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# Services for cleft lip and palate

## Maxillofacial surgeons use strict surgical protocol

EDITOR,—It is important to debate the problems of the apparent poor results of surgery for cleft lip and palate.[1,2] As editor of the specialist journal I note some important developments.

The authors of the paper and letters on the subject may not be aware of an important initiative being taken by a group of maxillofacial surgeons (current estimates suggest that up to a fifth of primary clefts in England and Wales—and most in the rest of Europe—are treated by this specialty). This initiative entails using a strict surgical protocol in conjunction with regular audit or outcome. One clinician closely supervises the surgical technique and interpretation of the surgical protocol. At present, about 120 patients are monitored a year.

This is a particularly exciting project as it is also being extended to France and Germany. This process clearly overcomes the problems of small numbers for audit and also allows a more convenient, local service to be provided for patients. The important part played by local paediatricians may also be enhanced. Incidentally, the surgical technique involves a different philosophy, placing much greater emphasis on a "functional" repair, and early results show great promise (J P Hayter; S D Adcock; meeting of British Association of Oral and Maxillofacial Surgeons, 1995).[3]

It may be an error in this controversial issue to rush headlong into expensive and inconvenient (for patients) centralisation without good scientific evidence that it will improve results. Indeed, plastic surgery has traditionally operated from regional centres, yet, sadly, the outcome for cleft lip and palate at these "centralised" units has formed the basis of some of the studies by Williams and colleagues and the apparent poor outcome.

There are many other elements to good outcomes. Surely the frequency with which a surgeon operates in the mouth and jaws must be of great relevance in the decision on how many operations for cleft lip and palate he or she must do to be competent. Trying to define the "correct" number of cases is a nightmare. The rate of stroke after carotid endarterectomy drops from 7% to 3% if the surgeon performs over 10 operations a year.[4] Yet of the 16 surgeons who performed a low number of operations, seven had had no patients with stroke in three years, which suggests that number of operations is not the only criteria for success. These are complex issues that need broad, careful consideration and much more scientific evaluation.

PETER WARD BOOTH
Honorary editor

British Journal of Oral and Maxillofacial Surgery,
Department of Maxillofacial Surgery,
Queen Victoria Hospital,
East Grinstead,
West Sussex RH19 3DZ

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## Surgical caseload is only one variable that influences outcome

EDITOR,—Recent studies have highlighted deficiencies in the overall standard and organisation of repair of cleft lip and palate in England and Wales, but, contrary to the opinions expressed in these papers, there is no conclusive evidence that surgical caseload is a critical factor in determining outcome.[1,2] In a retrospective European multicentre study the number of operations carried out by an operator was just one of several variables that may have influenced the outcome of treatment in patients with cleft lip and palate.[1]

Alison Williams and colleagues admit that the minimum number of primary cleft repairs that a surgeon should undertake each year is not known.[2] They go on to suggest, however, that an annual caseload of 40-50 repairs would be desirable and cite a report by the Standing Dental Advisory Committee as the source of this recommendation. Unfortunately, this report has not been published and it is therefore impossible to comment on the validity of this figure.

Although there is a strong case for centralising many specialist surgical services, there is little evidence to support the unqualified acceptance of this process for services for cleft lip and palate. The advantages of local treatment are often dismissed as secondary considerations, but having to travel long distances regularly may present considerable problems for young families. Contrary to the views expressed by P J Sykes, it is not surgeons, managers, or purchasers but paediatricians who are often keen to instigate local services for cleft lip and palate as they are sympathetic to these problems and are concerned about the lack of coordination that often exists between local and centralised services.[3] In some areas local services have been developed as a consequence of patients' dissatisfaction with the regional service.

While there is no place for "occasional" cleft lip and palate surgeons, there is no reason why local units with the necessary multidisciplinary skill cannot cooperate in an effective multicentre treatment programme and thereby provide the caseload necessary for meaningful clinical audit. This is precisely why maxillofacial surgeons involved in the primary management of cleft lip and palate in England and Wales have established a multicentre audit, based on a well defined treatment protocol. Such initiatives should be encouraged as they provide an opportunity to improve the standard of management of cleft lip and palate, which has been dominated by clinical dogma for too long.

CHRISTOPHER PENFOLD
Senior registrar

Maxillofacial Unit,
Queen Victoria Hospital NHS Trust,
East Grinstead,
Sussex RH19 3DZ

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# The fibromyalgia syndrome

## Outcome is good with minimal intervention

EDITOR,—Michael Doherty and Adrian Jones paint an unnecessarily pessimistic picture of the outcome in patients with the fibromyalgia syndrome.[1] They say that patients "cannot cope with a job or ordinary household activities" and that "the prognosis for fibromyalgia is poor." They base this on the one study in a British hospital population. Such populations will contain patients with worse symptoms, comorbidity, and psychosocial stress. The busy, practical, and focused outpatient care that might be suitable for dealing with many rheumatological problems may not be suitable for fibromyalgia, which often requires protracted counselling and multidisciplinary strategies.

Furthermore, most people with this condition do not attend hospital clinics but are seen in the primary care sector. Studies of this group have shown a good outcome with minimal intervention.[2] Observations of patients in community referral rheumatology practices in Australia indicate a considerable improvement with appropriate intervention. This is not to say that many patients do not have a chronic disabling condition, but the adoption of a positive approach to outcome is appropriate. Linking the diagnosis of fibromyalgia with a poor outcome can become a self fulling prophecy and inappropriate medical dogma. This may preclude appropriate strategies that might otherwise greatly improve patients' quality of life.

GEOFF LITTLEJOHN
Associate professor of medicine

Rheumatology Unit,
Monash Medical Centre,
Clayton,
3168 Victoria,
Australia

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## Electroacupuncture is a potentially valuable treatment

EDITOR,—In their review of fibromyalgia[1] Michael Doherty and Adrian Jones omit to mention electroacupuncture, which is a potentially valuable treatment. Deluze *et al* described a controlled study of 70 patients who met rigorous criteria for the diagnosis of fibromyalgia.[2] The group that was treated with electroacupuncture showed highly significant improvements in seven of the eight variables measured. Most importantly for the patient, pain scores improved by 70%, whereas they increased by 4% in the control group. The pain threshold was raised, as assessed by pressure gauge, and the evaluations made by the patients and the (blinded) examining doctor also showed highly significant improvements.

Deluze *et al* presented results as mean scores for the whole group, which conceals the fact that symptoms almost completely disappeared in a quarter of the patients given electroacupuncture. The research needs repeating, and follow up studies are necessary; meanwhile, such an important finding should not be neglected. Doherty and Jones's conclusions about the poor prognosis for fibromyalgia look unnecessarily pessimistic.

Modern acupuncture is now a reproducible technique that can be easily learnt by doctors and can be subjected to rigorous trials. Its physiological effects include the release of neurotransmitters[3] as well as deactivation of trigger points.[4] Acupuncture seems to retain its effectiveness even when much of its Chinese philosophical background is discarded, although many empirical observations need a good deal of further research.

ADRIAN WHITE
Research fellow in complementary medicine

Postgraduate Medical School,
University of Exeter,
Exeter EX2 4NT

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