sion of HIV can be reduced to less than 5% is almost unbelievable—but he does not stop there. He then wags a righteous finger at women who do not know they have HIV infection for not finding out, by not having themselves tested antenatally, in spite of all the known reasons why women do not get tested antenatally. The Department of Health had a consultation with a large group of women from a range of voluntary organisations involved in HIV/AIDS work in January 1994, in which the problematic issues of antenatal testing were thoroughly aired. It seems that the message—that the supposed benefits to both mother and baby are not at all clear cut—has been lost.

One hospital, Steer says, emphasises to women that "knowing their HIV status may save their baby's life." In so many words, he is saying that 95 out of 100 babies of HIV positive women need no longer be at risk of HIV infection. This is patently false. It is ridiculous and dangerous to reduce the situation in this manner, especially since someone might believe him.

MARGE BERER
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1 Steer P. Recent advances in obstetrics. *BMJ* 1995;311:1209-12. (4 November.)
2 Vernal DAA. Practising obstetrics and gynaecology in areas with a high prevalence of HIV infection. *Lancet* 1995;346:293-5.
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Author's reply

EDITOR,—My review (PS) recommended that pregnant women should be advised to have a test for HIV antibody so that if the results were positive they could opt for interventions to minimise the risk of transmitting the virus to their baby.[1] The discussion of HIV infection was but a small component of the paper, and it was not possible to cite all the documentary evidence in support of this proposal.

We stand by the statement that the evidence for the role of breast feeding in the transmission of HIV is incontrovertible. In our maternity service 85% of mothers breast feed. We know from anonymous testing during 1994 that nine of the HIV positive women who delivered in this unit were not tested and, as far as is known, were unaware of their HIV infection. If eight of these women breast fed it is possible that one or two of their babies became infected with HIV when this might have been prevented by their avoiding breast feeding. In addition, they were denied the opportunity of discussing delivery by caesarean section or treatment with zidovudine.

People have a right to accurate information, and this is important in informing their choice regarding HIV antibody testing. This is an essential aspect of pretest counselling, whether the patient is pregnant or not. When presented with the evidence most mothers we look after who know that they are HIV positive choose both caesarean section and zidovudine. They clearly disagree with Marge Berer's conclusions.

Berer refers to a meeting she attended, together with a variety of representatives from women's groups, hosted by the Department of Health in January 1994. One of us (JRS) attended such a meeting, but after two days of discussions no agreement could be reached between the women's groups' representatives and the medical staff present, with the former being reluctant to accept the value of the scientific evidence being reviewed.

It is not clear to us why Berer takes such issue with our attempts to offer women the choice of methods which we believe reduce vertical transmission. We strongly support further trials of these and other strategies but feel that the current evidence justifies us recommending to women that they consider interventions to benefit the health of their children.

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Evidence-Based Medicine

Commentaries should be evidence based too

EDITOR,—As enthusiastic supporters of the recent drive towards evidence based health care we eagerly looked forward to the first issue of the journal *Evidence-Based Medicine*, published by the BMJ Publishing Group.[1] When we read it, however, we were disappointed both by the way in which it reviews individual articles rather than focusing on areas of clinical practice and by the lack of objectivity of the commentaries on the articles reviewed.

We were struck by the inclusion of unsubstantiated statements in the commentaries, four of 23 commentaries being unreferenced. The value of such unsubstantiated commentaries has recently been questioned.[2] Furthermore, no detail is given about the process used to select the authors of commentaries, which leads to concerns about the representativeness of the views expressed and about potential conflict of interest.

There has been a welcome trend towards basing conclusions on evidence from a variety of sources, including randomised controlled trials, meta-analyses, and, particularly, systematic reviews of all published and unpublished studies.[3] Selecting individual articles from the world literature moves away from this approach. This could potentially undermine the value of systematic reviews as perceived by the clinical community.

We advocate that the commentaries in *Evidence-Based Medicine* should be substantiated by references, that the process for choosing commentators should be published, and that the findings of systematic reviews should be incorporated in the journal. Finally, we would request that future journals published by the BMJ Publishing Group should be encouraged to include a letters section (*Evidence-Based Medicine* does not do so).

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Editors' reply

EDITOR,—Evidence based medicine requires the integration of individual clinical expertise with best available external evidence from systematic research.[1] Good doctors use both. Without the former, practice quickly becomes "evidence tyrannised"; without the latter, practice quickly becomes out of date. Journals such as *Evidence-Based Medicine* strive to bring both to a readership that can find less than 30 minutes a week to read about subjects relevant to patients. We serve our readers by monitoring both the current literature and other sources (including both the Cochrane and the York reviews) and extracting just the 2% of reports that are both pertinent to front line clinical practice and scientifically rigorous. They are summarised in structured abstracts (as external clinical evidence), and one of our panel of seasoned clinicians (who are required to disqualify themselves if they have any conflicts of interest) places them in clinical context through accompanying commentaries, synthesising the clinical evidence with clinical experience.

The page headed "Purpose and procedure" appears in every issue of the journal and answers the points raised by N J Pearson and colleagues. Because commentators provide the context of personal clinical experience they add references only when they introduce evidence not already cited in the abstracted original. Thus two of the four unreferenced commentaries in our first issue accompanied exhaustive systematic reviews, rendering any further references repetitious. The third commented on placement of a central line under ultrasonographic guidance and provided exactly what was called for: personal clinical experience with the procedure.

Pearson and colleagues' claim that we have ignored systematic reviews is wrong. Our inaugural issue contained a Cochrane review on stroke units and a routinely published systematic review on β agonists, and our next issue contains several more. But good systematic reviews are rare, and they necessarily lag behind important and often definitive trials by several years. Moreover, they are just beginning to address clinically important topics in diagnosis and aetiology.

Although we provide an opportunity for authors to append brief letters to the pages on which their work appears, we have decided not to have a letters section for two reasons. Firstly, authors of the most helpful letters we have received (which are leading to improvements in the journal) do not request publication. Secondly, having a letters section, although it might provide interesting "theatre," would mean fewer abstracts and commentaries, and we do not think that the trade off would serve our readers.

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1 Sackett DL, Rosenberg WMC, Muir Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996;312:71-2. (13 January.)

Management of blood loss in children of Jehovah's Witnesses

EDITOR,—David Busuttil and Adrian Copplestone's editorial on the management of blood loss in Jehovah's Witnesses touches on, but does not resolve, the clinical and ethical issues of treating children of Jehovah's Witnesses.[1] The authors concentrate on the use of recombinant erythropoietin in the postoperative management of anaemia at the expense of considering other pharmacological agents, such as aprotinin or desmopressin, which can reduce intraoperative blood loss. As paediatric surgeons we are aware of the need to preserve circulating blood volume and have been early to adopt techniques that provide

improved haemostasis. Use of predeposited autologous blood, intraoperative autotransfusion, and haemodilution are not readily adaptable to neonates having extensive surgery, although they may be appropriate for older children.[2]

After our success in resecting a large sacrococcygeal teratoma with minimal blood loss when we used aprotinin in the child of Jehovah's Witnesses[3] we have observed both subjective and objective reductions in blood loss and transfusion requirements in neonates having surgery for sacrococcygeal teratoma, necrotising enterocolitis, and massive cervical cystic hygroma when we used a bolus of aprotinin (10 000 kIU/kg (=1 ml/kg)) on induction of anaesthesia followed by an infusion at 1 ml/kg/h during the operative period. Our only other experience in the perioperative use of desmopressin is in patients with von Willebrand's disease. We suggest that further evaluation of the use of aprotinin perioperatively may obviate the need for expensive recombinant erythropoietin to treat postoperative anaemia.

The legal recourse available when transfusion is necessary deserves clarification. While the courts may uphold the decision of an adult Jehovah's Witness to refuse transfusion, parents would be charged with neglect for failing to seek, or permit, desirable medical treatment for their children, even if that treatment were to contravene religious doctrine. Parental refusal of transfusion does not necessarily necessitate making the child a ward of court and thereby removing all parental authority as in most cases this is a conflict of interest between religious beliefs and the wellbeing of the child. Parents may be absolved of this particular responsibility by a specific issue order, which gives legal sanction to only the action identified, such as the administration of blood. A specific issue order is made under the private law provisions of the 1989 Children Act, and the High Court is approached direct.

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Dangers of cocaine and adrenaline paste

EDITOR,—Martin Burton and Richard Marks are correct in emphasising that recommended doses of cocaine should not be exceeded during nasal surgery.[1] However, adding adrenaline to cocaine paste (as opposed to a 10% solution) increases the unpredictability of the absorption of cocaine, and this was why we condemned this particular combination in our article.[2]

Peter Williamson and Robert Slack are incorrect in their statement that "overdose of almost any anaesthetic drug will result in death."[3] Toxic side effects depend on the therapeutic ratio of a drug, and therefore some drugs have a substantial safety margin even when used in overdose. Williamson and Slack are right to recommend the use of less concentrated formulations of cocaine for nasal surgery and to measure the volume given accurately, so as not to exceed the current recommendations in the *British National Formulary*, which are accepted by the British Association of Otorhinolaryngologists-Head and Neck Surgeons.

P D M Ellis and B R Wilkey state that anaesthetic technique is crucial for patients having nasal surgery for whom topical cocaine and adrenaline paste is used.[4] They fail to acknowledge that all patients having surgery experience anxiety and may have high circulating catecholamine concentrations. They cannot judge that anaesthesia was extremely light in the cases that we reported and that this contributed to the arrhythmias or, indeed, attribute the arrhythmias to any other factors and absolve cocaine and adrenaline paste from blame. Many patients breathe halothane spontaneously during surgery without experiencing arrhythmias.

Our condemnation of the topical use of a combination of 25% cocaine paste and adrenaline for nasal surgery was meant to be alarmist.

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Few reprint requests come from less privileged countries

EDITOR,—David Cummins and Richard Osborn urge the *BMJ* to supply free reprints to authors of published articles.[1] One argument put forward is that authors' reluctance to pay for reprints means that "those working in less privileged countries are seriously disadvantaged." I have recorded the country of origin of 248 requests for reprints that I have received over the past five years. Very few were from less privileged countries (table 1). This may reflect many factors, ranging from lack of interest in the published material to lack of information about its existence. I sent a questionnaire to 72 consecutive people who requested a reprint to find out the reason for the request. Thirty one (43%) replied, of whom 24 said that the main reasons were inability to obtain the journal and the greater ease of sending for a reprint than obtaining a photocopy. The latter is perhaps not surprising as many computer search facilities now automatically produce reprint request postcards for dispatch.

Reprints seem to be requested more commonly by people in countries where facilities for photocopying should be readily available. With the increasing transfer of data by electronic communications the need for reprints will be drastically reduced and their usefulness may be questionable.

Table 1—*Country of origin of 248 requests for reprints*

Country	No	Country	No
Argentina	1	Israel	1
Australia	1	Italy	6
Austria	14	Japan	2
Belgium	6	Lithuania	5
Brazil	2	Luxembourg	1
Bulgaria	1	Mexico	5
Canada	11	Nigeria	1
China	1	Pakistan	1
Colombia	6	Poland	8
Cuba	5	Romania	2
Czechoslovakia	24	Spain	8
France	39	Switzerland	4
Germany	16	United States	71
Hungary	5	Venezuela	1

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1 Cummins D, Osborn RM. BMJ should review its policy on reprints. *BMJ* 1995;311:1169. (28 October.)

Life's unfair

EDITOR,—How sad that poor Tony Smith should have reached the age of 60 before discovering a fact that I learnt at my mother's knee: that life is unfair and we just have to get on with it. What a time he must have had these three score years, and at the end of them he cannot even get a free bus pass.[1]

But there have been consolations: men do not menstruate month after month for most of their lives (or worry when they do not—it is called "the curse" for good reasons); men do not have to agonise about taking the contraceptive pill every day with no one knowing the potential risks; men do not know the discomforts of pregnancy or the pain of giving birth; they do not get postnatal depression. It is still rare for a man to be the partner who juggles job and family and feels guilty about looking after neither properly or, indeed, to be the partner who has to decide whether to put his career on hold, risking never catching up.

In middle age, men do not bump their heads on the glass ceiling when trying to continue onwards and upwards. Men are free to make the sort of statements at work that female colleagues try to avoid for fear of being labelled emotional. Men's management styles are more easily understood by other men (the management majority) than those of the women managers who refuse to be honorary men for work purposes. Most people would agree that men do not have to go through the menopause: certainly they miss the experience of showering three times a night after sweats and still having to arrive at work on time in the morning or, as an option, agonise about whether to take hormone replacement therapy when no one really knows the potential risks. If a man develops symptoms of heart disease his general practitioner organises investigations instead of talking about indigestion brought about by middle age spread.

In older age, even today, if a man is married his wife will probably continue doing household chores while he will regard himself as retired and so due special consideration. This may be one reason why his wife is likely to be more active as they both continue to age. She may well remain fit enough to get very tired indeed when he becomes frail and she chooses to nurse him herself for longer than logic would suggest: they may not say so outright, but both would probably want him to stay in his own home as long as possible. Finally, a man is unlikely to be the partner left to face life alone.

Women have many advantages, and I would not swap sex with Smith for a moment, but I cannot agree that, on balance, those with only one X chromosome have such a bad time. There is more to life than wishing for just a few more years of it or a free bus pass (though now Smith at least has the comfort of free prescriptions).

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1 Smith T. Unfair to men. *BMJ* 1995;311:1097. (21 October.)