

major oncology centre. If the management is directed by the major centre there should be an adequate check on standards and back up in the event of complications.

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## Outcomes research in clinical practice

### Descriptive studies are unhelpful

EDITOR.—In the issue that included an editorial discussing the importance of outcome research in clinical practice,<sup>1</sup> the paper by D J Houghton and colleagues concluded that “general practitioners should no longer request sinus radiography” without measuring any outcomes at all.<sup>2</sup>

This was a descriptive study in which local general practitioners’ knowledge of indications for sinus radiography was assessed. The authors extrapolated the fact that half the population have minor changes on such radiographs and concluded that the indications given were worthless. The requests perceived as due to patient pressure were dismissed on the grounds that general practitioners should invoke the college guidelines. Studies have shown that using the guidelines reduces the number of referrals,<sup>3</sup> but in an age of patient’s rights it is difficult to dissuade a demanding patient completely.

A more appropriate method would have been to examine the actual requests received by a radiography department and measure the outcomes of these in terms of radiological findings, clinical outcomes, and patient satisfaction. Apart from principals answering a questionnaire, the general practice input is non-existent and consequently is unlikely to change clinical practice.<sup>4</sup> As it is, the authors should remember that a descriptive study has the weakest methodological rigour and is certainly not the basis for such sweeping conclusions.

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### Patients’ views ignored

EDITOR.—Andrew Haines and Roger Jones give a welcome reminder of the importance of implementing findings of research into medical practice.<sup>1</sup> If it is true, as has been suggested,<sup>2</sup> that no more than 15% of all practice within the NHS has been properly evaluated, there is a long way to go before we can claim with any confidence that the health service is demonstrably cost effective.

However, there is a serious bias in the article. In all the examples given and strategies suggested it is implicit that the experts decide what is effective treatment and that health professionals are then suitably persuaded to change practice (sometimes by the indirect route of informing the public of research results). What is missing is the involve-

ment of patients and public in assessing the outcomes of care in the first place. The conference on outcomes research in clinical practice noted that the list of possible groups concerned with outcomes failed to mention patients at all.<sup>3</sup> The bias against including patients’ experience seems pervasive.

There is one area of developing practice where this bias is apparent and particularly topical: the use of counselling in general practice. A review last year stated that “many attempts to evaluate its effectiveness have shown little or no benefit,”<sup>4</sup> and this is the tone of many such reviews in the medical press. Such a conclusion is seriously at odds with the positive experience of patients and doctors in practices where counselling is provided.

In fact there is good evidence of benefits from a systematic meta-analysis of all British studies of counselling in general practice that fit precise selection criteria.<sup>5</sup> It is possible that the review articles are seriously biased in not taking into account subjective experience and in considering only benefits at longer term follow up at one or two years. The value of counselling, which may be rapidly apparent to patients and general practitioners, could be reduced for many patients with self limiting emotional problems. Neither general practitioners nor patients are likely to accept that weakening effects over time are a justification for declaring such treatments as ineffective.

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## Use of benzodiazepines

EDITOR.—Neil Wright and colleagues report a 0.5% point prevalence in a single general practice for prescribing of benzodiazepine anxiolytics taken during the day.<sup>1</sup> Furthermore, they found that almost half the patients in their study wished to continue taking benzodiazepines.

However, the level of prescribing of benzodiazepines may reflect the policies of only the general practitioners concerned. We are currently carrying out a study of benzodiazepine prescribing in 16 Leicestershire practices, total population 117096, and have found wide variation in the prevalence of long term benzodiazepine users between practices. The range for users of anxiolytic benzodiazepines was 0.3% to 1.9%, and for users of hypnotic or anxiolytic drugs was 0.6% to 3.9% of the practice populations, indicating that the practice in the study reported by Wright and colleagues had a relatively low proportion of long term users.

Patients in our study were classed as chronic benzodiazepine users if they had taken the drug for longer than one month, to accord with the Committee on the Safety of Medicines’ guidelines, which state that benzodiazepines should be prescribed for only two to four weeks.<sup>2</sup> Although this cut off point is earlier than that of Wright and colleagues, this cannot account for the difference in prevalence levels as 96% of the patients in our study had been taking the drug for more than a year.

Our study has identified a total of 2178 long term benzodiazepine users (hypnotic or anxiolytic). Even if only half of these want to stop taking their

medication, as indicated by Wright and colleagues, we have found just over 1000 patients from 16 practices who may benefit from being offered assistance with withdrawal. Therefore it would be unwise to imply that withdrawal programmes are not required.

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## Health needs of elderly people

EDITOR.—In her editorial on priorities in geriatric research, Christine K Casel states that the world’s elderly population is increasing dramatically and most visibly in “developed” countries.<sup>1</sup> This reflects our society’s myopia with respect to the health of those in so called “developing” countries, where the majority of the world’s elderly live.

The world population aged over 55 years increases by one million people per month. Eighty per cent of growth is in developing countries where, by the year 2020, the elderly population is likely to exceed one billion. Over the next 30 years the proportion of the world’s elderly population living in developing countries is projected to increase from 58% to 72%.<sup>2</sup> Current public health policies in many Third World countries, supported by international agencies, focus on maternal health, contraception, and infant health. The result will be the aging of society in Africa, Asia, and South America, and chronic, non-communicable diseases in these populations will become a prime health concern.

Is this not evidence enough to support the urgent need for research into the health care needs of elderly people worldwide? We must be less parochial if we wish to address the genuine needs of the world’s elderly population. The effects of demographic changes on patterns of health demand that we formulate plans to deal with the associated medical problems in rich and poor countries alike.

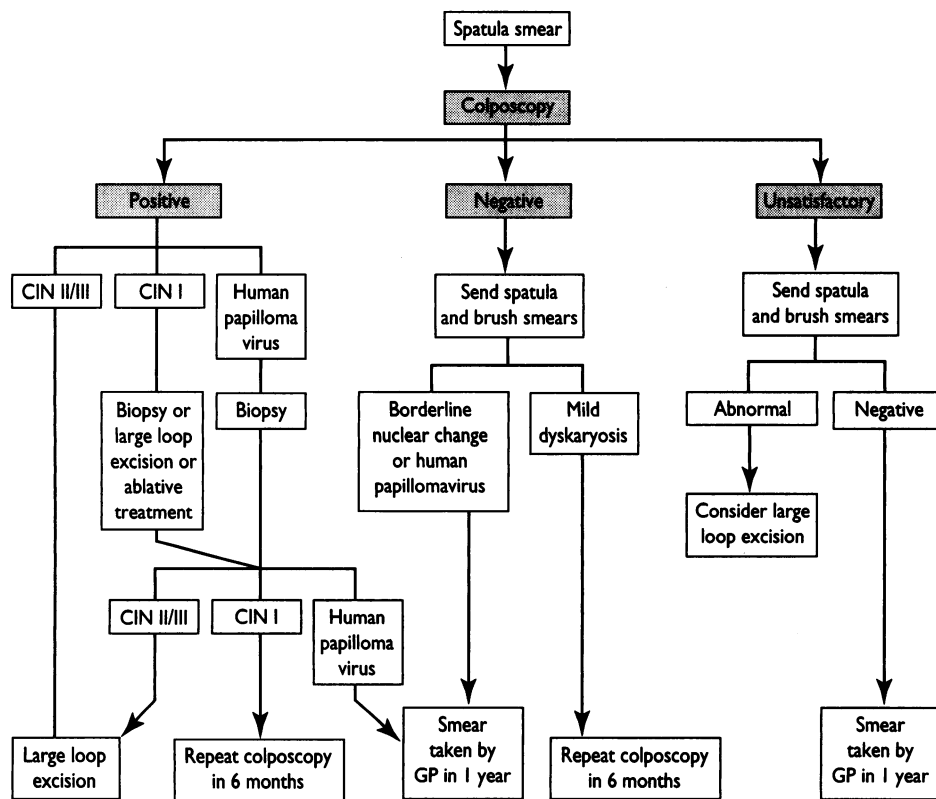
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## Management of mild dyskaryosis

EDITOR.—Flannely and colleagues,<sup>1</sup> Soutter and Fletcher,<sup>2</sup> and Hammond<sup>3</sup> all recommend immediate colposcopic referral for mild dyskaryosis. This policy would have significant implications for the colposcopy workload, and although immediate referral would reduce the volume of pre-colposcopic surveillance, colposcopy itself often leads to frequent follow up smears. Selective referral according to smoking habit is an increasing possibility and might have public health benefit. In any event, continuing education about cervical



Guideline for colposcopic management of mildly abnormal results of cervical cytology (CIN=cervical intraepithelial neoplasia)

screening and the importance of not defaulting is vital. Most cases of cervical cancer occur in those who are unscreened or screened infrequently.<sup>4</sup>

If immediate referral for mild dyskaryosis is adopted, colposcopy must seek to detect and treat any significant abnormality (cervical intraepithelial neoplasia grade II or worse), avoid overtreating very mild lesions, and where possible expedite return to cytological surveillance. The correct management of cervical intraepithelial neoplasia grade I remains a grey area.

In 1991, 46% of referrals to the Oxford colposcopy unit were for persistent mild abnormalities (borderline nuclear change, human papillomavirus change, mild dyskaryosis). This prompted us to draw up guidelines (see figure) for the management of such cases and we have now reviewed the first 100 patients so managed. Our guidelines recommend biopsy rather than "see and treat" unless colposcopy suggests at least cervical intraepithelial neoplasia grade II.

Forty seven patients (mean age 33 years) were referred for mild dyskaryosis, 53 (mean age 39 years) for borderline nuclear or human papillomavirus changes. At first visit a colposcopic diagnosis of cervical intraepithelial neoplasia II or III was made in eight patients, seven of whom had been referred with mild dyskaryosis. After initial assessment 44 patients were discharged untreated for follow up cytology at one year, 22 were kept under review, and 34 were treated (23 at the first visit) by large loop excision of the transformation zone or cold coagulation.

After one year 56 of the 100 patients had been discharged untreated (15 of these were referred with mild dyskaryosis), 40 had been treated (29 referred with mild dyskaryosis,  $P < 0.001$ ), and four remained under review (three referred with mild dyskaryosis). Histological examination for treated patients showed 15 cases of cervical intraepithelial neoplasia II or III, including 13 with mild dyskaryosis on referral ( $P < 0.01$ ). Eleven patients may have been overtreated in that histology showed less than cervical intraepithelial neoplasia I.

These guidelines are helpful in a unit staffed by several doctors. They promote consistency of

management, facilitate audit, and provide sufficient flexibility to take account of patients' particular needs.

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- 1 Flannely G, Anderson D, Kitchener HC, Mann EMF, Campbell M, Fisher P, et al. Management of woman with mild and moderate cervical dyskaryosis. *BMJ* 1994;308:1399-403. (28 May.)
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## Intrapartum care and cerebral palsy

EDITOR,—"This week in *BMJ*" for the paper by Geraldine Gaffney and colleagues referred to a retrospective investigation of 339 children aged 5 years, suffering from cerebral palsy.<sup>1</sup> The conclusion that only 6.8% of cases occurred in non-malformed term singleton babies following suboptimal obstetrical care, extrapolated to all patients with cerebral palsy in the region, is not supported by the data.

Nine subjects were born outside the area, 42 had abnormality or unidentified antepartum causes of cerebral palsy, 27 had postnatal causes, and the obstetrical antecedents of 125 were not investigated. There were therefore 205 children born in

the area who were investigated, of whom 138 (67%) may have suffered from intrapartum asphyxia. The obstetrical care of 128 was described in table V, which reveals 59 instances following suboptimal care. The exclusion of 10 mature asphyxiated infants without neonatal encephalopathy cannot be sustained: this assertion is close but not absolute, and it may be underdiagnosed.<sup>2</sup>

Suboptimal intrapartum care was recognised for 29% of all those investigated, and for either 46% or 49% of those in whom other identified causes were excluded. The criteria of suboptimal intrapartum care as defined in appendix 1 included delay in interpretation after the recognition of specified physical signs of "fetal distress" for more than 90 minutes, halved in the presence of meconium, but without any other qualification. These signs have been recognised as being ominous<sup>3,5</sup>; the arbitrary time frame for response has been consistent delayed decelerations following three contractions for patients monitored by auscultation, and 10 to 15 minutes after ominous observations consistently recorded electronically.

Had stricter criteria been applied to the quality of intrapartum care there would almost certainly have been more instances of failure to respond to fetal distress. In Victoria, comprehensive data over many years have shown that fewer than 6% of infants are premature. The exclusion of 36% of patients with cerebral palsy from investigation because of prematurity, a significantly overrepresented group, further detracts from the validity of the study.

While the conclusions of this investigation of the contribution of suboptimal intrapartum care as a cause of cerebral palsy after either mature or all live births cannot be accepted, the quality and size of the epidemiological database is unique. A re-examination of the obstetrical antecedents of cerebral palsy, with the application of more appropriate standards for the response to fetal distress—especially relating to premature delivery, multiple pregnancy, and impaired fetal reserve before labour—would be invaluable.

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## Authors' reply

EDITOR,—E L G Beavis's letter highlights the important fact that the term "cerebral palsy" is used to describe a group of conditions with different aetiological pathways.

As he correctly points out, among the recognised risk factors are preterm birth and multiple pregnancy. We, in collaboration with others, have been studying the factors which damage the developing brain in these groups of babies. Current evidence suggests that these factors can occur prenatally, during labour and delivery, or after birth. The extent to which "suboptimal care" during labour and delivery of the preterm baby contributes to the development of cerebral palsy is not known. As Beavis will be aware, there has been little systematic evaluation of different methods of management of preterm labour and delivery. Until current and new practice is rigorously tested for effectiveness