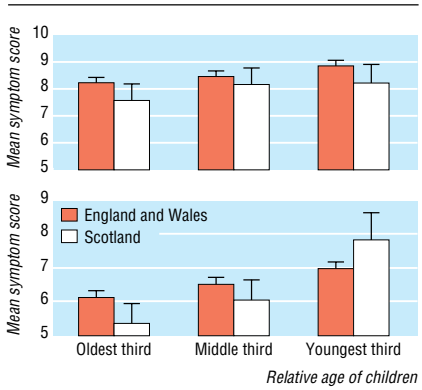
Letters

Child psychiatric disorder and relative age in school year



Comparison of parents (top) and teachers (bottom) in detecting psychiatric disorder by children's relative age (bmj.bmjjournals.com/cgi/content/full/327/7413/472/FIG1)

Holding back may cause more harm than good

EDITOR—If the increased psychiatric stress in the comparatively younger students in the study by Goodman et al is the result of inappropriate teacher expectations, holding back students may have no net benefit.[1] The held back student becomes one of the older students, raising expectations and increasing stress for those younger. Some held back students will be resentful and increase stress on everyone.

American schools have a conflict of interest. Holding a child back increases the number of years that the child spends in a particular school. This increases the total government funding that school receives. I have witnessed students denied early graduation for just this reason.

Held back students are injured in at least one way. They are stuck in an extremely lengthy educational process for one more year, having been denied one extra year of occupational income and freedom from schooling. Numerous American studies have found no psychological harm from grade acceleration of the academically capable. Accelerating the most gifted may accomplish the same goals that Goodman et al desire with greater benefit. There is no research showing that holding back on psychiatric grounds helps any student, let alone which students.

There is a politically correct hostility against streaming students and against grade acceleration.We need to find ways to shorten the time college bound students spend in school, not lengthen it. Obviously, my 13 year old daughter is more immature than others in her college classes, but that doesn't mean she would have benefited from being held back.

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Competing interests: None declared.

1 Goodman R, Gledhill J, Ford T. Child psychiatric disorder and relative age within school year: cross sectional survey of large population sample. *BMJ* 2003;327:472-5. (30 August.)

Holding back may cause more harm

EDITOR—Radecki's perspective from the United States (previous letter) on the problem of age and psychiatric disorder in children discussed by Goodman et al is interesting.[1] In Australia holding back is very much encouraged by education authorities and the media and is deemed almost mandatory for boys, who are regarded as suffering far more disadvantage from "early" school starts.

In New South Wales the school year begins in late January, and a child may start if he or she has turned 5 or will turn 5 by the end of June, but many are held back until the following year, resulting in a possible age spread of 18 months in a single class. This situation seems to put even more emphasis on the need for teachers to be aware of the differing ability levels in their classroom. However, it is parents and parental attitude to schooling which are generally portrayed as the major cause of dysfunction in children.

The *Sydney Morning Herald* ran a brief report on the research paper by Goodman et al.[2] Although the authors made no mention of parents as a risk factor in the development of a child's psychiatric difficulties, the *Herald* report suggests that "pushy" parents with unrealistic expectations for their children's academic success are the primary cause of the dysfunction reported in the original paper.

This is quite typical of media attitudes and public perception in Australia. Radecki said that in the United States gifted children who would benefit from academic acceleration may be held back by school administration. In Australia, such children are often held back because parents fear the social disapproval that results from suggesting that a gifted child has different educational needs. The paper by Goodman et al already seems to be on its way to becoming part of the justification for forcing academically gifted children into lockstep progression with their age peers.

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1 Goodman R, Gledhill J, Ford T. Child psychiatric disorder and relative age within school year: cross sectional survey of large population sample. *BMJ* 2003;327:472-5. (30 August.)
2 Bradley M. Why the class baby may get mental woes. *Sydney Morning Herald* 2003, 29 August. www.smh.com.au/text/articles/2003/08/29/1062050664727.htm (accessed 17 Sep 2003).

Children need to be regarded as individuals in education

EDITOR—Goodman et al said that teachers often forget to make allowances for a child's relative age.[1] They also seem to forget to make allowances for a child's educational needs, intellectual potential, and already obtained academic ability. Children are not regarded as individuals in education.

Being the youngest in the year is associated with educational disadvantage only if the teacher does not make allowances for a child's ability or needs. It is not the parent that has the unreasonable expectation: it is the system, which expects everybody to function at a certain level at a certain age in their life regardless of their intelligence, ability, need, personality, or situation.

Grouping children by relative age would help solve the problem only if all those children at that particular age were at the exact same level and stage of their educational, social, and emotional development and had the same needs that needed to be met.

Children need to have their particular educational needs met to be happy and fulfilled in their education. Meeting children's age requirements is in most cases not meeting the child's educational needs and is very damaging to a child's self esteem and feelings of self worth, which in turn affects them psychologically and emotionally.

Surely a more sensible approach would be to start children at school when they are emotionally and socially ready to start school and then put them into classes at a level that is appropriate and suitable to their ability and need.

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1 Goodman R, Gledhill J, Ford T. Child psychiatric disorder and relative age within school year: cross sectional survey of large population sample. *BMJ* 2003;327:472-5. (30 August.)

Peer effects need to be considered

EDITOR—Goodman et al show clearly how small effects at an individual level can create opportunities at the population level for public health interventions.[1] As they say, the differential behaviour of teachers towards slightly younger pupils in the classroom may increase their risk of developing mental health problems. However, there are other players learning their parts in the classroom drama: the older children.

As professionals and adults it is easy for us to neglect the long term impact of early social adversity,[2] but patterns of bullying and sexual aggression can undermine mental wellbeing in the school age population. At 5, if there are going to be targets for classroom bullying, the younger (smaller, less articulate, less assertive) child may be at greatest risk. At 11 and older, the young people who reach puberty first may show aggression towards their less developed classmates.

Most children do not experience trauma during "the best years of their lives," but for some *Lord of the Flies* can be closer to their experience of schooldays. When young people do become trapped in harmful social situations, quite subtle differences in age and development might increase the risks. However, this growing knowledge base on child development and life trajectories could also improve our interventions to promote mental health.[1]

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1 Goodman R, Gledhill J, Ford T. Child psychiatric disorder and relative age within school year: cross sectional survey of large population sample. *BMJ* 2003;327:472-5. (31 August.)
2 Caan W. Good for mental health—an academy for the social sciences. *J Mental Health* 2000;9:117-9.

Social anxiety disorder has social and economic burden

EDITOR—Schneier described the current knowledge about social anxiety disorder: common, underdiagnosed, impairing, and treatable.[1] Patients with this disorder commonly underperform educationally[2] and have a lower probability of marrying, a lower economic status, and a higher probability of losing their job. They are frequent users of the public health system.[3] All these problems can be worsened if the social anxiety disorder is accompanied by other mental disorders.[3]

Some patients with phobic symptoms can work and try to adapt their life to their symptoms. The early onset of symptoms in adolescence interferes with the acquisition of social skills, resulting in social isolation.

Although psychopharmacological treatment is available for social anxiety disorder,[4] most of the costs of the disorder are the result of lost income and disability among people who are receiving no treatment for their disorder. One of the astonishing things about anxiety disorders is how media educational campaigns result in a dramatic increase in the number of treated patients with these conditions; patients often have symptoms for years, with no awareness that others have similar symptoms or that specific medical treatment exists.

Education, information, and knowledge leading to an early diagnosis and treatment are key elements for lowering the social and economic burden of social anxiety disorder. The limitation of lives and the economic and social problems are always underestimated.

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Competing interests: None declared.

1 Schneier F. Social anxiety disorder. *BMJ* 2003;327:515-6. (6 September.)
2 Liebowitz MR, Gorman JM, Fyer AJ, Klein DF. Social phobia. Review of a neglected anxiety disorder. *Arch Gen Psychiatry* 1985;42:729-36.
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Role of living liver donation

Requirement for transplantation is high

EDITOR—Neuberger and Price make a good case that living liver donation should be available in the NHS, and one might well ask why this is taking so long when the procedure has been in use so widely over the past five years.[1]

There is certainly a need for more liver transplant operations as the figures quoted for 2002 show: 62 deaths in patients on the waiting list and another 25 patients removed from it because they had become too ill. The waiting list for recipients requiring blood group O cadaver organs in some transplant centres is now around 12 months, which is unacceptable.

The UK transplant rate is already one of the lowest in the West, and the chief medical officer in his annual report two years ago drew attention to the substantial and worrying increase in the number of deaths from cirrhosis in men of working age. Cases may not be referred for a variety of reasons. Eligibility criteria are strict, and many believe it is reasonable that these should be relaxed in the context of living liver donation.

The small number of transplant centres in this country also perpetuates the view that liver transplantation is a very difficult procedure, whereas in many countries elective grafting with cadaver organs has become almost a routine procedure.

Neuberger and Price also refer to "a few" living liver transplants having been done in the United Kingdom. In the programme at the Cromwell Hospital, which I started in October 1998 with Nigel Heaton, Mohamed Rela, and the surgical team from King's College Hospital, we have now treated 17 patients. Survival among recipients is 77%, and no major complications have occurred in the donors.[2] It was set up for overseas patients because of the time they were having to wait for a cadaver organ graft.

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Competing interests: RW is the director of the living donor liver transplant programme at the Cromwell Hospital, London.

1 Neuberger J, Price D. Role of living liver donation in the United Kingdom. *BMJ* 2003;327:676-9. (20 September.)
2 Williams RS, Alisa AA, Karani JB, Muiesan P, Rela MS, Heaton ND. Adult to adult living donor liver transplant: UK experience. *Eur J Gastroenterol Hepatol* 2003;15:1.

Surgery violates principles of beneficence and autonomy

EDITOR—Neuberger and Price admit that there is a significant morbidity and an up to 1% mortality among living liver donors.[1] They argue that a combination of the potential benefits to the recipient, the right of donors to make an altruistic decision to help someone else, an acceptable "societal ceiling" concerning mortality and morbidity, and an acceptable risk-benefit ratio, are sufficient for living liver donation to be morally acceptable.

However, the fundamental goals of medicine, without which medicine could not exist as a practice, are more important than either the notion of patient autonomy or a utilitarian cost-benefit analysis. The fundamental end of medicine is to help an individual sick or injured patient; from this prime goal stem the principles of nonmaleficence, "Do no harm," and beneficence, "Benefit the patient."

The surgery to remove a portion of a healthy person's liver may benefit the recipient, but at considerable risk to the donor's health, with some risk to the donor's life. The surgery is not for the benefit of the donor's health; the surgery can only cause bodily harm to an individual who would have remained healthy otherwise. This violates both the ends of helping this individual patient and not harming this individual patient.

Utilitarian considerations, such as the benefit to the recipient or even the potential satisfaction of the donor should the transplant be successful with minimal complications to both parties, do not change this fact. Neither does the principle of patient autonomy, which is not an absolute right (as Neuberger and Price themselves recognise), but is valid in so far as it fits into the fundamental goal of medicine to help an individual patient in need.

Since surgery on the donor does not benefit the health of that individual patient and is potentially harmful, it violates both the principles of beneficence and autonomy, and should not be considered a morally acceptable part of the practice of medicine.

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1 Neuberger J, Price D. Role of living liver donation in the United Kingdom. *BMJ* 2003;327:676-9. (20 September.)

Falls, chronic diseases, and drug use in elderly women

Lack of association may be explained

EDITOR—In a cross sectional study reported by Lawlor et al use of cardiovascular drugs was not independently associated with a fall.[1] The authors have not, however, addressed certain issues concerning prescribing patterns of these drugs that may have influenced this result.

Appropriate prescription of cardiovascular drugs—for example, angiotensin converting enzyme (ACE) inhibitors—may present with difficulties. ACE inhibitors improve prognosis of patients with heart failure,[2] yet a doctor may decide to exercise caution in prescribing these drugs to patients with an increased risk of falls because of, for example, aortic stenosis or symptomatic postural hypotension. Other patients are inappropriately deprived of ACE inhibitors because of older age[3] or unfounded concerns about adverse effects.[4] A similar pattern may exist for other cardiovascular drugs—for example, calcium channel blockers or nitrates.

A significant proportion of patients in this study that were at risk of falls may not have been prescribed cardiovascular drugs, appropriately or inappropriately, by their medical practitioner. This may explain the lack of association between falls and cardiovascular drugs reported in this study.

The result of this study should not distract from the issue that patients at risk of falls should be prescribed cardiovascular drugs after careful consideration of other factors such as concomitant medical conditions and drug treatment. A comprehensive geriatric assessment in a falls clinic may be able to provide optimal treatment in these situations.

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Competing interests: None declared.

1 Lawlor DA, Patel R, Ebrahim S. Association between falls in elderly women and chronic diseases and drug use: cross sectional study. *BMJ* 2003;327:712-7. (27 September.)
2 SOLVD Investigators. Effect of enalapril on survival in patients with reduced left ventricular function and congestive heart failure. *N Engl J Med* 1991;325:293-302
3 Echemann M, Zannad F, Briancon S, Juilliere Y, Mertes PM, Virion JM, et al. Determinants of angiotensin-converting enzyme inhibitor prescription in severe heart failure with left ventricular systolic dysfunction: the EPICAL study. *Am Heart J* 2000;139:624-31.
4 Large State Peer Review Organization Consortium. Heart failure treatment with angiotensin-converting enzyme inhibitors in hospitalized Medicare patients in 10 large states. *Arch Intern Med* 1997;157:1103-8.

Authors' reply

EDITOR—We agree with Epstein that our study was unable to determine whether the participants had been appropriately prescribed cardiovascular drugs. This was not the aim of the study. He says that we may have underestimated the effect of cardiovascular drugs on the risk of falling because doctors may not prescribe these drugs to patients at greatest risk of falling, implying that our estimate of no effect on falls of cardiovascular drugs represents reduced risk of falling in those prescribed these drugs, appropriately matched by an increased fall risk among women prescribed these drugs inappropriately.

This issue of confounding by indication for treatment is problematic in observational studies of this nature. We could find no systematic review or randomised controlled trial examining the risk of falls associated with angiotensin converting enzyme (ACE) inhibitors or other cardiovascular drugs. However, risks of feeling dizzy or fainting were high in both those treated with enalapril and placebo (57% *v* 50%, relative risk increase 14%, 95% confidence interval 6% to 21%),[1] implying, firstly, that these drugs are still capable of causing falls in people with correct indications for treatment, and, secondly, feeling dizzy and faint is a common experience among patients with heart failure. Therefore, Epstein's suggested balance between falls caused and falls avoided due to confounding by indication seems an unlikely explanation for our findings.

We agree with Epstein that patients with heart failure and coronary heart disease should be prescribed appropriate cardiovascular treatment that may improve their prognosis and that their propensity to fall be assessed clinically. Our study strongly supports such practice as we showed no association between most classes of drugs and falling. Interestingly, we also showed that some factors commonly supposed to be associated with falls (and that Epstein says are used clinically by doctors to identify groups at high risk) such as postural hypotension, alcohol intake, and reduced physiological reserve (as evidenced by low forced expiratory volume in one second) were not associated with falls. It would be useful to validate prospectively such clinical markers of risk of falling as it may be that clinicians are unwittingly denying their patients life-saving, and life-enhancing, drugs such as ACE inhibitors, on spurious grounds.

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Competing interests: None declared.

1 SOLVD Investigators. Effect of enalapril on survival in patients with reduced left ventricular function and congestive heart failure. *N Engl J Med* 1991;325:293-302.

Morphine for management of refractory dyspnoea

Opiates should be used with caution

EDITOR—Abernethy et al identify that hypercapnia and respiratory depression are impediments to the use of opiates in patients with chronic obstructive pulmonary disease, yet they do little to allay those concerns in their report.[1]

Most (88%) of their patients were reported to have chronic obstructive pulmonary disease. This is a diagnosis based on spirometric assessment,[2] but they present no such data. Spirometry would give confirmation of the diagnosis, prognostic information and perhaps selection criteria for the intervention. We disagree that measurement of pulmonary function would be neither generalisable nor ethical as spirometry is an easily performed, non-invasive procedure that is widely available.

The authors say that no respiratory depression was identified, but they present no data to support this. Oxygen saturation and respiratory rate, which are reported, may not identify respiratory depression. Alveolar hypoventilation, the result of respiratory depression, is a function of respiratory rate and tidal volume. The only valid parameter to assess respiratory depression is arterial carbon dioxide ($Paco_2$), and while we agree that arterial blood gas sampling is an invasive procedure, minimally invasive procedures such as capillary blood sampling or capnography would have provided useful results as increases in $Paco_2$ are associated with adverse outcomes.

This is particularly relevant since it seems from the discussion that some patients used non-invasive ventilation, presumably for hypercarbic respiratory failure. We recommend that for refractory dyspnoea opiates continue to be used with extreme caution, in chronic obstructive pulmonary disease at least.

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Competing interests: None declared.

1 Abernethy AP, Currow DC, Frith P, Fazekas BS, McHugh A, Bui C. Randomised, double blind, placebo controlled crossover trial of sustained release morphine for the management of refractory dyspnoea. *BMJ* 2003; 327:523-8. (6 September.)
2 COPD Guidelines Group of the Standards of Care Committee of the BTS. BTS guidelines for the management of chronic obstructive pulmonary disease. *Thorax* 1997;52(suppl 5):S1-28.

Authors' reply

EDITOR—We did not include spirometry data for patients, although they are available. The only source of patients with the diagnosis of chronic obstructive pulmonary disease in this study was a specialist respiratory clinic in a tertiary hospital and the diagnosis was not reconfirmed on entry to the study. Spirometry is a diagnostic criterion for the disease, but indicators of severity of disease include degree of dyspnoea.[1–3] In severe, late stage disease, with an already established diagnosis, spirometry may cause great discomfort to the patient, have questionable accuracy, and correlate poorly with the subjective sensation of dyspnoea.[4]

Our study was an efficacy study powered to detect a change in the subjective sensation of breathlessness. A study is currently in the final stages of planning, which is powered primarily on safety, including respiratory depression. Given our current data informing power calculations, this will be a much larger study. Ensuring non-inferiority of opioids over placebo will

be the primary end point, with dose ranging and effectiveness over time assessed. We welcome Berrill and Linnane's remarks about carbon dioxide monitoring in this context.

We agree that any drug treatment needs to be introduced after careful consideration of potential adverse effects and benefits. The patient's clinical course should be carefully monitored. Unfortunately, the concerns about opioids in patients with chronic obstructive pulmonary disease are not from systematic studies, nor are they using low dose sustained release morphine with its inherently lower peak concentrations.

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Competing interests: Placebo capsules of identical appearance were provided by the company that manufactures sustained release morphine sulphate (Kapanol, Glaxo Wellcome Australia); no direct funds were provided by the drug company.

1 McKenzie DK, Frith PA, Burdon JG, Town GI. The CPODX plan: Australian and New Zealand guidelines for the management of chronic obstructive pulmonary disease 2003. *Med J Aust* 2003;178(suppl): S7-39.
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Vaseline and burns

Vaseline should not be used as first aid for burns

Editor—We would like to draw attention to the inappropriate use of Vaseline as a first aid measure in burns.

A 3 year old Nigerian boy sustained a 15% scald to his back and perineum in a hot water bath. The mother removed him from the bath and applied Vaseline immediately to all the burnt areas (figure, top). When questioned as to why she had done this, she reported that it is common practice in Nigeria and that it is recommended on the container (figure, bottom).

This is not the only case we have encountered in which Vaseline was used as a first aid measure for a scald in a child. We examined the containers for Vaseline manufactured in this country and in Nigeria, and both recommend its use for minor burns. This information is misleading as the initial aim in first aid burn treatment is to reduce the latent heat of the burn, thereby reducing skin damage by immersing the burnt area in cold water.

Front (top) and back (bottom) of Vaseline container

Grease should never be applied to a fresh burn where the superficial part of the skin is missing. In addition to being occlusive, it is non-sterile, promotes bacterial proliferation on the surface of the wound, and may lead to infection.[1 2] We propose that the manufacturers change their labelling system, to clearly state that Vaseline is not to be used as an immediate first aid measure for burns, but can be used as a subsequent dressing for minor burns.

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1 Phillips LG, Robson MC, Heggers JP. Treating minor burns, ice, grease, or what? *Postgrad Med* 1989;85;219-222, 226, 231.
2 Clayton MC, Solem LD. No ice, no butter. *Postgrad Med* 1995;97:151-5, 159-60, 165.

Manufacturer's reply

Editor—We were extremely concerned to read this letter describing the burns that a 3 year old boy received to his back and perineum. Our number one priority is always the safety and wellbeing of people who use our products and, as such, we ensure that all claims that we make are accurate and directly supportable.

The burns described seem not to be minor and therefore outside the scope of intended use for the Vaseline petroleum jelly product referred to. The Vaseline label clearly states that this product is intended for minor burns and, indeed, our research has proved that the product supports the healthy healing of minor burns as it protects the damaged area from bacteria while not interfering with the healing process (see bmj.com for evidence).

Coincidentally, and for reasons wholly unconnected to your letter or the issue raised in it, the artwork on our Vaseline petroleum jelly has been changed. Although the product formulation remains the exactly the same, the new labelling does not make any reference to the use of Vaseline petroleum jelly in the treatment of burns.

Although we continue to stand by the previous labelling and the technical rationale behind claims contained in it, we hope our new packaging will prevent a situation of misuse from occurring again.

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Competing interests: JB is an employee of Lever Fabergé, which manufactures Vaseline.

Evidence to support claims for minor burns is available on bmj.com

Spoofs by any other name

Editor—The letter by Attia and Nair on abandoning ties and avoiding nose rings reminds me of an event many years ago when as a medical registrar I engineered a deliberate spoof at a hospital medical meeting that was otherwise serious, with the knowledge and consent of my then chief.[1]

It consisted of a tape in which I acted as a central European doctor responding in accented English to questions put to me by a pharmaceutical representative about a new drug that had just been released. Not only were the indications for prescribing the drug not clearly identified but a series of bizarre side effects were given, including loss of scalp hair, priapism, and a left sided abdominal rash.

What was rather disturbing was the discussion and questions that followed, in which it became quite apparent that the medical audience had not recognised the tape as being nonsense. The situation was such that I did not feel able to let the audience know that the whole thing was fictional.

Many years later when as a regional adviser in general practice, I was studying for a Master's degree in general education, I read a published paper in which an academic had lectured to an academic audience, deliberately talking what proved to be nonsense but articulating it in such a way as to make it credible.[2 3] The academic was trying to demonstrate that given the right circumstances, people, even knowledgeable ones, can be fooled into accepting and believing what is rubbish.

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Competing interests: None declared.

1 Attia J, Nair K. On abandoning ties and avoiding nose rings. *BMJ* 2003;327:345. (9 August.)
2 Houle CO. *Continuing learning in the professions*. New York: Jossey-Bass, 1984:245.
3 Naftulin DH, Ware JE, Donnelly FA. The Dr Fox lecture: a paradigm of educational seduction. *J Med Educ* 1973;48:630-5.