half have psychiatric disorders and a third have physical illnesses.[8] In an international comparison of suicide pacts, pacts between spouses were found to predominate in the United States and England, between lovers in Japan, and between friends in India.[9] The relationship between victims of suicide pacts is typically exclusive, isolated from others, and the immediate trigger for the pact is usually a threat to the continuation of the relationship, for example, impending death of one member from an untreatable physical illness.[10]

Suicide pacts have been associated with a rare psychiatric disorder called *folie à deux*.[11] In this condition, two people share the same or similar delusional beliefs. The relationship among people with this psychotic disorder is also usually enmeshed and isolated from the rest of society. Just as in some suicide pacts where one person instigates the plan, in *folie à deux* the delusion is characteristically imposed by the dominant member of the relationship on to the other person. While suicide pacts are usually seen between spouses, *folie à deux* is commoner among sisters, usually spinsters.

The potential negative role of the internet in relation to suicides has been highlighted previously.[12] An increasing number of websites graphically describe suicide methods, including details of doses of medication that would be fatal in overdose. Such websites can perhaps trigger suicidal behaviour in predisposed individuals, particularly adolescents.[13] Cybersuicide refers to suicides or suicide attempts influenced by the internet. Scientific literature on cybersuicide mainly pertains to solitary suicides, and little information exists about the internet and suicide pacts.

The recent suicide pacts in Japan might just be isolated events in a country that has even previously been shown to have the highest rate of suicide pacts.[9] Alternatively, they might herald a new disturbing trend in suicide pacts, with more such incidents, involving strangers meeting over the internet, becoming increasingly common. If the latter is the case then the epidemiology of suicide pacts is likely to change, with more young people living on their own, who may have otherwise committed suicide alone, joining with like minded suicidal persons to die together.

General practitioners and psychiatrists should continue to remain vigilant against the small but not insignificant risk of suicide pacts, especially while encountering middle aged depressed men who have dependent submissive partners. While assessing risk, one may specifically ask whether a depressed patient uses the internet to obtain information about suicide.

Sundararajan Rajagopal *consultant psychiatrist*

South London and Maudsley NHS Trust, Adamson Centre for Mental Health, St Thomas's Hospital, London SE1 7EH (Sundararajan.Rajagopal@slam.nhs.uk)

Competing interests: None declared.

1 BBC News Online. Nine die in Japan "suicide pacts." http://news.bbc.co.uk/1/hi/world/asia-pacific/3735372.stm (accessed 16 Nov 2004).
2 Brown M, Barraclough B. Epidemiology of suicide pacts in England and Wales, 1988-92. *BMJ* 1997;315:286-7.
3 Berman AL. Dyadic death: a typology. *Suicide Life Threat Behav* 1996;26:342-50.
4 Cohen J. A study of suicide pacts. *Medico-legal J* 1961;29:144-51.
5 Fishbain DA, D'Achille L, Barsky S, Aldrich TE. A controlled study of suicide pacts. *J Clin Psychiatry* 1984;45:154-7.
6 Rosenbaum M. Crime and punishment—the suicide pact. *Arch Gen Psychiatry* 1983;40:979-82.
7 Lasczkowski G, Rohrich J, Bratzke H. Suicidal excess--presentation of an unusual case. *Arch Kriminol* 1998;202:100-8.
8 Brown M, Barraclough B. Partners in life and in death: the suicide pact in England and Wales 1988-1992. *Psychol Med* 1999;29:1299-306.
9 Fishbain DA, Aldrich TE. Suicide pacts: international comparisons. *J Clin Psychiatry* 1985;46:11-5.
10 Rosen BK. Suicide pacts: a review. *Psychol Med* 1981;11:525-33.
11 Salih MA. Suicide pact in a setting of Folie a Deux. *Br J Psychiatry* 1981;139:62-7.
12 Thompson S. The internet and its potential influence on suicide. *Psychiatr Bull* 1999;23:449-51.
13 Becker K, Mayer M, Nagenborg M, El-Faddagh M, Schmidt MH. Parasuicide online: Can suicide websites trigger suicidal behaviour in predisposed adolescents? *Nord J Psychiatry* 2004;58:111-4.

Benign parotid tumours

Can be removed safely by extra-capsular dissection, a less invasive procedure

All surgical disciplines have moved towards subspecialisation with the development of less invasive procedures and reduction in surgical morbidity. The difficulty with salivary tumours is that they are rare and have a long clinical course that requires follow up data for a decade or more. Prospective randomised trials have therefore not been undertaken, and progress happens slowly, with new generations of surgeons building on the experience of their peers.

Improved methods of assessment (magnetic resonance imaging, computed tomography, ultrasound, and fine needle aspiration biopsy) have had a major impact on salivary gland surgery because of increased confidence in distinguishing benign from malignant tumours. Of discrete lumps, only 5% will prove to be malignant, and over half of these can be recognised on clinical examination alone.[1] The addition of modern techniques for investigation reduces further the risk of inadvertently encountering a malignant neoplasm. This then avoids the traditional "one approach fits all" attitude to parotid surgery.

Most benign parotid tumours are either pleomorphic adenomas (71%) or Warthin's tumours (22%).[2] Unfortunately pleomorphic adenoma has a reputation for recurrence that has lingered since the 1940s and 50s. The nature of pleomorphic adenoma was then unclear for, as its name implies, it has a variable appearance and so was thought to be a hamartoma rather than a neoplasm. Treatment was by crude enucleation, and in some centres the tumour capsule was even left in situ, with obvious consequences. The reputation of the tumour for recurrence was given further credence in 1958 by Patey and Thackray's work,[3] which showed an incomplete capsule through which small buds of tumour protruded. This was the rationale for the traditional superficial parotidectomy. The technique was promoted by Hamilton Bailey and others as

BMJ 2004;329:1299–300

a solution to the recurrence problem, which it proved to be. Superficial parotidectomy was adopted universally as the treatment of choice for the discrete parotid lump.

During the early years of debate, through serendipity, Alan Nicholson, a surgeon at the Christie Hospital in Manchester, held a different view. He felt that recurrence was due to inadequate surgical exposure, which leads to rough handling and rupture of the tumour rather than the biological nature of the tumour itself. At this time, parotid tumours were managed under local anaesthesia by an incision made directly over the tumour. In contrast he used wide exposure through a pre-auricular skin flap but then proceeded to a local dissection of the tumour rather than a parotidectomy. By the time the debate was resolved in favour of superficial parotidectomy he had 10 years of data, which showed no increase in the risk of recurrence by the less invasive method, and so he and his successors, Gleave and Hancock, persisted with the technique in isolation from the surgical community.

The recent analysis of this experience, underpinned by a mean follow up period of 15 years, shows conclusively that local dissection of benign parotid tumours is a safe procedure with recurrence rates of 2%—no more than that with traditional parotidectomy.[4] The advantage is that minimal surgery produced less morbidity as measured by nerve injury, Frey's syndrome (a disorder characterised by excessive gustatory sweating of the skin overlying the parotid), and the formation of neuromas.[5] Neither does it cause a deformity of the cheek due to loss of parotid tissue. The Christie data show that 70% of patients with discrete parotid lumps could safely avoid formal parotidectomy.

Surgeons are traditionalists, and the early experience of our peers has coloured current surgical opinion and slowed the introduction of conservative surgery for the benign parotid lump. This situation is now changing, and centres with experience of treating parotid tumours increasingly recognise that benign tumours can be removed safely by techniques much less invasive than a formal parotidectomy.[6–8]

Mark McGurk *professor*

Salivary Gland Service, Department of Oral and Maxillofacial Surgery, Guy's, King's and St Thomas's Hospital Trust, London SE1 9RT (mark.mcgurk@kcl.ac.uk)

Competing interests: None declared.

1 McGurk M, Thomas B, Renehan A. Extra capsular dissection for clinically benign parotid lumps: reduced morbidity without oncological compromise. *Br J Cancer* 2003;89:1610-3.
2 Bradley P. General epidemiology and statistics in a defined UK population. In: McGurk M, Renehan A, eds. *Controversies in the management of salivary gland disease*. Oxford: Oxford University Press 2001:3-23.
3 Patey DH, Thackray AC. The treatment of parotid tumours in the light of a pathological study of parotid material. *Br J Surg* 1958;55:477-87.
4 Leverstein H, van der Wal JE, Tiwari RM, van der Waal I, Snow GB. Surgical management of 246 previously untreated pleomorphic adenomas of the parotid gland. *Br J Surg* 1997;84:399-403.
5 McGurk M, Renehan A, Gleave EN, Hancock BD. Clinical significance of the tumour capsule in the treatment of parotid pleomorphic adenomas. *Br J Surg* 1996;83:1747-9.
6 Snow G. The surgical approaches to the treatment of parotid pleomorphic adenomas. In: McGurk M, Renehan A, eds. *Controversies in the management of salivary gland disease*. Oxford: Oxford University Press 2001:57-66.
7 O'Brien CJ. Current management of benign parotid tumours—the role of limited superficial parotidectomy. *Head Neck* 2003;25:946-52.
8 Ghosh S, Panarese A, Bull PD, Lee JA. Marginally excised parotid pleomorphic salivary adenomas: risk factors for recurrence and management. A 12.5 year mean follow-up study of histologically marginal excisions. *Clin Otolaryngol Allied Sci* 2003;28:262-6.

Managing osteoarthritis of the knee

NSAIDs and other measures offer only short term benefits—up to surgery

Papers 1317

A slightly swollen and aching knee. Walking is difficult, the stairs are almost impossible, and so begins the downward spiral of inactivity, immobility, and weight gain. Osteoarthritis of the knee is a familiar picture, presenting usually when it is too painful to ignore but too early for surgery. Patients have often already made the diagnosis themselves and seek a solution. They want pain relief so they can walk, kneel, climb a ladder, shop, or simply get around in comfort. Most patients have tried paracetamol, hot water bottles, someone else's great new tablets, a cabbage leaf, various herbal or homoeopathic medications, prayer, copper bracelets, and many other remedies before asking for help. Most general practitioners would reach for the keyboard tapping out their favourite non-steroidal anti-inflammatory (NSAID).

NSAIDs do not seem to offer a long term solution. In a comprehensive systematic review and meta-analysis of randomised placebo controlled trials in this issue of the journal, we learn that NSAIDs can reduce short term pain only slightly better than placebo (p 1317).[1] This study does not support the long term use of NSAIDs in osteoarthritis of the knee, and our prescriptions may, in fact, be doing harm. Good scientific reasons exist for this—prostaglandin inhibitors reduce the immediate inflammatory response in the acutely injured joint but may inhibit long term healing. Good medical reasons also exist—the gastrointestinal side effects are well known, but patients with osteoarthritis are older and the *British National Formulary* recommends that NSAIDs be used with caution in elderly people, who are more likely to have cardiac, hepatic, or renal impairment.[2] The EULAR guidelines recommend both pharmacological and non-pharmacological measures but advise simple analgesia at first.[w1 w2] Another recent systematic review concludes that paracetamol is an effective agent for relieving pain due to osteoarthritis and, although safer, is less effective than NSAIDs. They recommend paracetamol as a first line treatment for reasons of safety.[3]

What are the alternatives? An osteoarthritic knee is often a weak knee. Muscle dysfunction may be as important a cause as wear and tear.[4] Physical training

Additional references w1-w5 are on bmj.com

BMJ 2004;329:1300–1