Letters

Child Protection Companion: editorial group's reply to royal college rewriting history

Editor—Gornall is correct to raise the issue of Roy Meadow's and David Southall's omission from the reference list in the *Child Protection Companion*.[1 2] Southall, along with others, made contributions to the sections on fabricated and induced illness and imposed airway obstruction in chapter 6 of the *Companion*. Considerable notice was taken of Southall's views on these topics.

The editorial group discussed how to manage the references throughout the book and, for these sections, chose to reference only the two documents on fabricated and induced illness produced by the Royal College of Paediatrics and Child Health (2002) and the Department of Health (2002). We think that these documents covered the topic and referenced all the essential authors on this topic. In retrospect, however, the lack of appropriate reference to both Southall and Meadow is unsatisfactory, and their important work should have been acknowledged more fully.

Unfortunately, at the time of the preparation of the content of the *Companion*, the two professors were involved in the disciplinary process of the General Medical Council, which has still not been concluded in relation to Meadow and which reached an unfavourable outcome with regard to Southall.

We debated their difficult situation. We were concerned for them as individuals, particularly as they have both worked tirelessly in promoting the welfare and safety of children. We were also concerned about the outcome of the GMC hearings. We recognised the potential impact that an adverse outcome would have on the retention and recruitment of paediatricians into child protection and also considered any implications for the *Companion*, which we were in the process of producing. It is possible that had we referenced the two professors more fully, this could have provided lawyers and journalists with ammunition to undermine the value of the *Companion*.

We were always mindful of the objectives that we had set ourselves in producing the *Companion*. It was never intended to be a fully referenced textbook, and many seminal papers are therefore not referenced. It was written as a handbook that would be of help to paediatricians across the country on a day to day basis, in the management of children who may have been abused. The emphasis is on the common and everyday problems—such as the assessment of bruises, fractures, head injuries, and neglect. A decision was made to give less detailed advice on areas such as fabricated and induced illness and child sexual abuse because of other existing publications.

These decisions were collectively made by the editorial group and were not influenced by anyone outside of the group. Nor did anyone among the many who were involved in reviewing the whole document identify the particular issues raised by Gornall.

It took considerable time to reach completion of the *Companion*. We believe that this is a vital publication containing work in a form that has not been available previously. It has already been welcomed by many paediatricians. We apologise if we have inadvertently created the impression that we have not fully supported the work of our respected colleagues by not referencing and acknowledging them directly.

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Competing interests: None declared.

1 Gornall J. Royal college rewrites child protection history. *BMJ* 2006;333:194-6. (22 July.)
2 Royal College of Paediatrics and Child Health. *Child protection companion*. London: RCPCH, 2006.

Antibiotics and acute purulent rhinitis

There is no significant difference between antibiotics

Editor—Arroll and Kenealy suggest that amoxicillin may be the preferred antibiotic for purulent rhinitis.[1] The pooled effect of the two studies using amoxicillin was significant (relative risk 1.26 (95% confidence interval 1.11 to 1.45)), while cefalexin did not achieve significance in one study (relative risk 0.62 (0.26 to 1.47)). Altman and Bland have pointed out that reporting the P values of subgroups is not the correct method to compare the treatments, as it is confounded by the number of subjects in each group.[2] When the method suggested by Altman and Bland is used to compare the studies using amoxicillin directly to the study using cefalexin the relative risk reduction is 0.49 (0.20 to 1.18) (P = 0.11). This does not confirm a significant difference between the two antibiotics. Moreover, as the authors point out, half of the participants in the study by De Sutter et al had unilateral facial pain,[3] and this may also further confound this comparison. The data presented do not justify a preference in choice of antibiotic.

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1 Arroll B, Kenealy T. Are antibiotics effective for acute purulent rhinitis? Systematic review and meta-analysis of placebo controlled randomised trials. *BMJ* 2006;333:279-81. (5 August.)
2 Altman DG, Bland JM. Interaction revisited: the difference between two estimates. *BMJ* 2003;326:219.
3 De Sutter AI, De Meyere MJ, Christiaens TC, van Duriel ML, Peersman W, De Maeseneer JM. Does amoxicillin improve outcomes in patients with purulent rhinorrhea? *J Fam Pract* 2002;51:317-23.

Are antibiotics effective for acute purulent rhinitis?

Editor—Arroll and Kenealy conclude that antibiotics are probably effective for acute purulent rhinitis but suggest that most patients will get better without them and hence advocate a "no antibiotics as first line" treatment plan.[1] Their systematic review looked at seven studies comparing placebo with antibiotic treatment for "acute purulent rhinitis" and defined acute as "less than 10 days with this symptom." They considered all papers in the Cochrane reviews addressing the use of antibiotics for "the common cold and acute purulent rhinitis and for acute maxillary sinusitis."

They do not mention the evidence base used for the above definitions. The currently accepted definition of acute rhinosinusitis classifies an acute episode as lasting for "up to four weeks with total resolution of symptoms."[2] The authors have also grouped three different conditions together under the general heading of acute purulent rhinitis—namely, the common cold, acute purulent rhinitis, and acute maxillary sinusitis. In doing so, their statement that this is not a serious condition is misleading. Although the first two conditions may not have, acute

maxillary sinusitis has several uncommon but potentially serious complications. Periorbital cellulitis is the most common and carries a risk of permanent blindness. Rarer, but potentially fatal, are the intracerebral complications of meningitis, intracranial abscess, and cavernous sinus thrombosis.

Although treating a simple cold, or indeed acute purulent rhinitis, with conservative measures in the first instance is reasonable, patients with classic symptoms of acute maxillary sinusitis should be treated with antibiotics as well as a short-term nasal decongestant to minimise the risk of such complications.

A Cochrane review of antibiotics for persistent rhinosinusitis in children noted that most begin to improve spontaneously within 10 days of onset.[3] The authors' suggestion that antibiotics should be introduced when "symptoms have persisted long enough to concern parents or patients" is not evidence based and harks back to the days of "prescribing on demand" that we have tried so hard to move away from.

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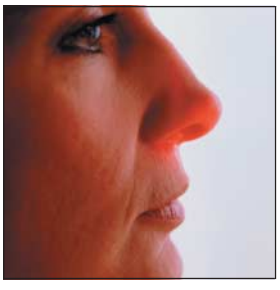
1 Arroll B, Kenealy T. Are antibiotics effective for acute purulent rhinitis? Systematic review and meta-analysis of placebo-controlled randomised trials. *BMJ* 2006;333:279-81. (5 August.)
2 European Academy of Allergology and Clinical Immunology. European position paper on rhinosinusitis and nasal polyps. *Rhinol Suppl* 2005;18:1-87.
3 Morris P, Leach A. Antibiotics for persistent nasal discharge (rhinosinusitis) in children. *Cochrane Database Syst Rev* 2002;4:CD001094.

Review is symptomatic of medicine today

Editor—The systematic review by Arroll and Kenealy shows the state of medicine today.[1] Journals contain volumes on the mysticism of ethics, conditions affecting communities with underlying problems far greater than the scope of the article, and a knowledge base of big severe illnesses but little on the most basic medical conditions.


OSCAR BURRELL/SPL

None of the articles quoted in the review gives any indication that the nose was ever examined. Was there any history of obvious causes of acute purulent rhinitis? Who is taught to examine a nose today? The article does not mention the conditions far more common than bacterial infection that cause acute discoloured secretions. There is no mention of the fact that discoloured secretion does not indicate infection: even eosinophils cause discoloration. The mention of the Cochrane analysis of chronic purulent rhinitis almost implies that there is a similarity to acute purulent rhinitis. And no attempt was made to show whether some of the side effects, diarrhoea, rash, etc, were part of the illness rather than problems from antibiotics.

The review simply shows the poor state of clinical capability in assessing the most basic and common conditions.

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Authors' reply

Editor—We agree with Cates's calculation and assertion. From the practical clinical point of view, if one wished to treat purulent rhinitis (and we do not recommend that routinely) amoxicillin would be a good choice as it is probably safer than co-trimoxazole; the only study that was significant in our review compared amoxicillin *v* placebo. This antibiotic is frequently used in general practice and would be our choice.

We agree with Rimmer and Almeyda that it is not clear in our review what the specific details were of acute purulent rhinitis, but that is a limitation of the original literature. We agree that acute maxillary sinusitis can be a serious condition and that those patients are likely to have been excluded by the studies in our review. Indeed, the American Academy of Pediatrics suggests antibiotics for severe or persistent symptoms of "sinusitis" and that amoxicillin should be the first choice.[1] The academy would not agree with them that patients with classic symptoms be treated but instead think that only those with severe or persistent symptoms should be treated.

The Cochrane review shows that antibiotics are also effective for chronic purulent rhinitis—that is, rhinitis lasting more than 10 days.[2] As to when to intervene with an individual or child otherwise well with a persistent purulent rhinitis we do not know. We would guess that three weeks would be a reasonable time to put up with such symptoms, but that is a guess. We suggest a negotiation with the patient would be the most patient centred way to deal with this. You could say, "At what point in this condition of coloured material coming out of your nose, which will probably not harm you, do you want to take an antibiotic which, on rare occasions, kills people." I suspect we will never have "evidence" about this sort of interchange with patients and in the mean time are reliant on good clinical communication skills to negotiate a pathway with our patients.

We agree with Friedman that the amount of literature on this common symptom is embarrassingly limited. However, would we want more trials on a condition that we know is usually benign and occasionally hazardous? Good (conservative with antibiotics) clinical management can probably cope with our current state of knowledge.

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Competing interests: BA is a member of the Future Forum, an educational foundation funded by AstraZeneca UK, and a committee member of the Pharmac seminar series (Pharmac is the New Zealand government funding agency for drugs).

1 American Academy of Pediatrics Clinical practice guidelines for the management of sinusitis. *Pediatrics* 2001;108:798-80.
2 Morris P, Leach A. Antibiotics for persistent nasal discharge (rhinosinusitis) in children. *Cochrane Database Syst Rev* 2002;4:CD001094.

Subarachnoid haemorrhage: lumbar puncture for every negative scan?

Editor—In their article on subarachnoid haemorrhage Al-Shahi et al continue the fallacy that, as 2% of subarachnoid haemorrhage is missed on computed tomography, every patient must have a lumbar puncture.[1] Quoting the sensitivity of computed tomography in this way may lead the unwary into the trap of thinking that about 1 in 50 lumbar punctures will be positive after a negative computed tomography. (I would probably consent to a lumbar puncture if there was a 1 in 50 chance of finding a severe condition such as a subarachnoid haemorrhage).

However, a bayesian thinker might not be convinced so easily. The chance quoted in the article of a sudden headache being due to subarachnoid haemorrhage is 25%, which we can use as the pre-test probability before computed tomography. The quoted sensitivity of scanning is 98%, giving a likelihood ratio for a negative test of 0.02. A pre-test probability of 25% and a likelihood ratio of 0.02 give a post-test probability of 0.5%. (I don't think that I would consent to a lumbar puncture if there was only a 1 in 200 chance of finding a subarachnoid haemorrhage.)

In practice, the increasing ease of access to computed tomography means that doctors are scanning a group of patients at much lower risk than in the past. As the article emphasises, clinical diagnosis of subarachnoid haemorrhage can be very difficult, so computed tomography is often ordered. So the real life probability before computed tomography is about 10%. This gives a post-test probability of about 0.15%. (I certainly would not consent to a lumbar puncture if there was only a 1 in 650 chance of finding a subarachnoid haemorrhage.)

The dogma that every patient with "query subarachnoid haemorrhage" and a negative computed tomogram must have a lumbar puncture is wrong.[2] Every such patient should have a discussion about lumbar puncture with a clinician who under-

stands diagnostic testing, so that the clinician can, with the patient, weigh the risks and benefits, explain the uncertainty, take the patient's attitude to risk into consideration, and come to a conclusion about whether further investigation should be undertaken.

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Competing interests: None declared.

1 Al-Shahi R, White PM, Davenport RJ, Lindsay KW. Subarachnoid haemorrhage. *BMJ* 2006;333:235-40. (29 July.)
2 Coats TJ, Loffhagen R. Diagnosis of subarachnoid haemorrhage following a negative computed tomography for acute headache: a Bayesian analysis. *Eur J Emergency Med* 2006;13;80-3.

Interpretation of screening test results

Best performers have the most to learn

Editor—Branwell et al essentially sought participants' estimation of a Down's syndrome screening test's positive predictive value.[1] Their results must be interpreted in the clinical setting.

The pregnant women and companions are consumers and therefore should be delivered the results by a health professional who should provide an explanation. Midwives do not order the test and therefore should not be expected to communicate or interpret the results. That they are the main source of information for pregnant women on this test is therefore surprising. They may be the source in general rather than specific terms.

It is the doctors' responsibility to order and communicate the results of a test. Therefore, even though the obstetricians did best, they are the ones who need remediation.

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1 Bramwell R, West H, Salmon P. Health professionals' and service users' interpretation of screening test results: experimental study. *BMJ* 2006;333:284-6. (5 August.)

JAMES KING-HOLMES/SPL

Scenario does not reflect day to day practice

Editor—Bramwell et al's article on the interpretation of screening results for Down's syndrome highlights the difficulties that even professionals can experience in interpreting data from screening programmes.[1] However, the scenario presenting such difficulty is not the one faced by professionals and patients on a daily basis when informing patients of their screening results for Down's syndrome. Rather, it is how likely a positive test from a screened population is in predicting a Down's syndrome pregnancy.

For women who are screened for Down's syndrome, their unique result will be presented either as, for example, "one in 100" or "1%," a much simpler scenario to convey even by statistically challenged obstetricians. However, there is ample published evidence that all women are made anxious by their positive screening test,[2] no matter how they are told, and women's experiences show that medical staff are unclear about the implications of screening tests and how to interpret risk.

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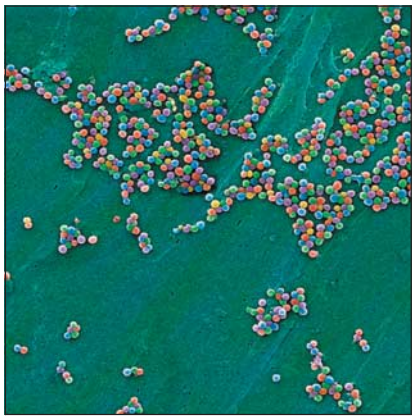
1 Bramwell R, West H, Salmon P. Health professionals' and service users' interpretation of screening test results: experimental study. *BMJ* 2006;333:284-6. (5 August.)
2 Statham H, Green J. Serum screening for Down's syndrome: some women's experiences. *BMJ* 1993;307:174-6.

Treatment of *Staphylococcus aureus* bacteraemia

Editor—In his editorial on *Staphylococcus aureus* bacteraemia Paul says that some doubt remains about the optimal duration of antibiotic treatment.[1] A prospective study of 278 cases of *S aureus* bacteraemia (mainly methicillin sensitive strains) looked at potential risk factors and outcome, using multiple regression analysis.[2] Factors related to death were duration of treatment less than 14 days, an uneradicated focus, septic shock, total daily dose of flucloxacillin <4 g, and age 60 years or more. Anecdotally, treatment of *S aureus* is often stopped before 14 days, as the patient seems to have recovered, and the requirement for this minimum length of treatment is not widely appreciated.

Close liaison between infection specialists (microbiologists and infectious disease doctors) and clinicians also needs to be emphasised. In a study of 244 patients with *S aureus* bacteraemia, clinical outcome was improved (better eradication of *S aureus* and less relapses of infection) when advice from an infectious disease doctor was taken, compared with when it was not.[3] However, telephoned blood culture advice is recorded in medical records in less than two thirds of cases,[4] so verbal advice may be forgotten. In



CDC/SPL

our hospital, an infectious disease doctor reviews at the bedside every case of *S aureus* bacteraemia on the medical and surgical wards. In this way, advice is given and documented on antibiotic choice, route of administration and duration, the removal of the infective focus when possible (such as intravascular lines), and the need for further investigations such as echocardiography.

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1 Paul J. Surveillance and management of all types of Staphylococcus aureus bacteraemia. *BMJ* 2006;333:269-70. (5 August.)
2 Jensen AG, Wachmann CH, Espersen F, Scheibel J, Skinhoj P, Frimodt-Moller N. Treatment and outcome of Staphylococcus aureus bacteraemia: a prospective study of 278 cases. *Arch Intern Med* 2002;162:25-32.
3 Fowler VG Jr, Sanders LL, Sexton DJ, Kong L, Marr KA, Gopal AK, et al. Outcome of Staphylococcus aureus bacteremia according to compliance with recommendations of infectious diseases specialists: experience with 244 patients. *Clin Infect Dis* 1998;27:478-86.
4 Greig JR. Accuracy and completeness of the documentation of blood culture results. *J Clin Path* 2003;56:558.

Outpatient treatment of falciparum malaria is possible

Editor—Whitty et al advocate admitting patients to hospital for initial treatment of malaria.[1] Evidence from Europe and St Thomas' Hospital, London (unpublished data) show that outpatient treatment with oral atovaquone and proguanil (Malarone) is safe in selected patients.[2] Given the financial pressures of many NHS trusts, the need to reduce length of inpatient stay, and patients' wish to avoid hospital admission, clinical microbiologists and infectious disease doctors should consider outpatient treatment.

Since June 2003, 151 cases of malaria have been diagnosed and managed without a single fatality at this hospital. Of these, 124 (82%) were caused by *Plasmodium falciparum*, most infections occurring in people from Ghana or Nigeria (85/124, 68.5%). With the exception of fever, most were well, despite being "semi-immune," having lived in the United Kingdom for many years. Doctors were encouraged to treat patients with *P falciparum* infection out of hospital, provided

that patients were aged 16 or older, were not of white ethnic group, were not pregnant, were clinically well (with the exception of fever), could tolerate the first dose of drugs without vomiting, had a parasitaemia rate of less than 2%, and had normal renal function. More recently, patients were followed up by telephone or seen in the outpatient clinic to ensure compliance and a successful outcome.

Over three years 95 patients were suitable for outpatient treatment and 41 were managed successfully without the need for hospital admission (four by general practitioners). Two patients with parasitaemia counts of more than 2% were treated as outpatients; one had refused hospital admission, and both survived. When admitted, the average length of stay was 2.2 days. Errors occurred more commonly in hospital, including wrong treatment (for example, oral chloroquine for *P falciparum*), doctors withholding treatment despite positive antigen tests, and delays in administrating appropriate antimalarial drugs.

For adults in non-endemic countries, outpatient treatment of *P falciparum* malaria in selected patients is practicable and safe. However, a prospective multicentre randomised controlled study is required to finally abolish the medical myth that all patients with falciparum malaria require admission to hospital.

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Competing interests: None declared.

1 Whitty CJM, Lalloo D, Ustianowski A. Malaria: an update on treatment of adults in non-endemic countries. *BMJ* 2006;333:241-5. (29 July.)
2 D'Acremont V, Landry P, Dorioli R, Stuerchler D, Pecoud A, Genton B. Treatment of imported malaria in an ambulatory setting: prospective study. *BMJ* 2002;321:875-6.

Overcoming barriers to recruitment in health research

Concerns of potential participants need to be dealt with

Editor—Hewison and Haines discuss recruitment procedures as barriers to participation in research on health.[1] We explored this as part of a survey of the attitudes of older people to physical activity.[2]

Altogether 887 people aged 65-84 were invited by a letter from their general practitioner to participate in a home interview study. They also received an information leaflet and a postcard to return to decline participation. Overall 54% refused, most (384) by returning the postcard; the remainder (91) refused when visited or telephoned. Ethics permission was obtained to investigate the reasons for refusal to participate.

After general practitioners excluded patients deemed ineligible, 417 people were sent an eight item questionnaire. Overall, 60% of those who initially refused to participate in the survey returned a questionnaire giving reasons for not taking part. The commonest reason (given by 56%) was that participants thought that they did not do enough activities to be of interest to the study. The other main concern was being visited at home by a research nurse (45%). Only 28% said they were not interested in research.

This study confirms the importance of investigating attitudes to participation. The high response rate among people who initially refused indicates a willingness to participate in research. The finding that many of those who refused did so because they thought they were not sufficiently interesting, implies that it was misperception rather than antipathy to the study that prompted refusal.

Tackling low response, and the bias it may create, requires understanding and addressing the concerns of potential participants. The requirement for opt-in systems, as Hewison and Haines point out, exacerbates low response rates. Research should be undertaken only when there is a high likelihood of producing valid findings. Ethics requirements which result in invalid research may themselves be unethical.

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1 Hewison J, Haines A. Overcoming barriers to recruitment in health research. *BMJ* 2006;333;300-2. (5 August.)
2 Crombie IK, Irvine L, Williams B, McGinnis AR, Slane PW, Alder EM, et al. Why older people do not participate in leisure time physical activity: a survey of activity levels, beliefs and deterrents. *Age Ageing* 2004;33:287-92.

Some research ethics committees believe in facilitating ethical research

Editor—In their article on overcoming barriers to recruitment in health research Hewison and Haines imply that all research ethics committees require that only patients who "opt in" after receiving a communication from a researcher can be included in a trial.[1] This is not true.

The Royal Free Hospital's research ethics committee is well aware of the reduced recruitment and bias that this may create. Researchers are encouraged to attend our meetings so that we may discuss with them their method of recruitment. Many researchers tell us that if they can recruit only subjects who opt in after receiving the invitation letter then they will not proceed because this bias and reduced recruitment will make the project meaningless. Very often we agree with them and permit them to make further contact with potential participants.

We do not think that this is unduly intrusive. Every morning all of us receive invitations that interest us but we put them to one side and forget about them. Have you ever tried to organise a retirement dinner. You send out letters. Lots of people want to come. They all forget to reply. You ring them up. They all come. They enjoy the dinner. It is the same with research. You send out invitation letters. The subjects are interested. They forget to reply. It is only when you ring them up to provide further information that they make the positive decision to enrol.

Some research ethics committees are interested in facilitating research. In the future, issues such as this should be discussed in a central forum so that any committee will give a similar response.

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1 Hewison J, Haines A. Overcoming barriers to recruitment in health research. *BMJ* 2006;333:300-2. (5 August.)

Reforming death certification

Editor—The government has cited cost and bureaucracy as reasons for not reforming death certification, as recommended by the Luce report and by Dame Janet Smith's report into the Shipman affair.[1] Both excuses ignore the recommendation in both reports to abolish the cost and bureaucracy of the "cremation form" system.

Most deaths in the United Kingdom are followed by cremation. For every cremation, these archaic and flawed forms are completed and fees of over £100 are charged. If these forms were abolished, could this money not be used to fund a modern death certification system?

The crucial difference is that fees for the cremation form are paid by the bereaved, not the state. This proposal would abolish a stealth tax on the bereaved, and transfer the cost to the exchequer, to be funded from general taxation.

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Competing interests: PNF has in the past benefited financially from cremation form fees.

1 Dyer C. Changes to death certificates waste golden opportunity. *BMJ* 2006;333:275. (5 August.)

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