pattern of pain is of no value in localising the site of the lesion.[2]

We advocate consultation with a senior doctor and consideration of early computed tomography for patients with a good history of neck rotation at the time of impact. This increases the chance of bony injury,[2] particularly between the occiput and C2, which is often poorly visualised in plain films. Computed tomography should also be considered in those with a fixed abnormal neck position, particularly if pain does not seem to be the restricting factor, and those with definite neurological signs and symptoms, even if their presentation is delayed.

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[1] Brown JN, Crosby AC. Acute soft tissue injuries of the cervical spine. *BMJ* 1993;307:439-40. (14 August.)

[2] Macnab I. The whiplash syndrome. *Orth Clin North Am* 1971;2: 389-403.

[3] Janes JM. Severe extension-flexion injuries of the cervical spine. *Mayo Clin Proc* 1965;40:353-61.

[4] Miles KA, Finlay D. Is prevertebral soft tissue swelling a useful sign in injuries of the cervical spine? *Injury* 1988;19:177-9.

Infantile colic and parental stress

EDITOR,—Päivi Rautava and colleagues suggest an interesting association between infantile colic and parental stress.[1] In their study, however, colicky symptoms were assessed by the parents themselves. It would not be surprising if stressed parents perceived their baby's crying as worse than did those under less pressure. Thus the authors' screening procedure is likely to have picked up infants with genuine colic and those whose parents had an exaggerated awareness of their child's screaming. The only way to avoid conflating these two groups is for continuing tape recordings to be made of the infant. Otherwise, results such as this may led to the premature conclusion that all instances of excessive, paroxysmal screaming of uncertain organic aetiology are a consequence of parental tension.

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[1] Rautava P, Helenius H, Lehtonen L. Psychosocial predisposing factors for infantile colic. *BMJ* 1993;307:600-4. (4 September.)

Description of ME revised in disability handbook

EDITOR,—Anthony David's contribution to Medicine and the Media contains several factual errors concerning myalgic encephalomyelitis.[1] Firstly, the all party lobby of nearly 100 members of parliament, which is working with patients' organisations on problems with state benefits and other matters of concern, has been concentrating on the disability living allowance, not invalidity benefit as stated. As a result of this joint action the Disability Living Allowance Advisory Board has agreed to important changes to the clinical description of myalgic encephalomyelitis in its "disability handbook." The next revision of this will make it clear that myalgic encephalomyelitis is a separate clinical entity from the chronic fatigue syndrome (although they have several features in common), is not hysterical in origin, and can result in severe and permanent disablement. In common with the tenth revision of the *International Classification of Diseases* the handbook will also refer to myalgic encephalomyelitis as a neurological disorder.

Secondly, there is no evidence to support David's view that myalgic encephalomyelitis has become "a no go area" in the quality press. During August and September both the *Times* and the *Independent on Sunday* devoted a total of three pages to the subject, with four separate views being expressed.[2,3]

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[1] David A. Camera, lights, action for ME. *BMJ* 1993;307:688. (11 September.)

[2] Marcovitch H, Stuttaford T, Wessely S. What exactly is the chronic fatigue syndrome called ME? *Times* 1993 Sept 14:16.

[3] Woodham A. Stop the world, I want to get off. *Independent on Sunday Review* 1993 Aug 29:40-1.

Discharging patients into the community

EDITOR,—Jane Yeo reports the problem she experienced earlier this year with a patient newly discharged from an old fashioned institution to the community.[1] This problem, however, should be considered in the context of the relocation of 240 patients with learning difficulties from a hospital condemned as unsuitable for their care into many small and friendly homes across the district, West Berkshire. This relocation, which was completed in March, has produced, on one hand, two complaints (of which Yeo's was one) and, on the other, a dramatic improvement in the quality of life for most of the patients.

Meanwhile the process of change continues and two full time consultants in learning difficulties were recently appointed to lead the community team. This trust is committed to designing the best possible service for these patients and, despite hiccups in the transitional phase, wishes to work closely with general practitioners towards this aim.

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[1] Yeo J. Neuroleptics in learning disability. *BMJ* 1993;307:620-1. (4 September.)

Provision of highly specialised services

EDITOR,—The current purchaser-provider arrangements are designed to ensure, as far as possible, that the health care needs of local people are met by local services. Luisa Dillner's report on the initial findings of the Clinical Standards Advisory Group[1] and Nick Kitson's letter[2] highlight the difficulties that patients with highly specialised needs face in getting access to appropriate services. But in addition to the threat to the provision of services there is a more insidious threat.

By bringing together professionals with highly specialised skills, many highly specialised services provide both services and training. Training offered in such units ensures the continuity of services and allows services to develop new methods of treatment. It is by this means that the supraregional deaf mental health services have established a unique outpatient child psychiatric service for deaf children and their families and pioneered family therapy for deaf people in Britain.

Thus the possible demise of highly specialised services threatens not only the immediate provision of services but also the gathering together of skilled professionals that ensures that their skills are further developed and disseminated. Because these professionals' patients are often widely spread across Britain, however, they do not represent a large enough constituency in any single district health authority to register effective protest against threats to services.

Some district health authorities have developed consultative processes between the users and providers of services to ensure that local health needs are adequately met. Such arrangements are of no use to patients with highly specialised needs, such as those described by the Clinical Standards Advisory Group and Kitson. The advisory group offers important professional advice to the Department of Health with regard to a small group of such patients. But there is a growing need for monitoring bodies that can represent users and providers of services and the Department of Health and can ensure that district health authorities and general practitioner fundholders make adequate provision for people who require highly specialised services.

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

[2] Kitson N. Availability of specialist services. *BMJ* 1993;307:567. (28 August.)

Prioritising resources

EDITOR,—The question of the prioritisation of resources in health care is clearly of utmost importance.[1] One of the main factors that should be taken into account in prioritisation is the evidence that interventions do more good than harm—that is, effectiveness. One of the few instruments available to purchasers that provides objective evidence on effectiveness is the series of bulletins *Effective Health Care.* Thus we were disappointed by Chris Ham's dismissal[1] of some of the topics that we have chosen to study—namely, the treatment of persistent glue ear and screening for osteoporosis to prevent fractures. When Ham questions the relevance of these topics he surely misses the point: it is the impact of changes in decision making at the margin that is the most important consideration,[2] not simply the total volume of activity or the prevalence of the condition.

Topics assessed in *Effective Health Care* are selected on the basis of their implications on resources, uncertainty about their effectiveness, and their likely impact on health status. The selection process entails considerable market research and discussion by a steering group comprising senior health service managers, directors of public health, and academics.

Glue ear is the commonest reason for elective surgery in children, yet large geographical variations in treatment rates exist and doubts remain about the appropriateness of surgery in many cases. These doubts are strengthened by the finding in a recent randomised controlled trial, in which surgery was undertaken on the basis of clinically determined need, that around a third of children were operated on unnecessarily.[3] Similarly, doubts exist about the likely impact of population screening programmes for osteoporosis. Estimates suggest that such screening is unlikely to prevent more than 5% of fractures in elderly women. The two *Effective Health Care* bulletins on these subjects have aided commissioning authorities in allocating resources towards proved therapeutic activities. There is considerable evidence that this information has been used around Britain in setting standards and changing decisions on commissioning.[4]

Commissioning in the health service is (and will probably always be) an uncertain science in which some of the most important decisions are taken around the margins of activity. Information based on evidence raises the level of debate in commissioning. Qualitative research is about posing the right questions to the right people. Perhaps Ham should have been more probing and questioned why these important issues, which have been extensively examined in other commissioning authorities, were not so addressed in the six that he chose to interview.

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1 Ham C. Priority setting in the NHS: reports from six districts. *BMJ* 1993;307:435-8. (14 August.)
2 Robinson R. Purchasing, priorities and rationing. In: Harrison A, ed. *Health care UK 1992/3: an annual review of health care policy.* London: King's Fund Institute, 1993:106-16.
3 Black NA, Sanderson CF, Freeland AP, Vessey MP. A randomised controlled trial of surgery for glue ear. *BMJ* 1990;300: 1551-6.
4 Audit Commission. *Children first: a study of hospital services.* London: HMSO, 1993.

Guidelines on managing hyperlipidaemia

EDITOR,—S Bulusu writes that "practical guidelines on the management of patients with hyperlipidaemia are urgently needed; these should preferably be prepared by a national expert body along the lines of the national cholesterol education programme in the United States."[1] I wish to point out that the Royal College of General Practitioners published such guidelines last year.[2]

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1 Bulusu S. Serum lipid testing. *BMJ* 1993;307:502-3. (21 August.)
2 Royal College of General Practitioners. *Guidelines for the management of hyperlipidaemia in general practice.* London: RCGP, 1992. (Occasional paper 55.)

Managing patients in a persistent vegetative state

EDITOR,—My original articles on managing patients in a persistent vegetative state aimed to generate a mature debate.[1,2] I am not, however, surprised by the emotion they generated in the profession.[3-5] The legal outcome in the case of Tony Bland was always going to be a "no win situation." Many relatives worried that the legal decision would result in patients' treatment being withdrawn and feared the pressure that might be put on them to allow feeding tubes to be removed. Throughout the Bland case patients' relatives and staff in my unit for patients in a persistent vegetative state required enormous support. On the other hand, if the case had gone the other way there would have been other relatives who thought that they had been left in an equally untenable situation.

J G Howe states that Tony Bland received rehabilitation programmes similar to those carried out at Putney. This is not quite the case (and I have studied his mangement in detail), nor could it be. The treatment that Tony Bland received was excellent for treatment in a general unit with little or no experience of the persistent vegetative state but cannot be compared with treatment by a specialist team that works exclusively with people in such a state. This is not a criticism of Howe's treatment but does make me question what the courts in a future case will accept as rehabilitation before they decide that feeding can be withdrawn.

It seems to have been left to Howe and M F Helliwell to defend the motives of Mr and Mrs Bland. As an external assessor of Tony Bland, I would like to acknowledge publicly the dedication and love that Tony's family bestowed on him. It is my view that they tolerated the public trauma that they went through because they believed that withdrawing feeding was the greatest demonstration of their love that they could show. We must avoid such courage having to be shown by other families.

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1 Andrews K. Recovery of patients after four months or more in the persistent vegetative state. *BMJ* 1993;306:1597-600.
2 Andrews K. Patients in the persistent vegetative state: problems in their long term management. *BMJ* 1993;306:1600-2.
3 Tudor MA. Management of patients in persistent vegetative state. *BMJ* 1993;307:201. (17 July.)
4 Howe JG. Management of patients in persistent vegetative state. *BMJ* 1993;307:625. (4 September.)
5 Helliwell MF. Management of patients in persistent vegetative state. *BMJ* 1993;307:605. (4 September.)

Retinoblastoma and fetal irradiation

EDITOR,—C A Stiller's editorial on retinoblastoma and low level radiation noted that findings from the Oxford survey of childhood cancers concerning prenatal exposure to *x* rays have not been published separately for retinoblastoma.[1] Information, though limited, is provided here.

In a series of 15 229 children who had died of cancer before the age of 16 (1953-81) who were individually matched with live controls (that is, 15 229 case-control pairs with interview data) there were 86 retinoblastomas. In this subgroup 27 case-control pairs had records of prenatal exposure to *x* rays. After the exclusion of three pairs that were concordant for early exposures, there were 14 pairs in which only the case had had fetal irradiation and 10 in which only the control had. Three of the 17 cases that had had fetal irradiation had bilateral tumours.

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1 Stiller CA. Retinoblastoma and low level irradiation. *BMJ* 1993;307:461-2. (21 August.)

Fatigue varies according to where it is measured

EDITOR,—Stephen M Lawrie and Anthony J Pelosi point out that the characteristics of the populations and the severity of symptoms of fatigue vary depending on where fatigue is assessed.[1] In the community more women report "always feeling tired," and women who have children under 6 are twice as likely as men to report this symptom.[2] Women consult general practitioners more commonly than men. David *et al* studied patients attending a general practice for any reason between November 1989 and January 1990 and found that the ratio of men to women attending was one to three.[3] The average fatigue scores of the men and women attending were not significantly different.

We analysed the average fatigue scores of men and women who consulted their general practitioner with fatigue as a main symptom and found that they were not significantly different. For each patient recruited, a patient on the same practice list who was matched for age and sex was sent a fatigue questionnaire. In this comparison group of people in the community the average fatigue scores of the women were significantly higher than those of the men. Patients who consulted for fatigue were three times more likely to be women than men.[4] This sex ratio is similar to that found by Morrell *et al* in a prospective study of all symptoms presented to doctors in a practice in London over one year.[5]

We agree that there are similarities and differences in the characteristics of population samples when symptoms are measured at different sites—the community, the waiting room of a general practice, and the consulting room—and they require further research.[1,3,4] This would be particularly useful for general practitioners who have hitherto tried to understand why patients consult or ask to be referred and who advise them on the likely diagnosis, management, and prognosis on the basis of intuition, experience, and scientific evidence derived from the fewer than 2% who were referred to specialist care.[5]

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1 Lawrie S, Pelosi A. Fatigue in general practice. *BMJ* 1993;307: 564. (28 August.)
2 Popay J. "My health is all right, but I'm just tired all the time": women's experience of ill health. In: Roberts H, ed. *Women's health matters.* London: Routledge, 1992:99-120.
3 David A, Pelosi A, McDonald E, Stephens D, Ledger D, Rathbone R, *et al.* Tired, weak, or in need of rest: fatigue among general practice attenders. *BMJ* 1990;301:1199-202.
4 Ridsdale L, Evans A, Jerrett W, Mandalia S, Osler K, Vora H. Patients with fatigue in general practice: a prospective study. *BMJ* 1993;307:103-6. (10 July.)
5 Morrell DC. Symptom interpretation in general practice. *J R Coll Gen Pract* 1972;22:297-309.

Incidence of breast cancer

EDITOR,—Minerva reports that the incidence of breast cancer in women in the United States rose by 33% between 1973 and 1988; in women over 50 it rose by 40%.[1,2] Mortality, however, remained stable over this period. Minerva speculates that these changes are attributable to earlier diagnosis as a result of mammography and that the incidence will level off and the death rate will fall. A more credible explanation for these findings is that the incidence of and mortality from this disease have remained stable and that mortality is not influenced by mammography. The increase in the incidence may well be an artefact of mammography.

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1 Minerva. *BMJ* 1993;307:574. (28 August.)
2 Swanson GM, Ragheb NE, Lin C-S, Hankey BF, Miller B, Horn-Ross P, *et al.* Breast cancer among black and white women in the 1980s. *Cancer* 1993;72:788-98.

Sickness certification by general practitioners

EDITOR,—The issue of the *BMJ* published on 11 September contains two apparently conflicting statements. Stuart Handysides reports that "general practitioners say they are not trained to assess people's fitness for work."[1] Secondly, resolution 58 passed by the BMA's annual representative meeting, however, states that "this meeting rejects the government's assertions that general practitioners do not understand the criteria for sickness certification in relation to fitness for work."[2] Should we infer that doctors understand the rules but aren't trained for the job? This situation has arisen because sickness certification