

Hamstring *v* patellar tendon autografts

A patient's and clinician's perspective

EDITOR—As a patient who has had a bone-patellar tendon-bone autograft for anterior cruciate ligament reconstruction, I agree with Biau et al's findings that anterior knee pain can be troublesome at times.¹ Biau et al also emphasise the importance of discussing such potential problems preoperatively with patients, especially those from Asia. Being Indian in origin, I have had to sit cross-legged or to kneel for periods at religious or social events, and this has led to serious discomfort afterwards.

As a clinician and researcher, I note the sound methods of this meta-analysis but that the quality of the studies was generally poor. The authors do not discuss publication bias. There was also no mention of cost in the article (both financial and quality of life).

Such comparative data are probably hard to come by, but the time and effort (of patients, practitioners, and physiotherapists, etc) necessary to achieve a complete return to normal activities is significant. Most patients who undergo these procedures are young and active, so these are important considerations that I would certainly look into were I to undergo knee reconstruction now.

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1 Biau DJ, Tournoux C, Katsahian S, Schranz PJ, Nizard RS. Bone-patellar tendon-bone autografts versus hamstring autografts for reconstruction of anterior cruciate ligament: meta-analysis. *BMJ* 2006;332:995-1001. (29 April.)

When to operate is important

EDITOR—Blau et al's meta-analysis shows that there is little to choose between hamstring and patellar tendon grafts in knee reconstruction.¹ Patients and their doctors also need help in deciding when to operate and when to decide for a conservative approach. As Blau et al point out, the referring practitioner decides the surgical technique by choosing the surgeon. The decision to operate at all is also made by the surgeon, unfortunately often based on fee

for service objectives, although the outcomes remain controversial.

It would be of great interest to patients and doctors to add an additional control group of conservatively treated patients (no surgery) into the evaluation of long term outcomes of anterior cruciate ligament rupture and its appropriate treatment.

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Author's reply

EDITOR—We hope that doctors will give more information about the outcome and problems related to both reconstructions and that young orthopaedic surgeons will take more interest in hamstring autografts.

Meta-analyses are not free of bias. The quality of reporting in surgical trials needs to be improved, and multicentre randomised controlled trials are needed to overcome sample size issues.

We are currently performing a meta-analysis based on individual patient data with the help of the principal trial investigators. The issue of cost, both financial and the quality of life, was not reported in the trials selected.

The indication for operation was not the subject of the analysis but remains vague for some patients and therefore to some doctors. The prime indication for anterior cruciate ligament reconstruction is symptomatic instability; its aim is to restore functional stability without compromising other joint function.¹ Therefore what holds for a 20 year old patient practising contact sports may not hold for a 30 year old sedentary patient who has no episode of instability independent of whether the knee is unstable on clinical examination. Therefore, the indication may sometimes be equivocal and is best chosen after discussion with the patient.

The scientific basis for anterior ligament reconstruction is that early stabilisation reduces meniscal pathology, which may in turn have a protective effect on cartilage

damage. However, operative treatment seems to yield better functional results, but there is no evidence that anterior cruciate ligament reconstruction prevents late osteoarthritis.²⁻⁴ Sound scientific evidence is lacking when offering someone reconstruction because of the difficulty in conducting surgical randomised controlled clinical trials.⁵

In surgery, as opposed to pharmacological trials, visible evidence often links disease, treatment, and results so not treating patients is difficult. Nowadays not reconstructing a knee when it is symptomatically unstable from tearing of the anterior cruciate ligament seems almost unethical.

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Confounders in chronic stress at work and metabolic syndrome

EDITOR—Chandola et al have fallen into the trap of confusing a clinical clustering of risk factors, the metabolic syndrome, with a physiological construct.¹ Their definition of metabolic syndrome is that of the NCEP-ATP III, a panel concerned with clinical identification of subjects at high cardiovascular risk. The panel report notes that excess body fat (particularly abdominal obesity) is an important determinant of the cluster, and a major target of treatment. There is, then, a danger of confusing aetiology with outcome by including abdominal obesity as one of the three risk factors used to define the metabolic syndrome.

Previous studies from this group have shown cross sectional and longitudinal relations of employment grade or work stress

with central obesity and weight gain.^{2,3} Therefore at least part of the findings in the current study are likely to be the consequence of greater weight gain in people subject to chronic work stress.

The dominant paradigm to explain the metabolic syndrome is low grade inflammation consequent on generation of adipocytokines, particularly from visceral fat,⁴ which may also account for both insulin resistance and vascular disease.⁵ While longitudinal changes in body mass index are likely to represent the consequences of positive energy balance, the relation between employment grade, or work stress, and central distribution of fat is more intriguing.

While this may in part be consequent on differences in physical activity or in smoking, the potential role of the hypothalamic-pituitary-adrenal axis might be worth exploring, as well as the role of adipose tissue generated cytokines in its activation, and in the autonomic nervous system changes which this group has also linked to the metabolic syndrome. However, any independent relations of employment grade or work stress will require rigorous adjustment for the confounding influence of body fat mass.

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Depression should be managed like a chronic disease

Myth of 15% suicide rate was promulgated again

EDITOR—Scott's editorial arguing that depression should be managed as a chronic disease perpetuates the myth that 15% of people with depression will eventually commit suicide.¹

A much cited meta-analysis in 1970 found that 15% of people with depression committed suicide.² It focused primarily on people admitted with severe depression, so it should never have been generalised to the broader population of people with depression.

Several rigorous studies have subsequently been published refuting the 15% claim. A meta-analysis by Bostwick and



Pankratz found a hierarchy of lifetime suicide prevalences: 8.6% in people ever admitted for suicidality, 4% in patients admitted with affective disorder but not specifically for suicidality, and 2.2% in mixed inpatient and outpatient populations.³

Boardman and Healy analysed data from a database of suicide cases in North Staffordshire, and used psychiatric prevalences from the US national comorbidity survey to calculate lifetime suicide risk in people with depression: 2.4% for any affective disorder and 1.1% for uncomplicated cases with no mental health service contact.⁴

Blair-West and Mellsop also found a much lower risk: "The suicide risk in major depression as it is currently defined diagnostically is of the order of 3.4% rather than the previously accepted figure of 15%."⁵ They noted: "Because every major textbook quotes a suicide risk in major depression of 15%, every good psychiatry trainee and, quite reasonably therefore, any speaker who needs to emphasize the seriousness of major depression as a public health concern, uses this figure too. What is probably the most surprising is that a single paper, that by Guze and Robins, could be so uncritically accepted and so widely promulgated."

Why is it still being promulgated by the *BMJ* 36 years later?

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What exactly is "depression"?

EDITOR—Scott implies that depression is always a timeless, free-standing, internally coherent, universally valid, pathological entity with a life of its own out there.¹ Classification systems (generally called international but in fact merely Western) provide definitions which seem to assume this. How-

ever, disclaimers in small print say in effect that diagnostic categories are not facts of nature (as, say, a tree is) but cobbled together phenomena emerging as committee decisions. Indeed, it was not inevitable that depressed mood should be seen as the cardinal symptom and name the whole syndrome. Other symptoms could have been used: sleep disorder syndrome or concentration and drive disorder syndrome.

What is the evidence that depression is under-recognised and undertreated? Some might point to a few community surveys using quantitative instruments supposedly tapping depression. Such instruments, with their demand characteristics and narrow focus on symptoms, generate inflated estimates of prevalence because of their structural inability to assess the whole person in the context of his or her life. We do not have an epidemic of depression but an epidemic of antidepressant prescribing (up two and a half times in a decade) in an age of medicalising and professionalising unhappiness and the problems of living. Good news for the pharmaceutical industry.²

Sociological, anthropological, philosophical, and, indeed, political frameworks are needed to understand properly human pain and distress in all its nuances and ambiguities, shaped by context and culture and above all centred on meaning (no medical model captures meaning). The depression as disease model does have some purchase (there is a subset of seriously ill people) but as a general formulation it says less about the world than the dominance of medicalised ways of seeing.

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Psychological treatment centres

The case against

EDITOR—Layard makes a strong economic case for treating depression and anxiety in primary care settings.¹ However, the potential pitfalls in outsourcing psychological treatment (for that is what it would be) are many.

Depression has many characteristics of a chronic disorder: studies show that 72% of patients have more than one episode and patients move between levels of severity and are ill for 59% of weeks.^{2,3} These more disabled patients contribute disproportionately to overall morbidity and tend to have needs other than psychological treatment—for example, help with social problems, occupational rehabilitation, and physical comorbidities.

These patients are best managed using collaborative care and stepped care models.⁴

A key factor is integrating care for depression (psychological and pharmacological) with other aspects of care, both physical and social. Therefore effective management of these patients requires coordinating multiple inputs.

Two models are relevant. The outsourcing of business processes is now commonplace but works best with comparatively uncomplicated tasks. In health care the chronic illness care model shows that such conditions are best managed in multidisciplinary teams with clarity of role, high quality information and communication, and effective team leadership and management.⁵ The outsourcing of one aspect of care is likely to lead to preferential referral of less complex cases, and consequent dilution of the impact of investment.

New investment should instead create and strengthen multidisciplinary primary care mental health teams integrated with general practice and specialist mental health services. The challenge is to establish the effective team structures required. This needs not only more trained cognitive therapists but also effective clinical leaders and managers.

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Quality of psychological treatment is important

EDITOR—Layard presents a strong argument for the need for more practitioners trained in empirically supported psychological treatments for mood and anxiety disorders.¹ Treatments such as cognitive behavioural therapy are as efficacious as leading drug treatments for mood and anxiety disorders but have lower relapse rates. They can also be effectively administered in groups, typically of six or eight patients, and are more cost effective than drug treatments.²

Although such psychological treatments have been available for decades, the shortage of qualified practitioners is woeful, both in England and elsewhere, including North America. Layard estimates that to meet the need for providing empirically supported psychological treatments in England some 10 000 new therapists must be trained. To meet similar needs elsewhere in the world some tens of thousands of additional therapists are required.

Skilled providers in psychological treatments are typically clinical psychologists or

psychiatrists. University training programmes for these specialties are typically small: as few as 6-12 newly trained specialists might graduate from a clinical psychology programme or psychiatry residency programme in any given year. They are unlikely to have the necessary resources or number of faculty staff to be able to meet the training needs for the thousands of new therapists recommended by Layard.

Diploma programmes in community colleges or other institutions could train large numbers of therapists quickly. But the question arises whether diploma mills can produce therapists with sufficient skills for clinical practice. In addressing the important problem of making psychological treatments available on a large scale, we face the important challenge of balancing quality with quantity. Poorly trained therapists, like poorly trained practitioners in other parts of clinical practice, may do more harm than good.

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May be less effective than suggested

EDITOR—Layard proposes establishing 250 psychological treatment centres for cognitive behavioural therapy in the United Kingdom.¹ His cost-benefit analysis is based on one new therapist treating 80 patients a year.

One patient would receive 16 sessions of treatment. One therapist would deliver 80 lots of 16 sessions a year (each session being 50 minutes of treatment and 10 minutes of documentation), or 1280 hours a year. Assuming this therapist works effectively 40 weeks a year at 38 hours a week (1520 therapist hours), he or she in an average week would spend 32 hours seeing patients and documenting sessions but only 6 hours in supervision, team meetings, training, corporate induction, focus groups, appraisals, primary care liaison meetings, drinking tea, chatting with colleagues. This would be laudable but seems unrealistic. In most NHS settings clinicians spend considerably less than half of their time on clinical work.

Moreover, the cost-benefit calculation is presumably based on patients who complete treatment. Real world settings (unlike research trials) are unlikely to achieve drop-out rates of less than 40%—a maximum of 50 patients for each therapist a year completing cognitive behavioural therapy under the above (over)optimistic conditions.

A more organic, more diverse, and less centralistic growth in psychological treatment is required in the NHS.

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Layard's vision has already started

EDITOR—In Layard's vision psychological treatment centres will improve access to individual cognitive behaviour therapy.¹ Access to such treatment has been improved in Oxfordshire through a group programme run by the charity Mind that focuses on building self esteem, coping with anxiety, and managing depression.

Group cognitive behavioural therapy is less widely practised in primary care and thus the evidence base is not yet established. However, we can learn from the voluntary sector.

I work in partnership with Mind and the Complex Needs Service (Personality Disorder), observing, supervising, and training Mind group workers. We evaluate each group and the last sample (n=53), though modest, showed significant reduction in scores on the Beck depression inventory and Beck anxiety inventory and similar improvements on a self esteem score. Satisfaction measures were high, indicating that people like to be seen in non-clinical settings (family centres, resource centres, Mind day services). Learning skills with peers was seen as particularly powerful in reducing feelings of isolation.

The model entails training non-statutory workers and providing high quality support and supervision by a clinical psychologist. Our group programme has proved effective, popular, and economical and could find a place in Layard's vision of a psychologically healthier future.

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Research for profit

EDITOR—The stumbling block for clinical trials in both the developing and developed world is the same, enrolment.¹ It is difficult to enrol patients into trials, and we rely on consent forms and the investigating doctor to protect patients.

Unknown to most patients, however, is the conflict of interest that exists at the time of enrolment. When I first started in general practice over 10 years ago I was asked to conduct pharmaceutical company research. The motivation to conduct this research was financial with the potential to earn £10 000 (£14 500; \$18 500) on top of NHS income. This is still common, especially in the most deprived areas of the United Kingdom. I conducted the research and enrolled 10 patients—I told patients that I was being paid but did not disclose the amount.

Later I was again asked to act as an investigator in another trial. On this occasion, however, I decided on complete transparency and disclosed the fee to the patients at the time of enrolment. I was unable to recruit any patients. So ended my involvement in research for profit.

The greatest incentive for doctors to conduct research and enrol patients for pharmaceutical studies is financial, either directly or to their institution. This situation is not ethical. Patients agree to participate in trials for altruistic reasons and put trust in the professionalism of doctors. Ethics committees should recognise this and insist the exact amounts paid to doctors and hospitals be disclosed to patients. Perhaps it is time also that independent non-profit groups and charities oversee and organise clinical trials.

Money, medicine, and research is a heady and seductive cocktail but has the potential for excess, risk taking, and recriminations.

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1 Iheanacho I. Drug trials—the dark side: This World. *BMJ* 2006;332:1039. (29 April).

Vacuums and maggots in orthopaedic surgery

EDITOR—Enoch et al discuss the role of non-surgical treatments and drugs in cutaneous wound healing.¹ Vacuum assisted closure is useful in orthopaedics in treating various non-healing wounds such as those secondary to trauma, fasciotomy wounds after release of compartment syndrome, large cavitating wounds after extensive soft tissue debridement, dehiscence surgical wounds (such as after hip replacement surgery), and pressure ulcers.^{2,3}

We have also found maggots to be beneficial in treating selected non-healing wounds in orthopaedic patients.⁴ Sterile maggots (which digest slough and necrotic material from wounds without damaging the surrounding healthy tissue) are effective in chronic wounds when wound beds are covered by slough or non-viable tissue as frequently found in chronic pressure ulcers and various forms of neuropathic ulcers. They are also useful in infected total knee replacements when the prosthesis is exposed.

Vacuum assisted closure and maggots should be considered as firstline rather than alternative treatment in hard to heal, cavitating, intransigent ulcers with sloughy and unhealthy wound beds.

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Selecting medical students

Evidence based admissions procedures for medical students are being tested

EDITOR—Parry et al's comprehensive summary of admissions processes in English medical schools closes with a gloomy picture of the current state of UK medical student selection.¹

There is, in fact, much going on. For example, one medical school has run trials of a personal qualities assessment procedure (PQA) for selecting medical students. In addition, Lumsden et al, whom Parry et al cite in the long version of their paper, centred on the experimental use of PQA in applicants to all of the Scottish medical schools.² The aim was to gather the scores of prospective medical students, not to inform selection decisions but to form the predictor variables against which to compare the later performance in medical school and ultimately professional progress.



MAXIMILIAN STOCK/SPH

PQA is a portfolio of psychometric tests that we have designed to measure some of the qualities that the literature and many surveys have indicated should be looked for in applicants to medical school. We developed this fresh approach to student selection after extensive consultation with stakeholders. Since 1997 the test has been administered to more than 20 000 people in a health professional context. The reliability of the component instruments has been carefully monitored and documented, and details of their construct validity (does it measure what it purports to measure?) have been published in the international peer-reviewed literature (see www.pqa.net.au for references).

Currently we are collaborating with medical schools in England, Scotland, Sweden, Australia, and Canada to evaluate the long term predictive validity of the test. Thus, much of what Parry et al call for is

being done by the PQA research team in collaboration with medical schools.

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- 1 Parry J, Mathers J, Stevens A, Parsons A, Lilford R, Spurgeon P, et al. Admissions processes for five year medical courses at English schools: review. *BMJ* 2006;332:1005-9. (29 April).
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A struggler responds

EDITOR—As a teacher of medical students and residents for my whole career, I appreciate the study of Yates et al predicting who will struggle with medical training.¹ However, has the end purpose of medical training been kept in mind? What about the qualities that we don't measure, such as empathy, honesty, and trustworthiness?

I have always told my more idealistic and emotionally available charges (who are usually the strugglers) that caring is necessary but that only caring informed by academic dedication is sufficient to be a good doctor. One quality without the other can lead to either a popular quack or a technician whom patients attend only because they have no choice. So I wonder about this study and what kind of doctors these strugglers will become if they make it.

My guess is that they will have just as good a chance at becoming good doctors as the academic stars. Each will struggle with the difficult realities of practising medicine in this new century. After years of practice I have seen these divergent approaches merge in doctors, the technocrats become more caring and the strugglers becoming proficient in practising academically based medicine. In the end, taking proper care of people is what we all wanted when we started down this road, even those of us who struggled.

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1 Yates J, James D. Predicting the "strugglers": a case-control study of students at Nottingham University Medical School. *BMJ* 2006;332:1009-3. (29 April).

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