LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Expedition health and safety

Dr Anderson and Dr Johnson (November 2000 *JRSM*, pp. 557–562) conclude from their data that the health risks of participating in a well-planned expedition do not differ from those encountered at home during normal active life. Within the context of the article, their definition of an expedition is a good one—'an organized journey or voyage for a specific purpose'. But it also includes many package tours. Let me describe an incident in early 1999.

After ten strenuous days on trek in the mountains my party was staying at a resort in the Royal Chitwan Game Park, 4 hours by road from Kathmandu and reachable only by jeep or truck (or elephant in the rainy season) via 2 km of river bed. Came the tap on the shoulder that every doctor dreads: 'Excuse me, doctor, but I wonder if you could come and help us'. The patient was slumped at a nearby table in a party of elderly people. He was an Austrian aged 68, diabetic but carrying neither insulin nor pills (though, according to his wife, his doctor had advised him to do so). Fortunately, there was an Austrian nurse on hand to translate, unconnected with the party in question. He was on anticoagulants after recent major arterial surgery and was also receiving treatment for hypertension, heart failure and a gastric ulcer. The relevant pills had been transferred to 'non-medical' containers and could not be identified. His Glucometer could not be made to work, but we found some paper test strips among his possessions which confirmed our impression that he was hypoglycaemic. He responded well to correction of his blood sugar but then deteriorated sharply and seemed to have had a stroke. We considered the options—to do nothing, or to attempt evacuation to hospital. The decision was effectively taken for us, because the resort did not want the patient to remain and possibly die there. I leave to readers' imagination the difficulties of transferring the heavy and uncooperative patient, in darkness, first by chair and then by jeep and minibus, to the nearest hospital as he became more deeply unconscious. Eventually he was taken to a larger hospital in Kathmandu, where he died.

Exotic holidays are now being marketed aggressively to the older age group, who have time and money to spare. The advertisements sometimes give the impression that this is just another package tour, with first-world medical care to hand. They do not say that help may be hours away. Some insurance companies do require a declaration of good health; it is hard to believe that our Austrian patient, if he had revealed his history, would have been covered for travel to such a remote place. By the same token, it is wrong for large organizations to rely on fellow travellers to get their clients out of trouble. The Nepalese resort clearly had no contingency plans for such a major emergency. Three of us attended the patient during his transfer to the local hospital; the Austrian nurse and I lost a night's stay in the resort; and the party I was leading also suffered. Perhaps the worst part of our experience was the reaction of the resort management, whose interest was limited to getting the patient off their premises.

The big foreign tour operators must tighten up on the suitability of clients for such tours, and make sure that resorts have adequate plans for medical emergencies.

Simon Phillips
Institute for Refugee Health Care Studies, School of Postgraduate Medicine, University of Bath, Welfare Centre, Royal United Hospital, Bath BA2 3NG, UK

Why doctors get angry in Crown Courts

In his valuable essay (July 2000 *JRSM*, pp. 387–388) barrister Andrew Campbell-Tiech writes: 'The real problem is the system, adversarial at heart. It is not a search for truth'. To solve the problem, it helps to know where it came from. Chief Judge Richard Posner says the legal system derives from a small mediaeval craft guild or cartel whose members were mainly interested in money and status; the guilds, he says, 'were devices for maximising the net earnings of their members'[1]. The basic problem is the nature of justice. Former Justice Russell Fox says: '. . . the meaning which approximates most closely to it is ''Fairness'' . . . the public estimation must be correct, that justice matches with the truth'[2]. The cartel's post-November 1215 decision not to march with truth facilitated later anti-truth devices, including the adversary system, which is defined as one controlled by lawyers who can thus maximize their net earnings: judges have to make do with status.

Lawyers began to get control of civil litigation about 1450 but the criminal adversary system is barely 200 years old. From 1800, defence barristers effectively made it a get-the-guilty-off game via such truth-defeating devices as concealing relevant evidence and the 'reasonable doubt' formula, which jurors do not understand: former Justice Christopher Wright believes it results in wrong not-guilty verdicts in 25% of cases.

The community's witnesses, including doctors, have melancholy experience of techniques designed to pollute truth and create doubt—bullying, requiring yes or no answers, twisting words, tricks to force agreement that black is white. As Fox QC says, justice means fairness, and fairness requires a search for truth: Parliament should legislate to return control to judges trained for the first time in techniques of seeking the truth.

Evan Whitton
14/26 Cook Street, Glebe, NSW 2037 Australia

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Knowledge and the Internet

The eighth article in Dr Wyatt's series, on knowledge and the Internet (November 2000 *JRSM*, pp. 565–570), summarizes a complex and ever-changing topic particularly well. It seems that for doctors to fulfil the potential clinical uses of the Internet there are issues of software, hardware and connection networks to overcome. However, our recent survey of 200 British hospital doctors exposed even more basic problems with their use of computers. Although 59% (n=117) of our sample had easy computer access in their hospital, 36% (n=72) reported they could not type and 5% (n=10) that they could not use a 'mouse'. In these circumstances, computer use during consultations risks reduced eye contact and may jeopardize the doctor–patient relationship[1]. The desire of doctors to keep up as technology advances is perhaps reflected by 72% (n=144) of our sample welcoming a postgraduate course to increase their computer skills. Such courses should be encouraged to avoid a substantial proportion of hospital doctors missing the boat, and getting caught in the net.

G F Nash

N Donnelly

E F Nash

L F Turner

Hammersmith Hospital, St George's Hospital, Hillingdon Hospital, and Whittington Hospital

E-mail: guy.nash@ic.ac.uk

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Reversible dementia in Paget's disease

I enjoyed the report by Dr Chan and colleagues (November 2000 *JRSM*, pp. 595–596) but found their use of the term 'normal-pressure hydrocephalus' confusing. The syndrome of normal-pressure hydrocephalus (NPH) is characterized by the clinical triad of gait disturbance, incontinence and dementia, which may be caused by any form of chronic hydrocephalus. The cerebrospinal fluid (CSF) pressure is normal at lumbar puncture, and crucially, there is a communicating ('non-obstructive') hydrocephalus on brain imaging[1]. A small proportion of such patients have a past history of meningeal inflammation following, for instance, infection or haemorrhage, and the remainder probably have an age-related increase in the resistance to CSF outflow at the arachnoid villi. There is substantial clinical and radiological overlap between NPH and the effects of cerebrovascular disease, which may produce hydrocephalus *ex-vacuo* through brain atrophy. It is often difficult, therefore, to decide on the merits of placing a ventriculo-peritoneal shunt in the individual patient.

By contrast, the hydrocephalus in cases of Paget's disease with basilar invagination is 'non-communicating' or 'obstructive', resulting from distortion of the aqueduct of Sylvius and compression of the fourth ventricle and its outlets to the subarachnoid space. A single measurement of high-normal intraventricular pressure in an anaesthetized patient who has been positioned for surgery is unlikely to be valid, and cannot be used in the classification of that patient's hydrocephalus. The term NPH has a specific diagnostic meaning and should not be used for patients with tumours, colloid cysts, aqueduct stenosis, Paget's disease or other causes of obstructive hydrocephalus.

It is worth noting, also, that the Pagetic skull presents neurosurgeons with unusual technical difficulties. Not only can the bone be hypervascular and treacherously soft, but its increased thickness often exceeds the working length of standard instruments such as the powered craniotome.

Andrew J Martin

Institute of Psychiatry, De Crespigny Park, London SE5 8AF

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Management of colorectal liver metastases

In their article on alternative treatments to surgical resection for colorectal liver metastases (CLM), Professor Taylor and Dr Gillams discuss intrahepatic arterial chemotherapy and thermal ablation but not cryosurgery (November 2000 *JRSM*, pp. 576–579). Hepatic cryotherapy performed at laparotomy for non-resectable CLM is safe and feasible[1], and the reduction of serum carcinoembryonic antigen (CEA) after cryosurgery is predictive of survival[2]. Cryotherapy may be combined with regional chemotherapy with the rationale that cryosurgery destroys the gross disease within the liver whilst regional chemotherapy counters residual disease. Preketes *et al.* showed that patients who received regional chemotherapy after cryotherapy lived twice as long as those who did not[3]. Repeated cryotherapy has been difficult because of the need for multiple laparotomies, but repeated percutaneous cryotherapy under computed tomography guidance is now possible with rapid patient recovery (median hospital stay 3

days). The larger the ice-ball produced, the greater the fall in CEA and the slowing of metastatic growth[4]; however, there are no controlled data to suggest that cryotherapy produces greater survival benefits than other forms of interstitial ablation. We agree with Professor Taylor and Dr Gillams that controlled trials of liver resection with thermal ablation are required, but we suggest that a further arm of these trials should include percutaneous cryosurgery.

K S Hindle

S J Hindle

97 Queen's Drive, Surbiton KT5 8PP, UK

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4 Huang A, Mathur P, McCall J, *et al*. Dual-probe is more effective than single-probe cryotherapy for hepatic metastases. *Br J Cancer* 2000;**83**:45

Research as part of routine care

Sir Iain Chalmers, in his superb editorial drawing attention to the need for evaluative research to become part of routine care in the NHS (November 2000 *JRSM*, pp. 555–556), identifies the cultural and attitudinal changes that need to occur if this vision is to be realized, but there remain practical difficulties.

The first relates to funding. Until evaluation is built into the budget for the introduction of new technologies, it will continue to be difficult to secure funding for evaluation on a competitive basis, and even more difficult to time this so that the research can take place as the new technology is introduced. This is particularly a problem for service developments and for proper evaluation of changing roles.

Much could be achieved if routinely collected data about health service activity and quality were of sufficient validity to support health technology assessment. We are shortly to report a study which has sought to identify whether routinely collected data could be used with confidence in randomized controlled trials, and our preliminary conclusions suggest that they could if the availability and quality of the data could be improved. Improving the situation will, in itself, require culture change, but not a great deal of investment, as the processes for routine collection of data are in place. The problem is that they are under managerial and not clinical ownership and control. Until this changes, matters are unlikely to improve.

J G Williams

School of Postgraduate Studies in Medical and Health Care, Maes-y-Gwernen Hall, Morriston Hospital, Swansea SA6 6NI, UK

E-mail: john,williams@pgms.wales.nhs.uk