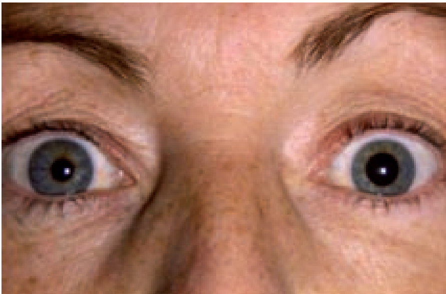
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS



A FIXED DILATED PUPIL

Pilocarpine: better than a scan

Williams et al describe a patient with a fixed dilated pupil after using a prescription hand cream with antimuscarinic properties.[1]

I was recently referred a 34 year old man admitted for investigation of an asymptomatic fixed dilated left pupil. The pupil abnormality was spotted by an observant staff nurse on the paediatric ward where he was visiting his daughter. He was sent to the accident and emergency department and later admitted for urgent investigations, which included computed tomography, magnetic resonance imaging and angiography of the head, and a battery of blood tests. When the results of all these investigations came back as normal, a neuro-ophthalmic opinion was sought.

My examination confirmed an unreactive mid-sized left pupil with no ptosis or ophthalmoplegia and no other neurological deficits. On closer questioning the patient explained that shortly before inserting his contact lenses that morning he had been manually crushing Vallergan tablets (an antihistamine with antimuscarinic properties) to administer to his sick daughter via her gastric feed. Inadvertent muscarinic blockade from contamination of his contact lens was confirmed by demonstrating no miosis after topical administration of pilocarpine drops.

The clinical approach to an unreactive pupil in emergency medicine is fraught with anxiety over missing an acute neurosurgical emergency—in particular, coning or a posterior communicating artery aneurysm. For patients who are otherwise well with no other neurological symptoms I suggest two simple and cheap preliminary checks before the pupil sign is labelled neurogenic. Firstly, take a detailed history of possible exposure to chemicals with antimuscarinic properties that may have got on to the patient's hands. Secondly, instil a single drop of pilocarpine and wait 30 minutes: if the pupil remains large the cause is pharmacogenic (or local, that is, within the eye) not neurogenic, and the patient does not need to be admitted for further investigations.

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Competing interests: None declared.

1 Williams L, Sharma V, Downes T. Minerva. *BMJ* 2008;336:52. (5 January.)

SAFETY IN HEALTH CARE

Legal impediments

It is worth considering the wider context in which research and safety improvements must occur.[1] Many, perhaps most, avoidable serious and fatal adverse events occur as a result of multiple, often systemic, errors, rather than a single catastrophic blunder by one individual. Sadly, and also avoidably, these can recur, harming other patients. Research and action should therefore focus to some extent on individual and institutional factors which may prevent practical learning from past errors.

Institutions have their own imperatives independent of (and occasionally antithetical to) the purpose they are supposed to exist to serve. Admission of error is not comfortable or good for careers. It can also carry legal liabilities.

When an adverse event has given rise to fear of litigation among managers and doctors, they often take legal advice and follow it. Although hard numbers are difficult to find, it seems very common that the advice is to cease communications with the complainant, other than through legal channels, until any resulting case is settled. This can take many years.

This has an undesirable and wholly predictable effect. It severely delays learning from more dangerous mistakes—the ones that lead to lawsuits.

We need the advice of enlightened lawyers to chart a better path, such that where complaints become civil actions, the subject of the complaint does not hide behind sub judice as a reason not to examine and rectify policy or practice. Methods for achieving this could be a useful topic for multidisciplinary health service research for healthcare improvement.

Name and address supplied

Competing interests: The author is a doctor and experienced a life threatening serious adverse event after elective laparoscopic surgery in an NHS hospital. This is the subject of a complaint and an ongoing legal action. He is also concerned that his experiences may be avoidably replicated in hospitals throughout the UK up to 50 times a year, sometimes fatally.

1 Grol R, Berwick DM, Wensing M. On the trail of quality and safety in health care. *BMJ* 2008;336:74-6. (12 January.)

Research on safety is happening

Grol et al highlight the need to develop a new research community in health care specialising in the safety and quality of patient treatment.[1] Networks of patient safety researchers are now emerging in the United Kingdom and beyond. A Scottish patient safety research network (financed by the Scottish Funding Council) was established in 2007 (www.spsrn.ac.uk). In England, the NIHR (National Institute for Health Research) has recently funded two NHS trust and academic centres of patient safety and quality at Imperial College and King's College, London, as well as supporting new research projects at Lancaster and York.

These strategic, capacity building initiatives are enabling the development of patient safety research teams that are recruiting PhD students and postdoctoral scientists with expertise from a broad skill base. Some of these researchers have been trained in cognitive science, engineering, ergonomics, anthropology, and social psychology. Others are bringing experience from applied research in industries such as aviation and energy production. All these teams have experienced healthcare professionals and managers working with the researchers. The National Patient Safety Agency has been providing additional support by arranging research meetings to bring the new UK patient safety research teams together.

International collaboration on patient safety research is also being fostered. Framework 7 funding has been directed at establishing European networks of patient safety researchers and the World Health Organization has several specialist patient safety research groups that are due to report on research priorities, an agreed terminology, and methods and measures.

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Competing interests: None declared.

1 Grol R, Berwick DM, Wensing M. On the trail of quality and safety in health care. *BMJ* 2008;336:74-6. (12 January.)

KOJI SASAHARA/AP

PREVENTING FLU-LIKE ILLNESS

Reason for optimism

The US Centers for Disease Control and Prevention (CDC) claims that the single best way to prevent seasonal flu is to get vaccinated each year.[1] Such confidence in influenza vaccines seems misplaced for two reasons. Firstly, if CDC viral surveillance data are correct, then in recent years true influenza viruses have caused an average of only 12% of influenza-like illness[2] (the syndrome the public thinks of as "flu" and, most critically, the syndrome the public is trying to avoid). Since influenza vaccine does not work against non-influenza viruses,[3] how can the agency responsibly claim vaccines are the best way to prevent seasonal flu?

Secondly, the track record for influenza vaccination is not stellar. Over the past years, numerous reviews have shown that the benefits of influenza vaccination have been overstated—most importantly in elderly people, the group most needing protection.

With all the focus on influenza instead of influenza-like illness, we are missing the target, pursuing a health policy that has probably placed a prolonged undue reliance on vaccination and other pharmaceutical measures—and prematurely and (we now know) illegitimately demoting the role of physical barriers such as hand washing and masks. Official US recommendations for the prevention and control of influenza are 25 000 words long.[4] Only one sentence of that document mentions non-pharmaceutical interventions, only to brush them off as having "not been studied adequately." Jefferson et al have reviewed the literature—and the evidence gives reason for optimism.[5] Will policy change?

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Competing interests: PD knows some of the authors and had a chance to read and comment on the draft manuscript prior to publication.

1 Centers for Disease Control and Prevention. *Preventing seasonal flu*. www.cdc.gov/flu/protect/preventing.htm.
2 Thompson WW, Shay DK, Weintraub E, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. *JAMA* 2003;289:179-186. (Table 1.)
3 Centers for Disease Control and Prevention. *Key facts about influenza and influenza vaccine*. 2007.
4 CDC. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morb Mort Wkly Rep* 2007;56(RR06):1-54.
5 Jefferson T, Foxlee R, Del Mar C, Dooley L, Ferroni E, Hewak B, et al. Physical interventions to interrupt or reduce the spread of respiratory viruses: systematic review. *BMJ* 2008;336:77-80. (12 January.)

HOME HAEMODIALYSIS

UK nephrology misunderstood

Blagg criticises the UK renal community for lagging behind some other high income countries in the proportion of patients receiving home haemodialysis (HD).[1]

A generation of UK nephrologists was forced, by lack of facilities, to give patients a stark choice between home HD, home peritoneal dialysis, or death. As hospital and satellite dialysis facilities have expanded, the proportion of patients receiving home based treatment has rightly reduced. Whether that reduction is due to poor availability or to free choice between home HD and other options remains open to question.

Many patients perceive no advantage of home HD when the alternative is a local satellite dialysis unit. Patients receiving satellite or hospital based HD can also control many aspects of their own treatment. What the "correct" proportion should be cannot be based on comparisons with Australia and New Zealand, where for reasons of geographical dispersion, home HD remains the only viable option for many patients. Provision of home HD requires a community team of nurses and technologists. Some UK units therefore choose to refer their patients to a neighbouring unit for home HD rather than run their own home HD programme; this is not evidence in itself that suitable patients are not offered home HD.

Policy in the UK supporting the use of home HD is set by the Departments of Health and the National Institute for Health and Clinical Excellence (NICE). UK nephrologists fully agree that home HD should be offered to all suitable patients, but they have doubts that the NICE target—15% of all HD should be performed at home—is based on good evidence. Similarly, whereas they are enthusiastic about daily short hours or nightly long hours HD, this treatment is not endorsed by national policy or by NICE—largely because there is not, at this point, sound evidence of benefit.

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On behalf of the trustees of the Renal Association

Competing interests: None declared.

1 Blagg CR. Home haemodialysis. *BMJ* 2008;336:3-4. (5 January.)

Missing facts, different countries

Blagg states that home haemodialysis (HD) is cost effective.[1] In the United States, where there is less likelihood of receiving a cadaveric transplant than in the United Kingdom (45% *v* 30%), the economics are different. In the United Kingdom the break even point on the set up and running costs of home HD *v* in-centre HD is about two years. Analysis of data from the UK Renal Registry shows that within 20 months of starting, half of the patients receiving home HD would have received a kidney transplant. This makes the cost neutral point towards 3-4 years.

It will always be difficult to show that home HD improves survival as patients on the home HD programme in any renal unit are always highly selected. They are unlikely to have any comorbid conditions and have good fistulas (not central lines). It is difficult even with age matching to allow for all these selection factors in matching a similar cohort.

Short daily dialysis is a separate (and more costly) entity than standard home HD requiring specific equipment and is currently undergoing evaluation in the UK.

The high rates of home HD in New Zealand are related to some specific factors in their healthcare system but do not imply a free choice. The UK also has a larger peritoneal dialysis programme than the US and other EU countries. In those countries some patients receiving home HD may rather have chosen peritoneal dialysis. All these factors increase the complexity of any international comparison.

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Competing interests: None declared.

1 Blagg CR. Home haemodialysis. *BMJ* 2008;336:3-4. (5 January.)

Author's reply

Selection bias has an important role, but almost all reports on quality of life have shown the benefits of home haemodialysis (HD), and patients are vocal about the advantages they have experienced. Even if survival is no better, surely willing and suitable patients should have access to a treatment that provides, for example, opportunity for longer or more frequent dialysis, improved quality of life, rehabilitation, and flexibility of scheduling?

In terms of urbanisation, Australia ranks 19th in the world (91% urbanisation) compared with the UK, which is 20th (90% urbanisation), and New Zealand, which is 32nd (86% urbanisation).[1] On the basis of their registries, the rates per million for HD, peritoneal dialysis, and transplantation are also similar—303, 85, and 317 in the UK; 330, 88, and 322 in Australia; and 277, 176, and 302 in New Zealand.

In New Zealand there used to be little option but home HD if a transplant was not available. However, now 48% of patients receiving HD are in hospital based programmes. Also, while the total number of patients receiving dialysis per million now is roughly similar to that in the US and Australia, the proportion treated by peritoneal dialysis is almost double.

In our experience HD at home costs about half the cost of outpatient dialysis in a unit, but training costs are inadequately reimbursed in the US and break even is somewhere between one and two years. Patients receiving home HD are generally prime candidates, but in our programme only about 10% a year receive transplants.

In Australia and New Zealand dialysis programmes are primarily run from university and major medical centres that also provide widespread satellite units encouraging self care and independence for patients who do not want home HD. There are no for-profit dialysis corporations, which are only just beginning to see the benefits of home HD. The government of the state of Victoria, for example, actively encourages the use of home HD and pays a doctor more for patients who go home.

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Competing interests: None declared.

1 http://nationmaster.com/graph/peo_urb-people-urbanization

HEROIN PRESCRIPTION TO MISUSERS

Treat patients, not communities

Prescribing heroin to those who use it other than for analgesia simply redefines "offenders" as "patients."[1 2] The term "misuser" implies a lack of social acceptance. Prescription removes the "mis" but, in so doing, allows the "user" to re-enter the social group and solves crime at a stroke by legitimising criminal behaviour.

People with drug problems need services that take them through a continuum of making safe (reducing immediate risk of overdose), harm reduction (reducing later risk of bloodborne virus), dose stabilisation, detoxification, and relapse prevention. Prescribing of heroin probably affects those needing services towards the beginning of the continuum.

Current NHS services tend to concentrate on harm reduction and dose stabilisation, with the private sector offering detoxification and the criminal justice sector (often police custody sergeants) providing making safe services.

Despite its importance as the final part of a potentially curative process, effective relapse prevention—such as the use of naltrexone with low frequency TENS that I have previously described[3]—is of little interest to those in the public sector with a vested interest in acquiring ever growing numbers in their substitute prescribing programmes or those in the private sector who profit from repeating their detoxification interventions.

The answer to the question posed about heroin prescribing lies between "perhaps" and "probably," but it is a question that fails to address the real problem[1 2]: current treatment of individual drug users is palliative for communities rather than curative for individuals; those specialising in this field need to recognise their own vested interests in maintaining the status quo, not only to allow "offenders who act bad" to become "patients who feel better" but to help them move on to become "people who have got better."

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Competing interests: None declared.

1 Rehm J, Fischer B. Should heroin be prescribed to heroin misusers? Yes. *BMJ* 2008;336:70. (12 January.)
2 McKeganey N. Should heroin be prescribed to heroin misusers? No. *BMJ* 2008;336:71. (12 January.)
3 Ashworth AJ. Rapid response. Why let fact interfere with a good theory ? bmj.com 2007.http://bmj.com/cgi/eletters/335/7618/464-a#176174.

Prejudice based medicine?

Treating heroin addition is about changing the addict's behaviour.[1 2] This is not a moral issue. We are not trying to save their souls or turn them away from depravity. The point of treating our vulnerable heroin addicts is fivefold:

- To help them come off street heroin
- To reduce harm to the addict; the addict's family, especially children and cohabitees; society (in the sense of crime reduction)
- To treat the patient's physical health problems
- To treat the patient's mental and psychological health problems
- To provide social care including support, occupation, and safe housing.

These laudable aims are professed by the National Treatment Agency for substance abuse and shared by all of us who work at treating drug addiction in the UK. If just one addict can be helped to achieve these aims by prescribing heroin and the clinician in charge believes that other substances like methadone, buprenorphine, and the like are really not suitable then the addict must have the option to be prescribed clean pure white heroin.

Why is government so keen to micro-manage drug addiction treatment to the extent that they proscribe prescription of certain substances? This is in spite of evidence highlighted by your articles which seems to show benefits from heroin prescribing in a few cases. Is this another example of government trying to stop prescribers from acting on evidence—evidence based medicine (EBM)—and moving us to government controlled prescribing or, as I like to call it—prejudice based medicine (PBM)?

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Competing interests: RW runs a heroin addiction service from his GP surgery.

1 Rehm J, Fischer B. Should heroin be prescribed to heroin misusers? Yes. *BMJ* 2008;336:70. (12 January.)
2 McKeganey N. Should heroin be prescribed to heroin misusers? No. *BMJ* 2008;336:71. (12 January.)

Treat addicts, not the addiction

Rehm and Fischer, in calling for what amounts to the legalising of heroin,[1] have selected evidence to support their view. They did, however, not include the Cochrane review that concluded from randomised control trials that no definitive conclusions about the overall effectiveness of heroin trials are possible.[2]

The authors also seem to be unaware that heroin addicts continuously use other psychoactive drugs, and therefore simply by prescribing heroin all one is doing is treating that addiction rather than the addict, who is also likely to be experiencing severe emotional and mental problems. In prescribing heroin to heroin addicts one is instrumental in increasing the severity of the addiction. Would the authors recommend smoking for those with emphysema? Or alcohol for those with alcohol related liver disease?

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Competing interests: Drug and alcohol recovery counsellor.

1 Rehm J, Fischer B. Should heroin be prescribed to heroin misusers? Yes. *BMJ* 2008;336:70. (12 January.)
2 Ferri M, Davoli M, Perucci CA. Heroin maintenance for chronic heroin dependents. *Cochrane Database Syst Rev* 2003;(3): CD003410.

THE KURJAK PLAGIARISM CASE

Scientific misconduct in Croatia

In the wake of the reaction of academic institutions in Croatia to Chalmers's account of repeated plagiarism by Croatian clinician Asim Kurjak,[1] the *BMJ* called on Zagreb University School of Medicine to take action,[2] whose court of honour had recently failed to act on proved allegations of Kurjak's misconduct. After a request that both the *BMJ* and the *Croatian Medical Journal* investigate the articles by Kurjak that they had published, I asked the Committee on Publication Ethics (COPE) and the World Association of Medical Editors (WAME) for their expert opinion. This revealed unacknowledged duplicate publications. A report I prepared documenting this opinion was sent to the dean of the medical school, Nada Cikes, on 14 March 2007. However, my report was not mentioned in the ruling of the school's court of honour.

When I asked about this omission at the

school's council meeting of 27 November 2007, the dean answered that she could not recall ever having received my report. I also learnt that the court of honour was not provided with the National Committee for Ethics in Science's report on the Kurjak case,[3] although Dean Cikes told the *BMJ* in May 2007 that "it [the report] would be considered by the university's court of honour."[4] At the same school's council meeting, the dean proposed that my suitability as editor in chief of the *Croatian Medical Journal* be reviewed because of my interviews to the media about corruption in academia.[5]

I welcome the spotlight that has been provided by international exposure of the academic community reaction to scientific misconduct in Croatia. I am not asking for help but simply offering first hand testimony that many Croats detest the lack of public responsibility of the academic community in Croatia and wish to fight it, but it is difficult to confront entrenched attitudes during the transition from authoritarian to more democratic and accountable structures.

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Competing interests: MM is co-editor in chief of the *Croatian Medical Journal*.

1 Chalmers I. Role of systematic reviews in detecting plagiarism: case of Asim Kurjak. *BMJ* 2006;333:594-5.
2 Godlee F. Plagiarism and punishment. Editor's choice. *BMJ* 2007;335. (10 November.)
3 National Board for Ethics in Science and Higher Education, Republic of Croatia. Ruling on the Kurjak case in Croatian. http://www.azvo.hr/Default.aspx?sec=142
4 Watts G. Croatian academic is found guilty of plagiarism. *BMJ* 2007;334:1077.
5 Marusic M, Marusic A. Threats to the integrity of the Croatian Medical Journal. *Croat Med J* 2007;48:779-85.

Croatia is let down

In November 2006 the editors of the *Croatian Medical Journal* asked the Committee on Publication Ethics (COPE) to help it in dealing with allegations against Asim Kurjak of duplicate or redundant publication, or both. These were quite separate from the previous allegations of plagiarism by this author.

An investigation by COPE concluded in February 2007, in regard to the papers submitted to it by the journal, that there is strong evidence that Kurjak (or his co-authors) committed publication misconduct on at least three occasions in relation to papers submitted to the *Croatian Medical Journal*. In two cases, papers co-authored by Kurjak were submitted to the journal after similar papers had been accepted by another journal, and in one case the material published in the *Croatian Medical Journal* seems to have been inappropriately republished in another journal.

COPE advised the editors of the *Croatian Medical Journal* to send its report to the University of Zagreb, requesting that it conduct an inquiry into the allegations.

One problem that has beset COPE since it was founded in 1997 has been the apparent reluctance of some institutions to take seriously complaints made to them by editors about probable publication misconduct by their staff or employees. The University of Zagreb now seems to be one of them. COPE is appalled by Marusic's revelation (previous letter)[1] that the report was swept under the carpet by those entrusted with maintaining the integrity of research at the university's medical school.

Far from protecting the name of the university and its medical school, this action only serves to diminish their reputations and to cast doubt on the undoubted body of reliable and honest research carried out there.

COPE has written to the dean of the medical school, the rector of the university, and the Croatian minister of health, Professor Primorac, expressing its dismay. Let us hope that the minister directs that the court of honour at Zagreb University be reconvened to consider the complaint from the *Croatian Medical Journal*.

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Competing interests: None declared.

1 Godlee F. Plagiarism and punishment. Editor's choice. *BMJ* 2007;335. (10 November.)

THE TREATMENT PARADOX

The interpretation of evidence

Any trial generates four summary numbers: relative risk reduction, absolute risk reduction, number needed to treat, and personal probability of benefit.[1]

Each number is useful and gives some information, but no one number gives us the whole truth about the information. Using one figure on its own, particularly the relative risk reduction above all others, is very risky.

Each figure takes a different viewpoint on the evidence. The relative risk reduction is a public health (area wide) prediction.

The absolute risk reduction puts the starting risk back into the frame. The number needed to treat measures the workload needed to achieve the relative risk reduction. It's the beginning of health economics.

The personal probability of benefit answers the patient's question, "What's in this for me?"

All the figures are contained in every clinical trial, and they each give very different perspectives on the risks and benefits of treatment. I ask that all be reported in each clinical trial, and then an overall assessment of benefit can be made, with clarity about which perspective is being used.

Jenkinson and I have an article on a similar theme to Spence's piece in this month's *Student BMJ*.[1 2]

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Competing interests: None declared.

1 Spence D. The treatment paradox. *BMJ* 2008;336:100. (12 January.)
2 Jenkinson S, Davies P. Interpreting the evidence. *Student BMJ* 2008. http://student.bmj.com/issues/08/01/education/026.php

Extracts from other responses

Statins might prevent (or delay) cardiovascular death in a handful of those who take them, or they might slightly reduce the risk in everyone who takes them. To use an analogy, wearing thermal underwear in winter might prevent death due to hypothermia in only a few but the benefit of keeping warm would be felt by many.

Norman R Williams London

Statins do not treat or cure death: they only delay it. If you model the Kaplan-Meier survival curves, it is considerably less than one year. With one entire extra year of life gained for every 700 years of taking a statin, clearly, if you treat for 700 years you will create one added life year. This means that if you treated someone for 30 years you can expect to provide them with 30/700 added years of life. This is 15.64 days. In short, if a 50 year old man asked you how much longer he could expect to live if he took a statin for 30 years you can inform him "just over two weeks—max."

Malcolm Kendrick Wythenshawe

In the case of statins the benefit is not to get a cerebrovascular accident or a myocardial infarction (fatal or not), the usual end points in statin clinical trials. This benefit cannot diffuse. Therefore for every number needed to treat (NNT)+1 patients taking statins for several years, only one gets this benefit. The rest get practically nothing.

Michael Samarkos Athens, Greece

The marginal individual benefits of much modern medicine left the individual patient behind years ago, when we started treating "mild hypertension" (with an NNT of 800). With such an NNT, and a life expectancy of 20 years, how many of us will be eating "pills in the sky, in the sweet buy-and-bye"? May I again propose this new statistic, pill in the sky, representing the total cost of treatment taken by those who will not benefit?

L Sam Lewis Newport, Pembrokeshire

Full details for authors are available on bmj.com