"immediately necessary" are remarkably slippery categories, and such decisions can often be made only after the patient has been seen and assessed by a doctor. Competing interests aside, the potential for acrimonious disputes between patients and staff is also obvious.

We used the example of a failed asylum seeker deliberately. Behind the changes to eligibility and the introduction of identity cards lies, among other things, the desire of the government to appease perceived public wrath over immigration. The difficulty here, however, is the shortage of data. We are awash with anecdote about abuse of public services, some of it maliciously driven, but real evidence is extremely patchy. We have heard, again anecdotally, that the government is undertaking such research. Surely the evidence should be assessed before decisions are made. The new scheme might cost more to implement and police than the current situation, and a lot of distress will be caused in the process. The onus should be on the department to show the cost effectiveness of the proposal. Surely we should aspire to evidence based decision making in public policy as much as in health care.

The changes also raise questions about equity. The proposals to tighten the rules for eligibility create provisions to allow general practitioners to make private charges for the provision of primary medical services to patients who are unable to prove eligibility to free care. The government says that this will provide practices with local freedom and flexibility. It could also create an inequitable service, with different practices having very different thresholds for emergency and immediately necessary treatment.

In the end, denying treatment to those who can catch the next flight back and take up their albeit expensive health care at home is one thing. No harm has been done, and an abuse of scarce public resources has been prevented. Refusing treatment to a destitute failed asylum seeker, with only forced repatriation to a failed state to look forward to, is another matter. Ethically this is the crux. As in everything else, doctors no doubt will be divided over identity cards. Many will look forward to a simple and accurate method of assessing eligibility, provided its costs do not exceed its goal, and it does not further burden general practitioners with bureaucracy. As gatekeepers, general practitioners are accustomed to husbanding the scarce resources of the NHS, and this might look like a logical extension of their role. Others will want to play no part in such a system. If identity cards do go ahead, however, and general practitioners are asked to determine eligibility, then it is vital that some discretion, some necessary minimum of humane flexibility is encouraged. Without it, this could be one ethical conflict too far.

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Topical NSAIDs in osteoarthritis

Best used for short periods during flare-ups in the disease

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Worldwide, osteoarthritis is the most common disease of synovial joints and also a major cause of locomotor pain and disability.[1] Worldwide, symptomatic osteoarthritis, particularly of the knee and hip, has been estimated by the World Health Organization to be the fourth most important cause of disability among women and the eighth most important among men.

Osteoarthritis is a disorder whose time has come. Epidemiological and clinical research have suggested a range of preventive and therapeutic strategies over the past three decades. Preventive approaches are focused on modifying risk factors in the general population.[2-4]

Much energy has also been spent on developing non-surgical interventions to alleviate the pain and disability in patients with osteoarthritis, once the disease has become established. Non-pharmacological therapeutic options include education programmes and social support; a host of physical treatments (aerobic exercises, muscle strengthening exercises, and patella strapping); the provision of aids and appliances through occupational therapists; and advice on weight loss.[5]

Pharmacological modalities that have a place in the management of patients with osteoarthritis include simple analgesics such as paracetamol; non-steroidal anti-inflammatory drugs and cyclo-oxygenase-2 inhibitors; and intra-articular therapy with glucocorticoids and derivatives of hyaluronic acid.

Guidelines for the management of osteoarthritis have been assembled in the United Kingdom, Europe, and the United States. These generally agree on the joint approach to the disorder between primary and secondary care; and the importance of basing symptomatic management around simple analgesic agents as compared with non-steroidal anti-inflammatory drugs or COX-2 inhibitors. Although use of COX-2 inhibitors markedly reduces the risk of serious gastrointestinal events among patients with osteoarthritis, non-steroidal anti-inflammatory drugs remain in widespread use for the management of pain arising in musculoskeletal tissues, and with both classes of agent, adherence remains a problem.

The topical application of non-steroidal anti-inflammatory drugs provides an attractive means of reducing adverse events by maximising local delivery

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while minimising systemic toxicity. Although the way in which topical non-steroidal anti-inflammatory drugs induce pain relief remains uncertain, it is likely to rest on both bloodborne delivery and local alleviation of symptoms arising from periarticular, rather than intracapsular, structures.

The place of topical non-steroidal anti-inflammatory drugs within guidelines for the management of osteoarthritis has not been well defined. A systematic review of seven years ago included the results of 13 placebo controlled trials in which patients were being treated for a variety of conditions, including osteoarthritis. Topical non-steroidal anti-inflammatory drugs were found to be superior to placebo in reducing pain, such that 65% of treated patients showed a halving of their pain score compared with only 30% treated with placebo. In addition, a systematic review of topical capsaicin (an agent that depletes both afferent and epidermal nerve fibres of the neuropeptide, substance P) in the treatment of chronic pain reported the agent to have moderate efficacy at best, with a relatively high frequency (30%) of local cutaneous reactions.[6]

Given the widespread use of topical NSAID treatment, a review of the situation is timely. In this issue, Lin et al report a further meta-analysis exploring the use of these agents in the treatment of osteoarthritis.[7] This well conducted study found that topical non-steroidal anti-inflammatory drugs were superior to placebo in reducing pain and improving function over a fortnight, but that these effects were lost after four weeks had elapsed. The authors conclude that little evidence exists to support the long term use of topical non-steroidal anti-inflammatory drugs in osteoarthritis and suggest that current recommendations be revised. Most of the randomised controlled trials included in the review were of short duration (two weeks or less) and not a single study extended beyond one month. Marked heterogeneity became obvious in the results of the meta-analysis, with the strong likelihood that publication bias would, if anything, have acted to overestimate the benefits of topical non-steroidal anti-inflammatory drugs. Finally, the study found that the type of non-steroidal anti-inflammatory drug influenced the effect observed (studies used salicylic acid, eltenac, diclofenac, and ibuprofen).

Clearly, these data will have an impact on the enthusiasm with which practitioners and patients resort to the use of topical non-steroidal anti-inflammatory drug therapy in osteoarthritis. On the one hand, the clear evidence of effectiveness in pain relief over a two week period supports their inclusion as part of any multidisciplinary armamentarium. However, the waning of effectiveness over four weeks implies that topical therapy is best used for short periods during flare-ups in the disease. The comparability between topical and systemic use of non-steroidal anti-inflammatory drugs remains a difficult issue. The current review could only address this with limited statistical power, and further information will be gleaned from a trial comparing topical and oral ibuprofen supported by the NHS Health Technology Assessment.[7] Without results of comparative trials of different topical agents, one cannot convincingly argue that one topical non-steroidal anti-inflammatory drug is definitely more effective than another. Finally, and perhaps most importantly, the review shows the dearth of information available on a widely used treatment for one of our commonest causes of musculoskeletal disability. Carefully designed randomised controlled trials of interventions in osteoarthritis, which use appropriate end points and are conducted over sufficiently long duration to assess protracted effectiveness, are required so that we can delineate appropriate therapeutic strategies for a disorder whose frequency is bound to increase with the demographic changes in our population.

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Preventing malaria in UK travellers

Guidelines stress the need for compliance with prophylaxis and standby medication

The advisory committee on malaria prevention for UK travellers has updated the guidance for healthcare professionals who advise travellers.[1] Noteworthy changes have been made in the advice from the guidelines produced previously. The new guidance places greater emphasis on the use of certain malaria chemoprophylaxis and has important changes regarding emergency standby medication.

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Worldwide, over 40% of the population lives in malarious areas with an estimated 300-500 million cases of malaria occurring each year resulting in up to two million deaths.[2] Importantly malaria is one of the most common causes of serious illness in the returning traveller. At least 2000 cases (10 000 in Europe[3]) are imported into the United Kingdom each year, and nine of these on average result in death. The proportion of cases due to *Plasmodium falciparum* has