

Therefore, we conclude that these results were caused by unintentional bias and did not form a basis for rejecting the null hypothesis.

The second trial, by Dr William J Gilchrist and coworkers (p 1116), did not have large differences in age at entry and did not show any evidence to reject the null hypothesis using analyses of length of stay, mortality, or placement at discharge (although the patients admitted from and discharged back home were inconsistent between tables III and IV). We used Miller and Homan's graphs to estimate that a study of this size has an 80% power to detect a 50% change assuming the control group had an observed rate of 0.5 for the chosen dichotomous outcome measure (10 September, p 672). A difference of this magnitude probably did not exist, but the study was too small to conclude that smaller differences did not exist.

These two recent studies do not provide evidence that dedicated rehabilitation units improve outcome by 50% or more in patients with proximal femoral fractures. Equally, it cannot be concluded that such units do not improve outcome to a smaller extent. Therefore, orthopaedic-elderly units should continue to be considered for rehabilitating these patients and to be subjected to adequate randomised controlled trials so that smaller, but clinically important, improvements can be found if they exist. To this end, one of us is already concerned in a randomised trial in Salisbury Health District; we are also in the early planning stages of a study in West Berkshire Health District.

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1 Miller DK, Homan SM. Graphical aid for determining power of clinical trials involving two groups. *Br Med J* 1988;297:672-6.

Anxiety and depression in general medical settings

We agree with Professor P Silverstone (12 November, p 1271) about the use of instruments based on somatic symptoms for the detection of mood disorder in physically ill patients. Such scales will overestimate disorder and, if treatment decisions are to be based upon the scores, an overprescription of psychiatric treatments. We would therefore draw attention to the hospital anxiety and depression scale,¹ which we constructed especially for the purpose after a request from a general hospital physician. This scale resulted from an analysis of a wide range of items, and the study was conducted in a medical outpatient clinic. Items such as insomnia, fatigue, anorexia, or weight loss which could be symptoms of a physical illness were excluded. We agreed that clinicians would be helped by the provision of separate scales for depression and for anxiety, and the hospital anxiety and depression scale is a brief self assessment questionnaire that may be easily completed in a hospital or practice waiting room. The absence of items such as suicidal preoccupation, suggesting severe psychiatric illness, is one of the factors leading to the acceptability of the scale in non-psychiatric settings.² The depression subscale focuses on the concept of anhedonia as this seems to be the best clinical marker for the biogenic depressive state which might be considered to respond to antidepressant drugs.³

The hospital anxiety and depression scale is now in wide use in both clinical and research settings. Translations are available for all major European languages and for Hebrew, Arabic, Japanese, Chinese, and several Indic languages. A paediatric version of the scale has been proposed.⁴ Other validation studies are referred to elsewhere.⁵

The pharmaceutical firm Upjohn has generously made the hospital anxiety and depression question-

naire freely available to applicants from the United Kingdom and the Republic of Ireland (Medical Sciences Liaison Division, Fleming Way, Crawley, West Sussex RH10 2NJ).

Finally, we would point out that irritability should not be included in an anxiety scale. It is an independent mood state that may occur in association with most psychiatric disorders or be a normal trait of personality.⁶ It is certainly not specific to the clinical construct of anxiety.

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- 1 Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand* 1968;67:361-70.
- 2 Fallowfield LJ, Baum M, Maguire GP. Do psychological studies upset patients? *J R Soc Med* 1987;80:59.
- 3 Snaith RP. The concepts of mild depression. *Br J Psychiatry* 1987;150:387-93.
- 4 Cundall DB. Children and mothers at clinics: who is disturbed? *Arch Dis Child* 1987;62:820-4.
- 5 Snaith RP. The hospital anxiety and depression scale. *Br J Psychiatry* 1988;152:424.
- 6 Snaith RP, Taylor CM. Irritability: definition, assessment and associated factors. *Br J Psychiatry* 1985;147:127-36.

Points

Prescription of oxygen concentrators

Dr EDWIN MARTIN (Bedford) writes: The paper by Dr Martin J Walshaw and others (22 October, p 1030) makes depressing reading. There is no point in guidelines based on proper clinical trials being laid down by the government if these guidelines are not followed. Several other disturbing facts also come to light. Firstly, it is general practitioners who will have the day to day management of patients prescribed oxygen concentrators and yet they have no access to meter readings to judge how many hours' oxygen treatment such patients are actually using. Secondly, there is no mention in this paper of the general practitioners participating in this audit of care, even though they are the doctors who give most of the day to day care. This means as far as practitioners are concerned that this is an external audit rather than an audit carried out with a group of colleagues. At the end of the discussion the authors state that this study clearly shows the need for better cooperation among general practitioners, non-respiratory physicians, and respiratory physicians in this aspect of management. The practical effect of this study, however, because of the lack of participation of general practitioners is going to be a statement by consultants that "things must improve." Had general practitioners participated in the study itself the group could have continued from defining a problem to jointly planning a strategy to deal with it.

Death during sexual intercourse

Dr J F N SIDEBOTHAM (Ottery St Mary, Devon EX11 1JY) writes: I read Dr Bernard Knight's reply (12 November, p 1259) about death during intercourse. I have had two cases; both were women and both died of subarachnoid haemorrhage. The first was known to be hypertensive whereas the other was fit as far as was known.

Measles, mumps, and rubella vaccine

Drs BOB GRUNDY and RICHARD H PARROTT (Tamar Faculty Board, Royal College of General Practitioners) write: We are concerned that the current immunisation record card (FP7A), which has a vast area on which to record vaccination against smallpox, has no space for vaccination against measles, mumps, and rubella. Nearly two years ago a joint working party of the Tamar faculty of the Royal College of General Practitioners and the local medical committees of Devon and Cornwall developed a new "preventive care" record card on which measles, mumps,

and rubella vaccination could easily be recorded. The Devon and Cornwall family practitioner committees have already printed a limited number of these. The General Medical Services Committee has approved a slightly modified version of this card and has asked the Department of Health to fund its introduction, so far without success. Indeed, the department has recently printed huge quantities of the hopelessly outdated FP7A. If general practice is to achieve the proposed targets for the new vaccine it needs to be equipped with a proper record card to encourage standardised recording.

The bends and hyperbaric medicine

Dr P B JAMES (Wolfson Institute of Occupational Health, University of Dundee) and Mr DAVID PERRINS (International Society of Hyperbaric Medicine, 14 Rue Peiresc, 83000 Toulon, France) write: Dr Peter Wilmschurst (8 October, p 916) indicated that both the Department of Health and medical practitioners in general were not aware of diving related diseases and their correct treatment. Unfortunately, this also applies to many common clinical problems that respond to hyperbaric oxygen treatment. In this country only about six chambers are in use in the NHS and victims of carbon monoxide poisoning, air embolism, and gas gangrene are rarely treated correctly. Though these may be considered comparatively rare conditions, many common wound healing problems also respond to hyperbaric oxygen treatment,¹ and the reduction of morbidity and costs in the United Kingdom would be dramatic. The use of hyperbaric oxygen treatment is increasing rapidly in other countries. There are estimated to be over 1200 facilities in use in the Soviet Union, 370 in the United States, 310 in Japan, and 274 in the People's Republic of China. In the United States many conditions are accepted for insurance reimbursement because hyperbaric oxygen is either the primary treatment or an important adjunct in treatment. There is an extensive supporting bibliography.² Many other conditions seem to benefit from hyperbaric oxygen treatment, including cranial nerve disorders, peritonitis, ergotamine poisoning, botulism, acute liver failure, neonatal asphyxia, haemolytic disease of the newborn, paralytic ileus, and chronic peptic ulceration. These conditions share the common features of microcirculatory disturbance, increased vascular permeability, and oedema. The increase in intracapillary distances and diffusional barriers created by oedema cause tissue hypoxia, generating a vicious cycle.³ Until we recognise this we will continue to fail or produce less satisfactory results in many diseases in which these factors are important. In the 1960s Sir Hedley Atkins, then president of the Royal College of Surgeons, chaired a working party of the Medical Research Council to consider the future of hyperbaric medicine, but on his retirement it seems to have been disbanded. We submit that it should be recalled urgently.

1 Davis JC, Hunt TK. *Problem wounds: the role of oxygen*. New York: Elsevier, 1988.

2 Fischer B, Jain KK, Braun E, Lehl F. *Handbook of hyperbaric oxygen therapy*. London: Springer, 1988.

3 Yacoub MH, Zeitlin GL. Hyperbaric oxygen in the treatment of the postoperative low-cardiac-output syndrome. *Lancet* 1965;i:581-3.

Seeing the body after death

Mr SIMON CROCKER (Department of Obstetrics and Gynaecology, Norfolk and Norwich Hospital, Norwich NR1 3SR) writes: Ms Fiona Cathcart (22 October, p 997) raises important issues. Certainly the viewing and also holding of a stillborn child may help the parents to grieve, and this seems to be true whether the child is normal or abnormal. A photograph of the child may assist this process. When the parents decide not to see the child a photograph should still be taken in case the parents later wish for a closer association with the baby. I must disagree with Ms Cathcart over her statement that the photograph should be "retained in the case notes." The picture should be kept in a separate place—ours are in an indexed file held by the senior midwife—for if left in the case notes these photographs are liable to appear when the mother next attends the hospital, perhaps for an unrelated problem. Such unexpected and unwanted appearances of these photographs can be very distressing to the parents.