

The working group's recommendations that each locum should carry a logbook and that a central register should be set up need carry no threat to those who are competent. This majority must accept that appointment committees apply strict criteria before employing clinical staff and that it is right that those who replace them temporarily should also be subject to scrutiny.

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Histopathology departments already audit diagnostic errors

EDITOR.—John Warden, in his report on diagnostic errors made by locum consultant histopathologist Dr Samuel Kiberu, repeatedly asserts that there are no comparative data on mistakes in pathological diagnoses and states that the report on this case calls for new research.¹ The research that has already taken place, both in Britain and in the United States, seems to have been overlooked. In 1986 a review of 12 934 cases in the British Army Histopathology Registry detected 521 diagnoses (4.0%) that contained an error; 141 of these errors (1.1%) were classed as "clinically significant" and were likely to have affected the patient's care.² In an audit of 518 cases in Southampton in 1993, errors were found in 20 cases (3.8%), and in six (1.2%) the error was judged to be clinically significant.³ Two pathology departments in the United States have reported the effects of appointing an extra senior pathologist to check all their diagnoses. In one department the checker detected 14 discrepancies of potential clinical significance in 5397 cases (0.26%),⁴ while in the other department major errors were detected in 1.2% of 2694 cases.⁵ Although these studies used slightly different methods, it is notable that three identified a rate of important errors of between 1.1% and 1.4%.

Many histopathology departments in Britain now operate internal audit systems to detect diagnostic errors. The Southampton system has been running since 1988, and our error rates to the end of 1995 remain comparable with the published results.³ The emerging consensus is that in routine diagnostic pathology some form of error will occur in roughly 3-4% of cases and an error that is likely to affect the patient's management will occur in 1.0-1.5%. In this light, Dr Kiberu's error rates of 14% and 9%¹ certainly seem to be high.

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Adulterants of herbal products can cause poisoning

EDITOR.—Podophyllum poisoning has developed into a mini-epidemic in Hong Kong. Since Hong Kong is a major trading centre for Chinese medicines it is relevant to alert the international medical community to this problem.

The poisoning is caused by ingestion of the herb known in Cantonese as Gwai-Kou, which is derived from the roots and rhizomes of *Podophyllum hexandrum* (also known as *P emodi*; podophyllum). The herb appeared in Hong Kong in 1989 as an adulterant of Lung-Dam-Cho (*Gentiana* sp) and led to two cases of neuropathy and encephalopathy.¹ Around the same period, this herb was found in Taipei and Kuala Lumpur as an adulterant of another herb, Wai-Ling-Sin, which is the root of several species of clematis.² In Hong Kong, in 1995 and 1996 respectively, three and nine cases of neuropathy have been reported after consumption of the adulterant mixed with Wai-Ling-Sin. The Department of Health searched for Wai-Ling-Sin in 55 importers and 867 retail outlets and found podophyllum in 22 of the 234 samples analysed. The adulterated samples were imported by five importers and distributed to the retailers by 14 distributors. The department then publicly requested all shops to stop selling Wai-Ling-Sin.

The patients with podophyllum poisoning first developed serious vomiting and diarrhoea. In cases of mild toxicity (after ingestion of 2-8 g) neuropathy became manifest in one to two days. Patients complained of numbness of the arms and legs and difficulty in walking, and clinical findings included an absence of jerks, reduced plantar responses, lack of coordination of the fingers, ataxic and unsteady gait, poor standing balance, and impaired proprioception and vibration sense. Sensory responses and motor coordination returned partially over months. In the two cases that occurred in 1989, after ingestion of a high dose of podophyllum (probably >20 g), encephalopathy was still present five months after the incident.¹ Podophyllotoxin and related lignans in podophyllum have damaging effects on dorsal ganglion neurones and nerve fibres in the central and peripheral nervous system.³ No specific antidote is known.

Clinicians and herbal practitioners should be alerted about this adulterant in samples of Wai-Ling-Sin, which may have been re-exported to other countries.

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Unicef should do more in Sri Lanka

EDITOR.—The objective of Unicef is to safeguard the health and welfare of women and children. To do this it must work among those who are downtrodden by social inequalities, state neglect, and oppression and where health indices are low.

Sri Lanka has been engaged in a civil war for the past 15 years. The war mainly occurs in the North-Eastern Province, where over three million Tamils live. A military operation in Jaffna last October displaced 500 000 people; there were already over 350 000 refugees in the Northern Province.¹ These refugees have moved into a drought stricken area where the state has imposed restrictions on the supply of food and medicines and where more than three quarters of the households do not have toilet facilities.

P C Gunasekera and colleagues recently reported health indicators in Sri Lanka.² In most instances the mortality and morbidity statistics for Sri Lanka published by the state "exclude data from North-Eastern Province." This is given as a footnote in some government publications and is never mentioned in data provided for international use.³

Before the recent military operation, maternal mortality in Jaffna District was 220/100 000 live births, while the figure for Sri Lanka is 60/100 000.³ Similarly, infant mortality for Jaffna District was 430/10 000 live births, while the figure for Sri Lanka is 150/10 000. The rates are now said to be rising with the influx of refugees.

The prevalence of acute malnutrition among children in Jaffna has increased from 3.7% in 1975-6 to 18.9% in 1993.⁴ A slight reduction seemed to occur in early 1995, but this is being reversed with the recent displacement. Estimates in Jaffna showed that 60-100% of the mothers attending clinics were anaemic.⁵

Transport of vaccine is irregular and storage unsatisfactory. With a little effort this could be rectified. But little action has been taken to provide immunisation appropriate to age.

Of the 160 218 students studying in 454 schools in Jaffna District, 66.2% are unable to continue their education because their schools are damaged or used as refugee camps. Unicef is concerned about the increasing number of child combatants. Most of these children will be recruited to the ranks of child combatants unless they restart their education. Are we to wait until they become combatants to act?

Unicef works in close collaboration with the government. The population has a right to health, and the government and other authorities (including Unicef) have an obligation to ensure that health care is made available to civilian populations during armed conflicts. Should not Unicef influence the government to look into the plight of women and children in the wartorn areas?

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