LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Back pain in pregnancy

Dr Ashkan and colleagues describe the case of a woman with compression of the cauda equina due to prolapse of the lumbosacral invertebral disc (February 1998 *JRSM*, pp 88–90). Because the back pain was attributed to her pregnancy, referral was delayed and she was left with a residual neurological deficit after surgical decompression. We have lately been involved in a similar case of a young woman who developed back pain and signs of lumbar radiculopathy in the third month of her second pregnancy. Postpartum, magnetic resonance imaging (MRI) of the lumbar spine showed no abnormality and she was diagnosed as having obstetric palsy with secondary sympathetic dystrophy. Two years passed before the diagnosis was established by pelvic MRI, which revealed a mass adjacent to the greater sciatic foramen (Figure 1) which on biopsy proved to be a malignant peripheral nerve sheath tumour—a locally aggressive tumour whose prognosis is related to size at diagnosis[1,2]. This is another example of the serious consequences of failing to investigate pregnant patients with back pain and neurological signs. We agree with Dr Ashkan and colleagues that detailed history-taking and neurological examination are essential, and suggest that MRI of the pelvis should be considered especially in those with normal lumbar spine imaging.

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REFERENCES

1 Hruban HJ, Shiu MH, Senie RT, Woodruff JM. Malignant peripheral nerve sheath tumours of the buttock and lower extremity. *Cancer* 1990;**66**:1253–65

2 Kelso TB, Ferrari CJ, Frassica FJ. Sciatica caused by a neurilemmoma of the intrapelvic portion of the sciatic nerve. *J Bone Joint Surg* 1993;**75A**: 603–5

Confusion of roles

Mr Chant ruminates (February 1998: *JRSM*, pp 63–65) on roles past, present, and future in the delivery of medical care. My concept is that the best educated individual (currently the doctor by virtue of the depth and breadth of the medical school curriculum and postgraduate training) needs to devise the plan, initially diagnostic, and subsequently therapeutic, for the patient; the nurse should be the manager of the execution of that plan; and a technician should be the 'task-performer' in accomplishing the plan. The doctor's education heightens discriminatory power and brings an appreciation for uncertainty. Often times, however, the patient's problem is mundane, routine and not in need of this knowledge or skill. Such problems can be dealt with by (in American terminology) a 'mid-level provider'—either a nurse with advanced training or a physician assistant. Such an arrangement works in most cases, failing only when the patient's problem has the appearance of being mundane and actually is not. My experience is that the less educated individual lacks the discriminatory power to tell the difference between these two types of patients and treats the non-routine as the routine. Since this is not a common occurrence, safety can be assured with a well-designed back-up system.

This concept can be applied across the range of medicine, routine tasks (e.g. vein harvesting for cardiac bypass graft) being assigned to those with intermediate training and plans (e.g. postoperative care) managed (and not necessarily delivered) by a nurse, while the doctor assesses data, integrates, and devises the plan/or the highly skilled procedure. Such a structure is truly (again in current American lingo) 'collaborative' and not competitive.

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Duty of continuity

In their editorial (February 1998 *JRSM*, p 61) Mr Hill and Professor Schofield write about what patients might expect in terms of continuity of care and suggest the need

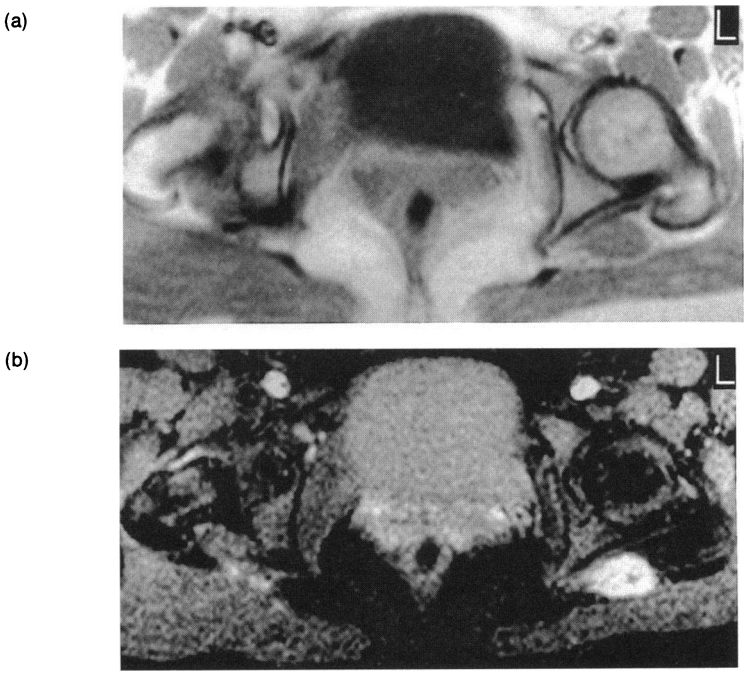

Figure 1 **Axial T1-weighted FSE (*a*) and axial STIR (*b*) images of the pelvis showing a mass in the region of the sciatic nerve anterior to the wasted adjacent gluteal muscles of the left buttock.** The lesion appears predominantly low signal on T1, typical of soft tissue tumours, but is much more conspicuous on STIR due to suppression of the signal from adjacent fat.