Making clinical informatics work

EDITOR,—We do not agree with Paul Lelliott's view that no existing hospital information system works.[1] At Burton Hospitals NHS Trust we have a totally integrated hospital information support system, which has been operating since April 1992. It provides many benefits for patients' care and for the wide range of staff who use it. We have married clinical activity (except for the doctor's record) with electronic recording on a hospital-wide basis and are now looking towards including doctors' notes.

Our system is clinically biased as it is used by all clinical staff; it also provides all the information needed for administration, management, and contracting as a byproduct. It is used by all junior medical staff, 98% of consultant staff, and nurses and other paramedical staff, and the demand for more terminals is a measure of its popularity. It is also used by managers and the contracting team. Our junior staff worry how they will manage at hospitals without the system.

Our project was not financially supported by the centre; there was a heavy commitment from doctors and other clinical staff, all of whom helped to select and implement the system. This created the sense of ownership so necessary for the project to succeed.

The system was supplied by MEDITECH, whose staff worked with us to provide the information system and have the insight to keep producing enhancements to get closer to the total electronic record talked about by so many.

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1 Lelliott P. Making clinical informatics work. *BMJ* 1994;308: 802-3. (26 March.)

Antidepressants and suicide

EDITOR,—Göran Isacsson and colleagues examined the use of various antidepressants among people who committed suicide and concluded that therapeutic failure may be a greater problem than toxicity.[1] They state that they refrained from ranking different drugs, but this occurred in practice because the differences found were explained on the grounds of the weaker antidepressive effect of the newer drugs, moclobemide and mianserin. The basis for the authors' conclusion was that, despite their relatively low toxicity, both drugs were overrepresented in the people who had committed suicide compared with their use in general.

The rate of suicide in Finland is among the highest in the world.[2] To obtain more effective means of preventing suicide a one year nationwide study was conducted during 1987-8. During the year of the study 1397 suicides were committed; toxicological screening was performed in 1348 cases. All antidepressants sold at that time in Finland were screened for (mianserin was on the market, but not moclobemide). Antidepressants were found in 38 cases (amitriptyline 16, doxepin seven, maprotiline eight, mianserin two, and others five) among 1083 suicides committed by means other than poisoning. When these figures are correlated with the sales of the corresponding drug the risks are opposite to those reported by Isacsson and colleagues: 16·6, 4·7, 3·9, and 2·0 cases/defined daily dose/1000 inhabitants/day for maprotiline, amitriptyline, doxepin, and mianserin respectively.

Other explanations besides effectiveness are possible for the results obtained in the Swedish study—for example, not all people who commit suicide are depressed, not all depressed patients are treated with antidepressants, and patients might have been selected according to a particular drug. The last mentioned reason is more critical in the case of a new drug. Moclobemide was introduced into the Swedish market in 1989 and mianserin in 1990, and the study period was 1990-1. Moreover, to the best of our knowledge, at that time in Sweden moclobemide was considered to be a second line drug, which might be tried after failure of other drugs.

A more informed view on the debits and credits of the management of depression has been presented by Henry.[3] His scheme of the fate of a depressed patient takes all critical points into consideration: diagnosis, treatment, compliance, and response. Toxicity is only one of the problems associated with antidepressants; at least in Finland, that is not only a marketing argument but also a genuine concern. In 109 fatal cases of poisoning with antidepressants in Finland during 1992 the most important toxicological finding was amitriptyline in 38 cases and doxepin in 38 cases; of the new drugs, citalopram was found in eight cases, moclobemide in eight, and mianserin in two. The difference in toxicity is well documented.[4,5]

We have doubts about the validity of a post-mortem study on the antidepressant effect of drugs, even in the case of suicidal depression. Our point of view is a clinical one. Whether some drugs are relatively more effective than the others in treating depression or preventing suicide requires properly designed clinical and prospective studies.

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Teaching medical students about disability

EDITOR,—In her editorial on teaching medical students about disability Alleyna Claxton is right to suggest that those affected by disability should be consulted.[1] ParentAbility, a self help support group within the National Childbirth Trust, is one group that medical colleges should approach to ensure that the attitudes, skills, and knowledge learnt during training are focused on meeting the needs of people who use services. ParentAbility's contact register includes about 400 mothers, and some fathers, with arthritis, cerebral palsy, spina bifida, epilepsy, multiple sclerosis, myalgic encephalomyelitis, and visual and hearing impairments as well as a number of rarer disabilities and problems arising from accidents and polio. The network is a rich resource and is currently contributing to the training of a range of health professionals, including student midwives in Northampton, Basingstoke, and Oxford. Any medical colleges wishing to contact the group should write to ParentAbility, National Childbirth Trust, Alexandra House, Oldham Terrace, London W3 6NH.

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1 Claxton A. Teaching medical students about disability. *BMJ* 1994;308:805. (26 March,)

Rational prescribing

EDITOR,—It is unfair that the Audit Commission should put the blame for the cost of medicines and prescribing on to general practitioners.[1] Pharmaceutical prices are agreed with the pharmaceutical companies and the Department of Health through the Pharmaceutical Price Regulating Scheme. The department is responsible both for the cost effective use of drugs in the NHS and for the welfare of the British pharmaceutical industry. The department therefore has conflicting aims. Any downward pressure on expenditure through doctors' prescribing will be countered by price increases agreed with drug companies through the price regulation scheme. Of course, profits earned from drugs by pharmaceutical companies go towards research into new medicines. To support research by the pharmaceutical companies at the present level any reduction in the cost of expensive drugs must inevitably lead to an increase in the cost of the cheaper ones.

The overall cost to the NHS of pharmaceutical products is not in the hands of general practitioners but is controlled by the Department of Health through the Pharmaceutical Price Regulating Scheme.

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1 Tonks A. GPs' prescribing is irrational, says Audit Commission. *BMJ* 1994;308:675. (12 March.)

Sumatriptan

EDITOR,—According to extensive clinical trials, sumatriptan combines high efficacy with good tolerability and safety in acute attacks of migraine.[1] Although it has not shown any addictive properties in short term and long term safety studies, we report on seven patients with a longstanding history of migraine in whom misuse of sumatriptan developed. One similar case has been reported recently.[2]

The seven patients (five women, two men) were aged 47-65 (average 54) and attending specialist headache clinics. Two had migraine with aura and five had migraine without aura.[3] The average age at onset of the condition was 20 (range 14-25). All patients had chronic daily headache and used sumatriptan daily or almost daily (four took it orally and three subcutaneously; they took 15-60 (average 32) doses a month). All patients had previously suffered from drug induced headache (average duration 10 years) caused by ergotamine (one patient), analgesics (three), and mixed ergot-analgesic preparations (three).

Four patients had previously undergone one or more attempts at withdrawal of analgesics or ergotamine compounds. The patients switched from misuse of analgesics or ergotamine to misuse of sumatriptan within one week to 36 months (average nine months). In all cases sumatriptan led

to fast and efficient relief of acute headaches, but the patients had to use it daily or almost daily (in one case alternating it with ergot preparations) to prevent recurrence. Treatment consisted of abrupt withdrawal of sumatriptan and introduction of prophylaxis against migraine. Subsequently, daily headaches resolved in all patients.

All of these patients had a long history of misuse of drugs for migraine and were misusing those drugs when they switched to regular use of sumatriptan. Therefore our data provide no evidence that sumatriptan has addictive properties in patients without a history of uncritical use of drugs for headache. Possibly, however, sumatriptan has a similar risk of misuse to that associated with analgesics and ergot compounds in people with chronic headache with previous drug dependency. The long term effects of daily use of sumatriptan are unknown. Although sumatriptan given for 7-10 days alleviated rebound headache when ergot preparations were withdrawn in a small number of patients who misused them,[4] this finding needs confirmation.

Sumatriptan is approved only for the treatment of acute migraine attacks. We believe that it should not be prescribed to patients who are taking analgesics and ergot compounds daily and should be prescribed with caution to patients with a history of misuse of analgesics and ergot compounds.

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Enforced hysterectomies

EDITOR,—I am not surprised that Caroline Richmond has collected 11 cases of women who have had hysterectomies against their will.[1] In my research,[2] in which 500 women were questioned, over a fifth stated that their experience of obstetric or gynaecological procedures was "very distressing" or "terrifying." Indeed, on a clinically validated questionnaire,[3] 30 women were found to have post-traumatic stress disorder as a result of their experiences. Many described their treatment as resembling an assault, which accords with others' findings.[4]

As a general practitioner, I have received letters about patients from gynaecologists to the effect that "while I was in there, I decided it was better to take it all away, rather than have to go back in later if she develops ovarian cancer." Prophylactic oophorectomy is, in my experience, carried out in many cases without proper discussion with the patient, who is often devastated after the operation to find that she is rapidly undergoing postmenopausal aging, which cannot be reversed by hormone replacement therapy.

Until women are involved in the decision making process affecting their own bodies, and are given information, choice, control, and the freedom to withhold consent, my concern is that many will continue to be traumatised by a system which is fond of its own power.

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Reforming the NHS reforms

EDITOR,—In his paper discussing both historical and developing complex issues facing everyone involved in health care in Britain A W Macara, the chairman of the BMA's council, gives a clear summary of the current situation.[1] Sadly, this is marred by many phrases indicating that the government needs to "reinstate" and "restore." One thing that any government is unlikely to do (probably because it can't, not because it won't) is to reinstate or restore anything.

The first step in promoting change is to recognise that a problem exists—which Macara outlines. The second is to accept responsibility for doing something about it and not to blame others. The medical profession would do well to stop "looking to government to restore the . . . key values" and thinking that "resolution of these issues requires a resolve by government." No: it requires doctors to take charge.

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1 Macara AW. Reforming the NHS reforms. *BMJ* 1994;308:848-9. (26 March.)

Minerva taken in by myth

EDITOR,—Minerva reports that the breast implant of a woman diver exploded during ascent from 30 m, causing major injuries to her chest wall and fracturing two ribs. This apocryphal tale can be traced from Minerva's source (*Diver Magazine*) through the newsletter of a small diving club back to a United States newspaper, the *National Enquirer*, which is renowned for its sensational stories, but not for their accuracy. Under the headline "Ka-boob!", the accident was alleged to have occurred in Mexico.

Women divers with breast implants are naturally concerned by such stories, particularly when credence is added by publication in a major medical journal. Before such an implausible report is repeated, surely the accuracy and provenance of the story should be checked.

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1 Minerva. *BMJ* 1994;308:1050. (16 April.)

Gulf illness

EDITOR,—Recently, the Gulf war has been held responsible for a new mystery illness, the "Desert Storm syndrome" or "Gulf illness." I wish to describe the steps being taken by the defence medical services to investigate these claims. During the past year we have assessed patients who have developed symptoms which they maintain were caused by service in the conflict in the Gulf in 1990-1. Because about half of the troops who served in the Gulf have left the services it has not been simple to identify, let alone gain access to, all those who claim to exhibit such symptoms.

For those who are still serving, referral for assessment is a simple, well established procedure. For those who have left the services and write direct to the Ministry of Defence for help, we ask that they first see their general practitioner to arrange a formal referral. The assessment is then carried out. The procedure for ex-service personnel has been repeatedly publicised on television and radio and in the press.

A register of all referrals is maintained at the Defence Medical Services Directorate, and all assessments are conducted at one service hospital for clinical consistency. A detailed medical and occupational history is taken. The particulars of the patient's experience in the Gulf are determined; this includes precise locations, movements between locations, and the timings of those movements. In addition, memorable events experienced by the patient are noted.

A complete medical examination and routine screening blood tests follow. Subjects with specific, localising symptoms and signs have the relevant special investigations, which may include endoscopy, biopsy, electroencephalography, electromyography, computed tomography, and magnetic resonance imaging. We try to avoid using too rigid an investigative protocol, preferring to assess each patient as required.

So far 33 Gulf veterans have been referred for assessment. Ten have had a complete assessment and been discharged from hospital follow up. Eleven have had initial consultations and are awaiting follow up to discuss the results of investigations. Twelve are awaiting their initial hospital consultation.

The symptoms described are diverse and non-specific. They include fatigue, weakness, muscle or joint pain, headache, hair loss, poor concentration, diarrhoea, depression, mood swings, disturbance of sleep, breathing difficulties, and cough. Most patients describe three or four symptoms from this list, but no consistent symptom complex has emerged. The commonest symptoms are fatigue and weakness. Consistent findings have been an absence of physical signs and no abnormality on investigation. Patients who have completed the assessment have responded well to the reassurance it gave them.

In summary, we have no evidence to support the claim that a medical condition exists that is peculiar to those who served in the Gulf conflict. Medical statistics that we have compiled also indicate that the incidence of the diverse symptoms alleged to make up the syndrome has not increased. There is no doubt that the symptoms reported are real; what is in doubt is whether the non-specific symptoms of Gulf illness have a higher prevalence in Gulf veterans than in the general population. American work indicates that they do not.[1]

Neither chemical nor biological weapons were used by Iraq, but the threat they posed was well known to all personnel who went to the Gulf. The circumstances of the conflict were therefore highly stressful, and we bear this in mind in our continuing investigation of Gulf illness.

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