Letters

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Neonatal screening for cystic fibrosis

Cystic fibrosis should be added to diseases sought in all newborn babies

EDITOR—Wald and Morris's editorial on neonatal screening for cystic fibrosis is a good example of the different viewpoints held by doctors concerned with public health and by clinicians and highlights the need for both groups to have input into health service policy.[1] They reviewed papers describing nutritional benefits of neonatal diagnosis of cystic fibrosis[2 3] with extrapolations predicting long term individual health benefits and short to medium term costs of a screening programme. The differences between screened and unscreened patients were small in terms of growth during the first 10 years. Healthcare purchasers are more easily persuaded by short term financial arguments than by long term predictions, particularly when the predictions involve many uncertainties, but clinicians can advance other persuasive arguments in favour of screening newborn babies.

Firstly, for parents to be confronted with the diagnosis of cystic fibrosis in their baby is always unpleasant. The shock can be mitigated by the knowledge that the diagnosis was made early, perhaps even before symptoms were noted; that attempts will be made to prevent or minimise lung damage; and that a programme of expert care is being offered. In contrast, many parents describe feelings of anger and mistrust when the diagnosis has been delayed and when irreversible lung damage—which may or may not have been preventable—has already occurred. It is in the interests of all, particularly the affected child, that complete confidence should exist between the doctor and the parents, who must deliver most of the care.

Secondly, the prognosis for cystic fibrosis is steadily improving[4] and there are real prospects that effective, if not curative, treatment based on an understanding of the pathophysiology of cystic fibrosis at the cellular level will be available before long.[5] Children who will then derive most benefit will be those for whom treatment can be started before lung damage has occurred. We should not wait for this treatment to be announced before we start screening, because that would deprive a considerable cohort of children of its maximal benefits. Dankert-Roelse and te Meerman are right[3]: now that we have reliable methodology, screening for cystic fibrosis should be added to screening for phenylketonuria and hypothyroidism for all newborn babies.

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1 Wald NJ, Morris JK. Neonatal screening for cystic fibrosis. *BMJ* 1998;316:404-5. (7 February.)
2 Farrell PM, Kosorok MR, Laxova A, Shen G, Koscik RE, Bruns WT, et al. Nutritional benefits of neonatal screening for cystic fibrosis. *N Engl J Med* 1997;337:963-9.
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Early diagnosis allows option of prenatal diagnosis in subsequent pregnancies

EDITOR—Like Wald and Morris, we do not advocate neonatal screening for cystic fibrosis, although the situation is not as simple as they seem to suggest. The benefits of screening are not limited to early treatment of affected children; early diagnosis allows parents to have the options of prenatal diagnosis in subsequent pregnancies, although only a minority of carrier couples can be detected in this way.

Data from the confidential inquiry into counselling for genetic disorders confirm that delay in the diagnosis of cystic fibrosis is an important factor in the birth of a subsequent affected child. We know of 68 second affected children born between 1991 and 1995. For 22 of these the delay in the diagnosis of cystic fibrosis in the first child was stated to have led to the birth of the second affected child. The median delay in diagnosis after the birth of the first child with cystic fibrosis was 38 (range 17-96) months. Although families with two affected siblings from separate pregnancies are a highly selected group in which other causative factors may be concentrated, this is to some extent balanced by families with two affected children in which the diagnosis has yet to be made.

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1 Wald NJ, Morris JK. Neonatal screening for cystic fibrosis. *BMJ* 1998;316:404-5. (7 February.)
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Early diagnosis is important to parents even if it makes little difference to outcome

EDITOR—Wald and Morris have rightly cautioned[1] against accepting at face value an enthusiastic interpretation[2] of the recent results of the Wisconsin trial of screening for cystic fibrosis.[3] Despite its attractively simple design, this is not an easy study to interpret: the screening method was changed part way through to one of "greater sensitivity and specificity"[3]; follow up of cases found to be positive on screening to produce the "early diagnosis" group was quite leisurely by United Kingdom standards; and, as Wald and Morris point out, the four year blind period effectively precludes analysis of short term benefits. Wald and Morris may, though, present too negative a message. The subtitle to their editorial—"no evidence yet of any benefit"—suggests an excessively austere approach to what may be allowed as a benefit, while their statement in the opening paragraph that "early knowledge of a serious disorder will cause more harm than good if there is no effective remedy" is not supported by the available evidence.

The NHS Executive Health Technology Assessment Programme recently commissioned two studies of neonatal metabolic

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screening. The brief included gathering and using information on the psychological and social impact of neonatal screening, including acceptability to patients. For the psychological section of the Sheffield based study[4] two of my colleagues (P Nicholson and J R Tawnily) examined 758 papers found by systematic search of the literature and identified 57 of sufficient relevance and quality for detailed review. They concluded that there is considerable evidence of parental support for diagnosis based on screening, even for diseases such as Duchenne muscular dystrophy for which there is no effective treatment, and no evidence that diagnosis through screening produces greater distress overall than diagnosis by conventional methods. These findings support the general clinical observation that early diagnosis is important to parents even if it makes little difference to outcome.[5]

Roughly seven tenths of infants with cystic fibrosis are symptomatic by 6 weeks of age. Many suffer significant malnutrition before diagnosis, and parents may become involved in a distressing diagnostic odyssey. Neonatal screening can be seen as an obvious step in the general movement towards the earlier and more effective treatment of cystic fibrosis. Evidence for improved long term outlook is fragmentary, but this should not lead us to ignore the more immediate and tangible benefits of systematic early diagnosis.

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1 Wald NJ, Morris JK. Neonatal screening for cystic fibrosis. *BMJ* 1998;316:404-5. (7 February.)
2 Dankert-Roelse JE, te Meerman GJ. Screening for cystic fibrosis—time to change our position? *N Engl J Med* 1997;337:997-8.
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Many patients with psoriasis use sunbeds

Editor—Psoriasis usually improves in sunlight, but many patients look for an alternative source of ultraviolet light, either because they are embarrassed to sunbathe in public or because of the unpredictable availability of sunlight. Sunbeds that emit ultraviolet A light might seem an attractive option, but their use, at least for tanning purposes, is discouraged by dermatologists and other healthcare workers.[1 2]

To investigate our patients' use of sunbeds, we posted a questionnaire to the latest 339 patients who were new referrals aged 16-65 years and in whom a diagnosis of plaque psoriasis was made (localised and guttate psoriasis were excluded). All had had psoriatic lesions for at least a year when they received the questionnaire. We received replies from 248 patients (response rate 73% (248/339)), of whom 128 (52%) had used a sunbed to treat their psoriasis. Linear logistic regression showed highly significant and non-interacting effects of age and sex ($P < 0.001$), indicating that sunbed use was generally higher among females and tended to decrease with increasing age (see table). Of the 97 patients who reported the effect of sunbed use on their psoriasis, two found that their condition worsened, 17 reported no change, and 78 reported an improvement. We detected no associations between perceived efficacy and age, sex, or tanning ability (χ^2 $P > 0.1$). Of the sunbed users, 56% (72/128) reported that they had treated themselves more than 20 times in a year, and 13% (17/128) had treated themselves more than 80 times in a year.

Our results suggest that a larger proportion of patients with psoriasis use sunbeds than the 13% reported for randomly selected British adults[3] and that their frequency of use may also be higher. Ultraviolet A accounts for about 99% of the ultraviolet emission from a typical sunbed lamp. Although highly effective for treating psoriasis when combined with psoralen (PUVA treatment), the effect of ultraviolet A alone is unknown as controlled trials have not been performed. Exposure to ultraviolet A can cause several adverse reactions in the skin and is a probable risk factor for non-melanoma skin cancer. Of most concern is whether the risk of melanoma attributed to sunbed use[4] will become significantly higher with longer follow up of sunbed users. The British Photodermatology Group suggested a maximum of 20 exposures annually for people who, despite its advice, wished to use sunbeds.[1] While it has been argued that this recommended maximum is pragmatic,[3] it is worrying that this exposure level was exceeded by over half of our patients who used sunbeds to treat their psoriasis.

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1 Diffey BL, Farr PM, Ferguson J, Gibbs NK, deGruijl FR, Hawk JL, et al. Tanning with ultraviolet sunbeds. *BMJ* 1990;301:773-4.
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Sunbed use by patients with psoriasis according to age and sex

Age (years)	Male		Female		Both sexes	
	No of respondents	No (%) of sunbed users	No of respondents	No (%) of sunbed users	No of respondents	No (%) of sunbed users
16-20	4	2 (50)	9	8 (89)	13	10 (77)
21-30	15	6 (40)	28	22 (79)	43	28 (65)
31-40	40	21 (53)	40	27 (68)	80	48 (60)
41-50	22	3 (14)	23	14 (61)	45	17 (38)
51-60	25	11 (44)	23	10 (43)	48	21 (44)
61-65	9	1 (11)	10	3 (30)	19	4 (21)
Total	115	44 (38)	133	84 (63)	248	128 (52)

Health beliefs among British Bangladeshis

Whole community must be studied

Editor—Greenhalgh et al attempt to combine the techniques of qualitative research with anthropological investigation, but their paper is flawed.[1] They draw attention to Bengali views on diabetes in an east London population without giving their reasons for being there. Is this genuine ethnography or is it an exercise in health promotion that has used ethnography to give it credibility?

Ethnicity may be a source of fascination, but it is insulting to set ourselves up to study it because, as in the case of the Native Americans and the Aboriginals, we become "interested" in a culture only when that culture no longer poses a threat to us. We are not anthropologists, we are doctors in the late 20th century and work in multicultural settings that we find as confusing as those immigrants whom we choose to study.

As general practitioners we work at the interface between a patient's conception of his or her problem and our own system of beliefs on biomedical health. The two are frequently at odds. On the one hand we worship at the feet of a sacred cow that we have prosaically named evidence based medicine, whereas on the other hand our patients follow their own beliefs and use alternative health care. We should remember that although these models seem quite different to us, they are both a part of the Western culture of consumption—a fact borne out by the enormous use of alternative medical practice and over the counter self medication.

We have a lot to learn from our patients. Greenhalgh et al identify the main point; we should really be studying the whole of a community (all of east London), with particular emphasis on how one group influences another—a process that anthropologists refer to as acculturation—rather than merely the exotic or idiosyncratic.

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1 Greenhalgh T. Helman C, Chowdhury AM. Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study. *BMJ* 1998;316:978-83. (28 March.)

Health promotion for Bangladeshi women in general practice must be appropriate

EDITOR—Greenhalgh et al's study contributes to documented evidence about how Bangladeshis in east London who have diabetes perceive their health.[1] This kind of information is important in shaping care and directing funds effectively.

Our clinical work with the Bangladeshi community has made us aware how inappropriate many approaches to health promotion are. For the past three years, therefore, the health promotion nurse and health advocate have run a Bangladeshi women's group in the practice, where women have been able to discuss health issues and worries, overcome individual isolation, and take exercise in a socially appropriate setting. This is a relaxed event in the early afternoon and attendance varies, especially around times of fasting and festival, when the group often does not meet for a while.

We found out that many of the women could swim and swam regularly in Bangladesh. Sessions for women only at the local pool allowed them to swim in leggings and other culturally appropriate attire. Older women taking part in programmes of increased activity report fewer aches and pains in joints and relief from constipation. They also support younger women and help them to take part in physical activity.

Having the group has given a social context to chronic disease management in primary care. Small funds from the London implementation zone, as well as practice funds, allowed the group to come together.

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Authors' reply

EDITOR—We share Hardy's concern that anthropological methods may be misused by the medical profession. Crude and superficial research aimed at describing the exotic and idiosyncratic aspects of ethnic and social minorities may serve a colonialist agenda that is both harmful and insulting to the people studied. We dissociate ourselves from such an approach, and we suspect that Hardy may have misunderstood some aspects of our paper.

Our aim was to move away from defining our Bangladeshi informants in terms of their differences from the majority culture. We aimed to show the complexity and diversity of health beliefs and behaviour in this community, as in every other society, and to show how these may be seriously misunderstood (and not respected) by the medical profession. One of our conclusions was that the barriers to successful health outcomes in this group are similar to those in other disempowered groups—they often relate more to structural and material barriers to change than to ethnic or religious customs.

All three of us have social science degrees. Two of us are doctors. MC was born in Sylhet, Bangladesh, and has a PhD in anthropology. He has spent 20 years researching different aspects of culture in Bangladeshi immigrants to the United Kingdom. CH is associate professor of medical anthropology at Brunel University and has written a standard text on the cultural aspects of health and illness.[1]

Our ongoing research in this field seems to be greatly welcomed by the Bangladeshi participants—we continue to have a response rate of over 90% to requests for interviews. Participants who acted as informants in the work reported in our *BMJ* paper have subsequently worked as partners in the design of a further stage in our research, an approach known as participatory research.[2]

We had no hidden agenda. We share Hardy's misgivings about the possible misuse of anthropology in health research. Our sole aim was to help in the design of diabetes services that are both medically effective and culturally acceptable to this community, and to develop these in partnership with this community.

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Long term effects of deprivation increase health's sensitivity to current policies

EDITOR—Gabbay spreads a dangerously widespread misunderstanding in his editorial on the government's green paper *Our Healthier Nation*.[1 2] He says that "even if new policies have favourable results, they are unlikely to show much effect by the year 2010." Both the influences of early life on later health and the long term cumulative health effects of deprivation are undoubtedly important. But these increase rather than decrease health's immediate sensitivity to current circumstances and policy.

Rather than protecting people from new hazards, vulnerability factors from the past make death rates more responsive to current circumstances. Just as it is the weakest trees that are blown over in a storm, so it is those people whose lung or cardiovascular function is already impaired who are most endangered by new challenges. In previous generations, when infections were more important, there were at least some reasons for thinking that populations challenged in early life would have better resistance later. But that is the opposite of the way that early vulnerability factors affect risks of later degenerative disease.

The short term sensitivity of health to the environment is amply shown by the dramatic rise in mortality in Russia so soon after the onset of economic dislocation. In the same vein but more formally, when analysing the pattern of Britain's decline in mortality this century I found that the cross sectional changes running across different age groups at a particular time were much more important than the longer term cohort effects.[3]

Effective government action should then reap benefits within the lifetime of a parliament. If we do not see mortality declining faster in poorer than richer areas well before 2010, let us not confuse the reasons.

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1 Gabbay J. Our healthier nation. *BMJ* 1998;316:487-8. (14 February.)
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Partnership with patients

Health professionals need to identify how much information patients want

EDITOR—In outlining the implications for professionals of the rise of "healthcare consumers" Richards emphasises two elements that are necessary for partnership: information of better quality and greater involvement for patients in decisions.[1] In both cases, however, true partnership goes deeper still. Information needs to be designed with the help of patients, and the extent of involvement in decisions needs to be tailored to the individual patient.

Health professionals and patients have different priorities for information about drug treatment.[2] Contrary to the beliefs of some health professionals, patients are keen to know more about possible side effects, although we need a better understanding of the best way to present this information. Information may be too complex or theoretical for patients to follow. The language may be wrongly pitched. When researchers in the United States reviewed literature on systemic lupus erythematosus they found that 89% of materials were too complex for half their patients.[3] The advice may not be practical: one leaflet for migraine drugs advised sufferers on "trigger factors to avoid … such as menstruation."[4] In such cases it is not inaccurate or misleading information but lack of user friendliness that alienates patients. Using patients to test information for patients can help to counter this alienation. One of the three key aspects of information quality that the Centre for Health Information Quality defines is that people who use information participate in designing this information. The challenge for health professionals is to recognise that

"informed" and "demanding" patients are not necessarily the same thing. Education for doctors, nurses, and pharmacists needs to embrace the concept of concordance and develop the associated skills.

One such skill will be identifying how much involvement the patient wants to have in decisions about treatment. Some people wish to make their own decisions, while others prefer to delegate decisions to professionals. In a paper that he presented to the King's Fund meeting described by Richards, John Ovretveit said that we should avoid thinking that "choice is primarily owned by doctors and is theirs to give away"; we should recognise that "people differ in the amount of choice they want and are capable of using with benefit." Eliciting patients' preferences will be a key future task for professionals—in particular, distinguishing between a patient who wishes to receive more information and one who actively wants to make decisions.[5]

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Telephone helpline services can meet patients' demand for information

EDITOR—Richards highlights the growing demand for access to detailed information by patients on all aspects of their health care and treatment and suggests some approaches to meeting these needs.[1]

Generally, drug information centres are staffed by pharmacists who have access to a wide range of up to date information sources and provide independent, evaluated information on all aspects of drug use, but only to healthcare professionals. To meet the growing demand for information by patients, we have established a public information initiative at the Trent Drug Information Centre, Leicester Royal Infirmary. The medicines helpline provides information and advice on all aspects of drug treatment direct to the public via the telephone. This service is free of charge, the only cost to the user being that of a local rate telephone call.

The helpline, established as part of an NHS funded project to assess the information needs of the general public, was piloted in Leicestershire from March 1995 and subsequently expanded to include Lincolnshire and Rotherham in December 1995. The service has been established with the cooperation of general practitioners and community pharmacists in the areas to which it is provided. To date, the helpline has answered about 3000 inquiries.

The National Health Information Service provides a wide range of health related information to the public.[1] It is not funded nor does it have the expertise to deal with specific questions related to drug treatment. The medicines helpline works closely with the Trent regional drug information centre, acting as both a referral service and an information support service.

A random follow up questionnaire has been used to obtain feedback from users of the helpline, and the results have been positive. Users value the availability of the service, which is viewed as an independent source of accurate information, and the anonymity of a telephone service.

Demand for public access to health related information is growing. As information about drug treatment may influence compliance and ultimately, therefore, the efficacy of treatment, it is essential that patients have access to appropriate sources of accurate information.

Our experience with the medicines helpline shows that it is a viable method, accepted by the public, for providing appropriate drug related health information. There is great scope for this service to be expanded further, possibly nationwide, and potential sources of future funding are being actively investigated.

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The hymen is not necessarily torn after sexual intercourse

EDITOR—We agree with Paterson-Brown that education about the hymen is urgently needed.[1] However, there is no evidence from the study by Emans et al[2] that the "appearances [of hymens] relate to tampon use," only that speculum examinations were rated as easy in 56% of the examinations of non-sexually active tampon users compared with 26% of the non-sexually active pad users and 81% of the sexually active females studied.

Furthermore, an opportunity to educate inexperienced health professionals regarding the elasticity of the postpubertal hymen has been missed; the study by Emans et al found that 19% of the sexually active postpubertal females had no visible abnormalities of the hymen. This has long been appreciated by forensic physicians who give evidence in court regarding serious sexual assaults. The practice of reconstructing "the hymens of adolescent girls who are no longer virgins but wish to appear so"[3] only serves to perpetuate the myth that the hymen is necessarily torn after sexual intercourse.

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1 Paterson-Brown S. Should doctors reconstruct the vaginal introitus of adolescent girls to mimic the virginal state? Commentary: Education about the hymen is needed. *BMJ* 1998;316:461. (7 February.)
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Childhood energy intake and adult mortality from cancer

Authors should have used family as unit of analysis

EDITOR—Frankel et al suggest that they have shown that restriction of nutrients in childhood protects against cancers not related to smoking.[1] Unfortunately, while working ingeniously with the data, they seem not to appreciate their more fundamental failings. Individual dietary assessment as a research tool is notoriously unreliable,[2] and when individual intake is estimated from family intake the potential for bias and error multiplies.[3] The authors acknowledge this in their discussion, but they still present a misleadingly precise looking table of age specific mean intakes, which must actually have been estimated from the family data.

An association was found despite the imprecision of the survey instrument, but the authors have not adjusted for all confounders. The two main determinants of energy intake are lean body mass and activity levels. Activity levels are not likely to be associated with risk of cancer, but lean body mass is strongly correlated with height. The data thus probably simply show that tall children eat more and also have a higher risk of cancer. The authors also treat their subjects as individuals, when the risk factor of interest has been measured at a family level, inflating the sample size threefold or fourfold. They should have used the family as the unit of analysis; if they had done so they might not have shown a significant association.

Energy intake throughout childhood seems unlikely to explain the relation between height and risk of cancer since it is predominantly in infancy that growth depends on energy; requirements for growth thereafter represent a tiny proportion of total intake.[4] Finally, despite the increase in the risk of cancer, all cause mortality was unrelated to energy intake, suggesting that it also protects against other causes of death. Throughout history energy restriction has led to increased death rates, which have plummeted in the developed world as the food supply has improved. I would therefore suggest that much more

than replication of these findings will be needed before there can be any implications for public health.

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1 Frankel S, Gunnell DJ, Peters TJ, Maynard M, Davey Smith G. Childhood energy intake and adult mortality from cancer: the Boyd Orr cohort study. 1998;316:499-504. (14 February.)
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Authors' reply

EDITOR—The implications of deriving individual estimates from grouped family data are dealt with in the discussion of our paper; such misclassification would be expected to bias the results towards the null hypothesis rather than exaggerate any possible effects. Adjustment of standard errors for clustering effects arising through use of the family as the sampling unit has little effect on the significance of the results we reported.

Wright seems to regard height as a confounding factor. This begs the question why taller children may have higher rates of cancer and reflects a misunderstanding of the role of confounding in epidemiological studies. Height in adulthood is associated with cancers that are not related to smoking, which has been interpreted as reflecting an influence of energy intake in childhood.[1 2] Growth in infancy and early childhood may be more sensitive to diet than later growth, but this does not exclude the importance of diet throughout childhood; the study she cites did not have the power to detect small but important effects of diet on growth. If height is serving as a proxy measure of the exposure under consideration it should not be treated as a confounding factor. Wright, however, requests these analyses, which showed that in the two thirds of the sample for whom anthropometric data are available adjusting for childhood height and body mass index leaves unchanged the hazard ratios of energy intake on mortality from cancers unrelated to smoking.

Wright wrongly asserts that activity levels are not likely to be associated with risk of cancer. Evidence suggests that exercise protects against some forms of cancer.[3] As energy intake will, on average, be higher in those who expend more energy in exercise our inability to adjust for physical activity should result in underestimation of the true effect of energy intake on mortality.

The children in our study showed marked heterogeneity in energy intake, which reflects the prevailing socioeconomic conditions of the time. The association between energy intake and mortality from cancer emerges only when the confounding effects of socioeconomic position are removed. This is to be expected if poverty has an adverse effect on disease levels through mechanisms unrelated to energy intake. The allusion to underdeveloped countries, where energy restriction may imply starvation or semistarvation, is inappropriate given the different setting from which our data arose. Our findings, if replicated, are of importance in understanding the possible mechanisms involved in the development of cancer.

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Author overestimated need in community population with faecal incontinence

EDITOR—In his review on advances in the understanding of faecal incontinence Kamm focused on structural damage as an aetiological factor and surgical intervention as a treatment.[1] A review of epidemiological evidence suggests that this focus is misplaced for several reasons.

Kamm states that the prevalence of faecal incontinence is 2% in the adult population and 7% in healthy independent adults aged over 65. These figures probably relate to anal incontinence (loss of gas or mucous as well as solid or liquid faeces) rather than just faecal incontinence and to episodic rather than frequent (daily or weekly) incontinence.[2] These figures may therefore overestimate the level of need in a community population. The literature suggests that faecal incontinence occurs on a weekly to monthly basis in less than 1% of the population aged under 65.[2 3] Faecal incontinence, however, is closely associated with age (prevalence about 15% in adults aged ≥85 living at home) and is even more common in residential and nursing homes (prevalence ranges from 10% to 60%).[4] It is surprising, then, that attention is given to disorders in children and adolescents even though the condition is much greater in elderly people and those living in residential homes.

There is also little epidemiological evidence of a higher prevalence of faecal incontinence in women than men.[3 5] It is unlikely, therefore, that childbirth is a major cause of faecal incontinence in the community. Kamm fails to mention that isolated faecal incontinence is relatively rare compared with double incontinence (urinary and faecal) and that both need to be considered when urinary incontinence is presented.[2 5]

Research studies have consistently reported that factors associated with increased risk of faecal incontinence are age, poor general health, limited physical activities, dementia, and stroke.[2 5] Faecal incontinence in elderly people is often curable and preventable. Relatively conservative medical treatments aimed at the relief of faecal impaction, increased mobility, regular toileting, and normalisation of faecal consistency are generally successful.[4] Similarly, the prescription of aids and adaptations to improve access to toilet facilities is a simple but effective means of preventing incontinence. Discussion of these topics by Kamm in more depth would have been helpful. The emphasis on sphincter damage and surgical treatments is misleading when much faecal incontinence is secondary to faecal impaction, diarrhoea, and disability and can be treated effectively by the general practice team.

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Management of deliberate self poisoning

Liaison psychiatric nurses can be used to increase psychosocial assessments

EDITOR—Kapur et al express concern about the management of episodes of deliberate self harm in different centres.[1] They found that 46% of patients referred to hospital after deliberate self harm did not receive psychosocial assessment, contrary to guidelines issued by the Department of Health and by the Royal College of Psychiatrists.[2]

Chelsea and Westminster Hospital has for some years had a team of social workers and psychiatrists who are involved in the psychosocial assessment of patients after deliberate self harm. The hospital experienced a 69% increase in the annual number of episodes of deliberate self harm for which patients were referred between 1992 (n=374) and 1997 (n=632). Despite the team having close links with the casualty department and medical inpatient wards, the proportion of patients leaving hospital without psychosocial assessment remained unacceptably high, ranging from 42% (158/374) in 1992 to 51% (325/632) in 1997—

Number of patients admitted because of deliberate self harm at Chelsea and Westminster Hospital who did not receive psychosocial assessment, before and after introduction of liaison psychiatric nurses in emergency department on 1 November 1997

	Monthly average, Jan-Oct 1997	Liaison nursing in operation			
		Nov 1997	Dec 1997	Jan 1998	Feb 1998
Total admitted	54	51	42	56	39
No (%) not assessed	29 (54)	17 (33)	17 (40)	22 (39)	15 (39)

figures not dissimilar from those reported by Kapur et al.

In response to the high levels of acute and chronic psychiatric morbidity, including deliberate self harm, identified in the hospital, in recent months a team of liaison psychiatric nurses has been put in place; this team works alongside the existing team of social workers and psychiatrists. The liaison psychiatric nurses have dealt with up to 100 referrals a month, over a third of which were referrals of patients after deliberate self harm (table). The proportion of patients discharged after deliberate self harm without psychosocial assessment dropped to an average of 37% in the four months after the new service started. Clearly, psychiatric nurses can play a crucial part in managing deliberate self harm and psychiatric morbidity in a general hospital,[2 3] especially at a time when there is renewed interest in the development and evaluation of interventions to prevent deliberate self harm being repeated.[4 5]

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Psychiatric services have limited role in deliberate self poisoning

EDITOR—Kapur et al have highlighted the large burden placed on society and the health services by deliberate self poisoning.[1] The authors, who are consultants in liaison psychiatry, suggest that every patient who presents after a deliberate overdose should receive a specialist psychosocial assessment. We disagree with this approach. Self harm is a symptom of a range of diseases, illnesses, and predicaments, of which only a minority are amenable to psychiatric intervention.

Every patient presenting with self harm must, of course, receive a psychosocial assessment. But in claiming that this is the role of specialists, are the authors not merely trying to create a source of steady work for a developing subspecialty?[2] The Health of the Nation targets for suicide were not adopted in Scotland, which recognised that psychiatric services have a limited role in this complex societal problem.[3] The first line of assessment is and should be general practitioners, accident and emergency doctors, and general physicians. All doctors have been trained in and must continue to practise psychological medicine. Transferring all these patients to psychiatry is not an appropriate use of already overextended mental health services, especially when evidence suggests that psychiatric treatment is of no value in most cases.[4] The high relative risk of suicide in the years after deliberate self harm is worrying,[5] but this must not lead to wasteful interventions.

A more rational use of medical resources would be achieved by strengthening rather than removing the filters that exist between the various levels of care for these patients. Specialist psychiatrists should offer efficient care in complex cases and should coordinate comprehensive services for patients after deliberate self harm in the light of available resources for mental health problems in the entire community.

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1 Kapur N, House A, Creed F, Feldman E, Friedman T, Guthrie E. Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *BMJ* 1998;316:831-2. (14 March.)
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Anticoagulation may be beneficial in high risk factor V Leiden carriers

EDITOR—Sarasin and Bounameaux's decision analysis model of treatment in factor V Leiden carriers[1] is in keeping with the results of our cohort study.[2] In our study the annual rate of recurrence when treatment with warfarin was stopped was 11.1 per 100 patient-years. Patients who had an idiopathic first event were more likely to have a recurrence than those whose first event was precipitated (log rank = 4.76, P = 0.029). The recurrence rate in these high risk patients was 28.6 per 100 patient-years.

In a previous prospective cohort study of patients who had had a first deep vein thrombosis 11.5% of recurrent events were fatal, but all deaths occurred in patients with cancer.[3] In the absence of cancer the risk of fatal recurrence was zero after a median follow up of nearly eight years. Even if 1% of events are assumed to be fatal in the absence of cancer, our study indicates that the risks of fatal haemorrhage and thrombosis would be roughly equivalent (0.28 *v* 0.25 deaths per 100 patient-years).

However, the aim of treatment is not only to prevent death but to prevent recurrence of non-fatal venous thromboembolism. Recurrence is associated with acute pain and venous obstruction and an increased risk of the post-phlebitic syndrome, itself a risk factor for further thromboembolism. Extended oral anticoagulant therapy may therefore be beneficial, particularly in high risk patients with idiopathic first events. Our study indicates that oral anticoagulation with a target international normalised ratio of 2.5 is effective in reducing the risk of recurrence but that after the initial six months of treatment the benefit: risk ratio is reduced. A lower intensity of long term anticoagulation should now be evaluated in a large prospective study.

Maintaining a lower international normalised ratio may lower the risk of haemorrhage while still preventing acute recurrent events. This may reduce a small risk of death but also a large risk of progressive morbidity due to the post-phlebitic syndrome. It seems feasible that such treatment would be effective since low dose warfarin regimens have been shown to be effective in other groups of high risk patients.[4 5]

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Treatment and prognosis after myocardial infarction

Echocardiography and rescue angioplasty are effective for high risk patients

EDITOR—Lim and Shiels state that pooled data suggest patients do not benefit from rescue angioplasty after failed thrombolysis and that their outcome is adversely affected when interventional techniques fail to open the vessel affected by the infarct.[1] They also state that "vigorous clinical assessment" is required before a patient can be classified as high risk after thrombolytic treatment to prevent misinterpretation of signs such as hypotension and sinus tachycardia. Both points should be addressed.

Firstly, the only large scale randomised trial comparing rescue angioplasty with conservative treatment for failed thrombolysis found a significant reduction in the incidence of death or severe heart failure among patients in the rescue angioplasty group (6% *v* 17%, P = 0.05).[2] Additionally, the trial was performed without the use of abciximab, a glycoprotein IIb/IIIa inhibitor shown to be beneficial in high risk angioplasty without increasing the risk of haemorrhage.[3] The trial also did not incorporate regular intra-aortic balloon pumping, a treatment shown to be effective in maintaining arterial patency after rescue angioplasty.[4] Thus, rescue angioplasty using the modern adjunctive treatments now available might offer more benefit to high risk patients than could be shown in the trial, although further trials are needed.

Secondly, while clinical assessment is clearly important, electrocardiography can be used to identify high risk patients after thrombolytic treatment for acute myocardial infarction. Purcell et al found 18.2% mortality in unselected patients with acute myocardial infarction and $<50\%$ resolution of ST segment elevation in the worst lead 60 minutes after the initiation of thrombolytic treatment.[5] Mortality in the group with $\geq 50\%$ ST segment resolution was just 1.3%. Thus, in Lim and Shiels's example of a dominant right coronary artery occlusion, the degree of ST segment resolution after thrombolytic treatment is equally as important in risk stratification as the clinical examination, particularly if signs such as hypotension and sinus tachycardia are, as the authors suggest, regularly misinterpreted as indicating a patient at high risk of further adverse events.

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Authors' reply

EDITOR—We expressed the need for careful clinical evaluation before subjecting patients to any procedure which might do more harm than good. The role for routine rescue angioplasty remains unproved, and this was the conclusion reached in a review by Davies and Ormerod.[1] Whether the use of newer adjunctive treatments such as glycoprotein IIb/IIIa inhibitors and intra-aortic balloon pumping will improve outcome in patients undergoing rescue angioplasty needs to be determined in further trials. As far as we are concerned, interpretation of the electrocardiogram and bedside echocardiography are very much part of the overall assessment of patients.

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1 Davies CH, Ormerod OJM. Failed coronary thrombolysis. *Lancet* 1998:351:1191-6.

Effectiveness of genetic testing in certain diseases must be evaluated

EDITOR—I was interested to read the series on the new genetics, having recently completed a review on this subject, commissioned by the 12 health authorities in South Thames.[1] We identified a major problem, which has not been mentioned in any of the articles—namely, the enormous head of steam that is building up as a result of research progress in the past few years. There is no apparent shortage of funds for the fundamental research of gene sequencing, and the literature is growing exponentially. Marteau and Croyle point out that more research is needed on the impact of genetic testing and especially the practicalities of counselling.[2]

A mechanism is needed to evaluate the effectiveness of testing in specific disease situations before a routine service is offered. This need is compounded by the speed of developments and the minimal delay—often only a few weeks—between the sequencing of a particular gene and the ability to offer a routine service. Health authorities are thus faced with demand for new service developments far outstripping their ability to evaluate and plan such services and allocate funds for them.

There is also a shortage of skilled staff to meet the training needs. Few regions in the United Kingdom have achieved the target (set in 1991) of two whole time equivalent clinical geneticists per million population.[1 3] In addition to providing an expanding clinical service, with a referral rate of 500 new families per million population per year,[4] most clinical geneticists already have a heavy teaching and training commitment. This includes a commitment to undergraduate medical students and specialist registrars from many disciplines, as well as their own trainees and non-medical coworkers. If primary care teams are indeed to be equipped to act as gatekeepers for the regional genetic service[5] an enormous educational effort will be needed, which our clinical geneticists are not in a position to take on at present.

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Title did not reflect author's views

EDITOR—The title of my recent article "Collaborative research with infant formula companies should not always be censored" was added by the *BMJ* and does not reflect my views.[1] It implies that in most or many instances censorship is or should be in operation. I would have chosen as a title "Collaborative research with infant formula companies should be encouraged"; as in pharmaceutical research, high quality product development is in the interests of child health.

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1 Lucas A. Should industry sponsor research? Collaborative research with infant formula companies should be encouraged. *BMJ* 1998;317:337-8. (1 August.)

Corrections

Racial discrimination in distinction awards

An author's error occurred in the letter by Nigel Dudley (27 June, p 1979). The second sentence of the second paragraph states: "Merit awards are received by 61 of 221 (27.6%) of white consultants compared with one of 18 (0.06%) non-white consultants." This should read "compared with one of 18 (5.6%)."

Impact of surgery for stress incontinence on morbidity

An authors' error occurred in this letter (11 July 1998, p 143). Mark James, research registrar in urogynaecology, Bristol Urological Institute, Southmead Hospital, Bristol BS10 5NB, omitted to mention his two coauthors: Paul Abrams, consultant urologist, and Sandy Gujral, specialist registrar in urology, both at the same address.