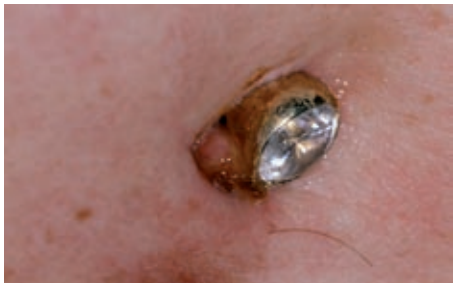
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list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

LETTERS



P MARAZZI/SPL

BODY PIERCING IN ENGLAND

Health and regulation issues for body piercing

Bone et al show that the prevalence of body piercing is increasing.[1] The body piercing industry is poorly regulated, practitioners require no formal qualifications, and there are no formal training programmes. The Local Government Act 2003, which came into force in 2004,[2] was supposed to remedy the situation, but enforcement is patchy and not much has changed since the act, despite the growth in the industry.

Body piercing is a public health problem with risks especially to people with underlying health problems.[3] It can also lead to unnecessary investigations and inappropriate treatments when patients present with persistent and "unexplained" signs and symptoms.[4] Piercing of the lips, nostrils, and tongue can present difficulties during resuscitation, especially in emergency situations, as valuable time is lost trying to remove the piercing and jewellery within them for effective resuscitation, many doctors being unfamiliar with the release mechanisms of these devices.[5]

Modern day "genital mutilation" (multiple genital piercing) occurs under the guise of body piercing. Bone et al limited their survey to the age group 16-24 years, but a lot of children and toddlers are undergoing body piercing as there is no minimum age of consent for it. When does the piercing of children become child abuse?

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Competing interests: None declared.

1 Bone A, Ncube F, Nichols T, Noah ND. Body piercing in England: a survey of piercing at sites other than earlobe *BMJ* 2008;336:1426-8. (21 June.)
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Double standards in obtaining consent for piercings

Piercing is a surgical procedure with substantial complication rates: a third get complications, a fifth require professional help, and 1% even require admission to hospital.[1] The risk of death is not negligible as piercing can transmit bloodborne viruses or result in life threatening sepsis.

Any doctor performing a procedure such as this would ask for explicit (usually written) consent with discussion of the risks being documented. Why is there no such requirement for tattooing and piercing, both of which may have long term or serious complications? Many young people under the age of 16 undergo such procedures, without parental consent being formally obtained, and are at risk.

The public seems happy to accept lower standards of information and consent from less qualified people than it expects from healthcare professionals. The consequences of tattooing and piercing can be irreversible; the standards of skill, sterilisation, and consent applied should be the same as that for any other surgery.

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1 Bone A, Ncube F, Nichols T, Noah ND. Body piercing in England: a survey of piercing at sites other than earlobe. *BMJ* 2008;336:1426-8. (21 June.)

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EMERGENCY ANAPHYLAXIS

Role of α agonists in treating anaphylaxis

We were disappointed to see no mention of the Resuscitation Council's advice regarding the treatment of adrenaline refractory anaphylaxis.[1]

We agree that early treatment with adrenaline (epinephrine) remains the cornerstone of anaphylaxis management, but it is clear that some patients with cardiovascular collapse fail to respond despite this.[1] It is our experience that in such cases, the administration of an intravenous direct acting α agonist (metaraminol, noradrenaline, phenylephrine, etc) can be life saving.[2] This practice is supported by several case reports,[3-5] predominantly in the anaesthesiac literature, and our subsequent unpublished experience.

After its independent review of the literature, the Resuscitation Council has also chosen to support the use of α agonists in anaphylaxis when adrenaline and fluids have not been successful. We hope that adjunctive treatment with α agonists, either by intravenous bolus or titrated infusion, may at least be considered by colleagues faced with such a dire situation.

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Competing interests: None declared.

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NICE ON REFEEDING SYNDROME

Attitudes to NICE guidance on refeeding syndrome

Any discussion on the risks of the refeeding syndrome should include the increased threat of infection that may often be silent in malnutrition.[1] Malnourished patients may develop infection without showing the usual septic markers—such as an increased temperature, leucocyte count, or C reactive protein. We therefore advocate septic screening and a low threshold for broad spectrum antibiotic cover for any patients with unexplained hypothermia, hypoglycaemia, and evidence of malnutrition.

Patients at high risk of the syndrome may also be at risk of acute renal failure, which may be missed as they have only slightly raised urea and creatinine measurements because of low muscle mass, leading to low production of these metabolites. When this occurs, renal dysfunction may hide low serum and total body electrolyte concentrations, and hence serum potassium, magnesium, and phosphate may

be reassuringly normal or even high. They are at even greater risk of precipitate falls in these circulating electrolytes once simultaneous nutritional and fluid therapy has started.

Our unpublished survey of doctors, nurses, pharmacists, and dietitians (all members of their respective nutrition societies) on their attitudes to the guidance from the National Institute for Health and Clinical Excellence (NICE)[2] showed widespread disparities in practice. Only 44% (8/19) of doctors compared with 70% (49/70) of dietitians followed the guidance. Overall, 39% (57/146) of all responders thought the guidance represented safe practice, whereas 36% (53/146) thought they were excessively cautious. Some responders thought that NICE guidelines were an obstacle to providing adequate nutrition, while others had never seen a case of the refeeding syndrome despite having always started nutritional supplementation at 100% of estimated requirements.

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Competing interests: None declared.

1 Mehanna HM, Moledina J, Travis J. Refeeding syndrome: what it is, and how to prevent and treat it. *BMJ* 2008;336:1495-8. (28 June.)
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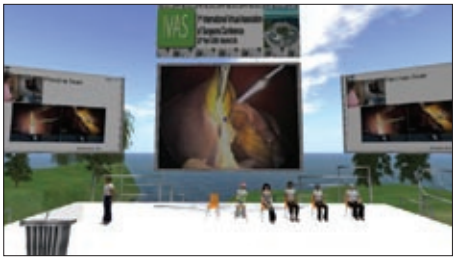
Cite this as: *BMJ* 2008;337:a680

INTERNATIONAL CONFERENCES

Surgeons have held conferences in Second Life

Robust alternatives to international conferences are currently readily attainable.[1 2] On 22 April 2008, the first international Virtual Association of Surgeons (iVAS) meeting was held in the virtual world of Second Life. Forty seven delegates from five countries attended, ranging from professors to students of medicine and engineering. Within this "metaverse," each person is represented by an avatar (a digital representation of the self), and is able to communicate with other users by voice over internet protocol (VOIP), instant messaging, body language, and multimedia slide presentations. The conference lasted for two hours, and ideas were exchanged about surgical robotics and technology. A questionnaire survey was completed by the delegates; of the people who responded, 96% "agreed" or "strongly agreed" that the overall experience was highly rated, and all delegates "agreed" or "strongly agreed" to attend another meeting in the same medium.



The cost of attending the conference was a computer with an internet connection and a headset for voice communication; and no travelling time or hotels were incurred. Using the Second Life platform is free; however, Imperial College London purchased the virtual "land" on which the meeting took place. The conference was set up on a virtual island with an "open air" lecture theatre with minimal rental charges, hence no commercial interests or attendance fees were incurred. The site can be visited at http://ubimon.doc.ic.ac.uk/iVAS/, and users can join the association within Second Life.

The environmental impact of virtual worlds is not entirely negligible, as international servers must be maintained.[3] However, if this model is extrapolated to a larger conference, then it is far less than the impact of 100 million person air miles.[1] Furthermore, the impact on healthcare provision is smaller than a real world conference. Users may have to give up only a few hours of their time to log in and learn and interact in an environment with their colleagues, rather than give up many precious clinical days. The combination of live links can further provide an even more immersive environment for craft specialties such as surgery. Although true "hands-on" workshops, such as surgical skills training, are not currently possible in this virtual world, the core agenda of a medical conference can, and has been, delivered using the set-up described above. The rapid evolution of this medium is likely to generate continued innovations that will facilitate this process.

It remains a challenge to hold large scale virtual conferences (with many thousands of delegates) and to run week long meetings. Furthermore, current platforms such as Second Life make personal identification difficult when used for serious purposes such as this. However, we struggle to find a more cost effective and easily accessible way to arrange an international academic meeting.

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Competing interests: The authors organised the iVAS meeting.

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Virtual congress of general practice is thriving

From my place of residence in India, I participated very actively in the 1st virtual congress of general practice and family medicine in Portugal from April to June 2008 (www.congressovirtualmgf.com).[1] More than 1600 family physicians from 65 countries attended symposiums, e-oral communications, e-posters, e-learning, discussion forums, and interactive sessions. New topics were posted every Monday and Thursday. The speakers' fees and travelling expenses, and other expenses for participants were small for this paperless conference. All the organisation was done by email, and the conference had an overwhelming response. The 2nd virtual congress of family medicine and general practice will be conducted from September 2009. Registration will start in September 2009.

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Competing interests: None declared.

1 Green M. Are international medical conferences an outdated luxury the planet can't afford? Yes. *BMJ* 2008;336:1466. (28 June.)

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NHS AND PRIVATE MONEY

National cancer director responds on top-up payments

I read with interest Coombes's article on the first *BMJ* lecture.[1] In that lecture, Chris Ham commented on the issue of "top-up" payments for drugs not available on the NHS and the review I am undertaking on behalf of the health secretary.

Chris is quoted as saying that "my suspicion is that Mike Richards already knows the answer." In fact, I have a completely open mind about the recommendations, which will come out of this review in October. I am keen to hear views and evidence from all sides of the debate. I would strongly encourage anyone wishing to give their view to email the dedicated address for the review at additionaldrugsreview@dh.gsi.gov.uk.

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Competing interests: None declared.

1 Coombes R. NHS might have to attract more private money if it is to improve standards. *BMJ* 2008;336: 1457. (28 June.)

Cite this as: *BMJ* 2008;337:a686