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Deciding who needs dual chamber pacing

EDITOR,—M C Petch's editorial on dual chamber pacing[1] challenges the practice of pacing and sensing the atria, "unless contraindicated," with sophisticated, expensive pacing systems as suggested by the British Pacing and Electrophysiology Group.[2] Petch implies that there must be a happy medium that would avoid sophistication when it is unnecessary while allowing those who can to benefit; I agree.

Just before the British Pacing and Electrophysiology Group's recommendations were published colleagues and I suggested a possible solution.[3] We had already presented a protocol for the choice of pacemaker; this developed into an algorithm, which was then reviewed retrospectively to examine whether the choice had been appropriate. We took into account the patients' ability to exercise, coexisting diseases that affected lifestyle and prognosis, the presence or history of cardiac failure, and the patients' activities and expectations. In addition, it was apparent that in some patients the indication for a particular type or mode of pacemaker was not clear unless their cardiac and electrophysiological disorder had been characterised—for example, by looking for retrograde conduction or block, the sinus node response to exercise, and additional arrhythmias. This algorithm required some patients to have been investigated before intervention, but in addition to allowing economies and benefiting patients it allowed easier follow up.

Although follow up showed that not every decision had been correct and I understand that others might make slightly different decisions, I believe that we found an acceptable middle way that allows the full benefit of modern technology with economical use of technical and medical resources. This led to the implantation of complex or dual lead systems in 43% of patients (and simple single lead pacing systems in the others)—about halfway between the 5% and the 75% extremes that Petch quotes.

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NSAIDs in the postoperative period

EDITOR,—We wish to restore some balance to the arguments over the use of non-steroidal anti-inflammatory drugs in the perioperative period. Conditions such as pre-existing renal disease, older age, use of diuretics, and congestive heart failure predispose patients to postoperative renal failure. The addition of a non-steroidal anti-inflammatory drug imposes a further embarrassment, but some of the patients described in the correspondence[1] in response to Dermot F Murphy's editorial[2] would probably have developed postoperative renal failure anyway. We do not advocate the use of non-steroidal anti-inflammatory drugs in patients such as these, but it must be remembered that the underlying surgical condition, perioperative renal support and fluid balance, and the stress response to surgery all play a vital part.

Unchecked increases in concentrations of stress hormones such as catecholamines, cortisol, antidiuretic hormone, renin, and angiotensin are almost the norm after major surgery as effective perioperative analgesia is withheld in most patients.[3] The use of a non-steroidal anti-inflammatory drug is important if stress responses are to be controlled and fully effective analgesia provided.[4] It should ideally be part of a pre-emptive, balanced analgesic regimen.[4] Mark H Worsley's suggestion that these drugs should be introduced later in the postoperative period when renal function is firmly established[1] misses the point of their role in preventing this stress response. Our results in thoracic surgery show that if stress responses are to be attenuated and the pulmonary complications of severe postoperative pain are to be greatly reduced a non-steroidal anti-inflammatory drug is essential.[4]

C A O'Callaghan and colleagues' implication that non-steroidal anti-inflammatory drugs can be replaced by opiates[1] is misleading. Opiates are ineffective for numerous causes of postoperative pain (for example, rib fractures, chest drains, continuing tissue damage), and the feared side effect of severe respiratory depression has not been overcome by any method of administration, be it neuraxial instillation or patient controlled.

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Availability of specialist services

Deaf people need psychiatric services

EDITOR,—The Clinical Standards Advisory Group has shown the need for a tier of management above district level but has focused on services at regional or subregional level for neonatal intensive care, cystic fibrosis, childhood leukaemia, and coronary artery bypass grafting.[1] The purchasing problems highlighted apply even more to less well known services that are needed at a supraregional level. Supraregional psychiatric services for deaf people (in sign language) are to lose their interim supraregional funding next year and face an NHS market that is already failing some less specialised services. This is particularly galling as less specialist, but more politically sensitive, services keep supraregional funding.

There are only three psychiatric units for deaf people, in London, Manchester, and Birmingham. For the national caseload of about 500 patients at any time, local services could not be viable or maintain acceptable standards of care. "Local purchasers cannot know what an appropriate level of contracting is and providers are uncertain of demand for the service," to quote Sir Terence English.[1]

Psychiatric services for deaf people give a wide service to a defined population, in contrast to the services reviewed by the Clinical Standards Advisory Group. Unlike other cultural and linguistic groups, the deaf population who sign are spread widely across Britain and are not best served by local purchasers. Because psychiatry needs good communication at all levels of care and because of the complexity of sign language it is inconceivable that local providers can have acceptable standards.

The fact that the Department of Health has said that it will look at ways of organising local purchasers is even less reassuring for a supraregional service. The tertiary referral arrangements that allow automatic funding of referrals from consultant to consultant do little for psychiatric services for deaf people. Medical practitioners are unable to take a history from deaf patients who sign unless they have an interpreter and are unable to perform a mental state examination without fluency in sign language themselves, so only a quarter of referrals come from consultants. Medical practitioners are incapacitated as gatekeepers for referral. To quote Professor John Richmond, the chairperson of the Clinical Standards Advisory Group, "These services are not well suited to markct forces."

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1 Dillner L. NHS reforms deny patients specialist services. *BMJ* 1993;307:151. (17 July.)

Process data on neonatal transfers

EDITOR,—Professor John Richmond's complaint on behalf of the Clinical Standards Advisory Group that information on the transfer of newborn babies between hospitals is not available is not wholly true.[1] The North Western Perinatal Survey Unit has obtained this information by consulting and cross referencing the admission books in all the neonatal units throughout the region. Last year there were 203 medical and 164 surgical transfers of neonates between hospitals in the North Western region; in addition 58 neonates were admitted from outside the region and 110 were transferred to adjacent regions. These figures, broken down by hospital and birth weight, have been tabulated for the past two years in the unit's annual report, which is circulated to all consultant paediatricians and obstetricians in the region.

There is no reason why this comparatively simple exercise should not be mandatory in every region in Britain and the figures made available to bodies contracting for specialist neonatal intensive care services. The tier of management above districts recommended by Professor Richmond could well be given the remit to see that basic information of this kind for each district is continuously collected, collated, and published.

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1 Dillner L. NHS reforms deny patients specialist services. *BMJ* 1993;307:151. (17 July.)

Anabolic steroids in sport

EDITOR,—Andrew McBride and K Williamson raise the issue of controlled studies being undertaken to establish scientifically the efficacy of high dose anabolic steroids on performance.[1] They point out that such studies could be considered ethically justifiable given the strong beliefs in the community and the dangers of doses currently being consumed by misusers.