering down reforms, is probably valid, but it can be equally applied to managers, as can the accusations of looking after self interest rather than the interests of the public and the safety of the public.

I agree with Walshe and Benson that radical reform is needed for healthcare professionals, including managers. However, that is very unlikely to happen under the current government as despite the very strong case and call for proper regulation of managers after the Bristol inquiry, the Department of Health chose not to introduce the recommended register and regulatory body for managers that would have been answerable to what is now the Council for Healthcare Regulatory Excellence. Instead ministers introduced another code of conduct in October 2002 that fails to deter wayward managers and offers no protection to the public.² That type of response to public concern generated by the Bristol inquiry should not inspire public confidence and looks like protection of self interest and painful sloth; however, it makes the attempts at reform by the General Medical Council over recent years look positively rampant by comparison.

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1 Walshe K, Benson L. Time for radical reform. *BMJ* 2005;330:1504-6. (25 June.)

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Future of singlehanded general practices

All doctors must show that they work to acceptable standards

EDITOR—Singlehanded general practice and the work of singlehanders in general practice have been in the news in the recent years after the events relating to the late Harold Shipman and the various inquiries that have resulted. That Shipman was a killer is now incontrovertible; that he was a singlehanded general practitioner is unfortunate and continues to cast a long shadow on primary care and singlehanded general practitioners. It is also recognised that there were failures at various stages in his career that should have alerted the authorities much earlier than they eventually did.

The issues raised by Majeed in his editorial on the future of singlehanded general practices are valid,¹ but the same needs to be said of all doctors. Isolation could, and does, happen in multidocor practices where hierarchical practice structure and specialisation by some doctors in general practice facilitate isolation. Working in a larger organisation does not ensure freedom from isolation unless there is a culture of openness, audit, and reflection allied to a programme of work and education to ensure that doctors do not become deskilled in large practices.

It is important for all doctors to show that they work to acceptable standards irrespective of the place of work. This can only occur from a commitment to quality demonstrated by publication of results in accordance with criteria set out in the General Medical Council's document *Good Medical Practice*.²

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The NHS has room for variety

EDITOR—In his editorial on the future of singlehanded general practices Majeed makes a plea for the continuation of singlehanded general practice in UK primary care.¹

I have experienced the growth of a practice from a small to a large partnership, then the trauma of divorcing myself from partnership and creating a singlehanded practice, which through necessity had to grow to accommodate the requirements and, sometimes, inappropriate demands of the NHS. I thus have much practical experience of the benefits and problems associated with practice dynamics.

Some 15 years ago I proposed to our local general practitioners that we should continue working in our own local practices but be linked to a central hub for administrative and “shared” resources. Such shared resources could be services currently provided under enhanced services—minor operations, family planning, and childhood immunisations, to name but a few. Maintaining independent but linked practices allows individual doctors and practices to develop good practice, which can then be shared between all practices in the locality through the shared central facility—like moons and satellites, rather than solar systems.

Fifteen years ago my ideas were laughed out of town. I believe that now is the time to reintroduce the concept of local “policlinics” with satellite practices providing the administrative and technological backup for practitioners who prefer to remain “solo” while still providing the opportunity for large practices to develop. Cost increases would be minimised as the current trend to “supersurgeries” raises NHS overheads while removing much of the personal approach that smaller practices offer.

The NHS has room for variety. Patients soon learn to choose the type and style of practice that suits them. Technology—if used appropriately and sensibly—allows the “virtual” supersurgery in any village, town, or city without the need to lose the identity and enjoyment of primary care.

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