

Many deaths in known drug misusers will not have been included in study

EDITOR—We were unable to find a definition of “accidental” in Roberts et al’s report on accidental drug poisoning in teenagers.¹ We then realised that a definition was implicit because the study is restricted to deaths ascribed by the Office for National Statistics to the international classification of diseases (ninth revision) codes E850-869, but we still found it difficult to relate their findings to our experience as pathologists. In England and Wales, accidental deaths are investigated by coroners, and they make a distinction between “accidental death” and “misadventure.” In practice, truly accidental ingestion of drugs is rare. The common situation is that the drugs are ingested deliberately, but the fatal outcome was not anticipated by the subject—a circumstance regarded by coroners as “misadventure,” not “accident.” Understanding emerged only when we telephoned the Office for National Statistics for clarification, when we learnt that both misadventures and accidents are coded within E850-869.

Roberts et al have dealt with another important confounding factor by recognising that many deaths from poisoning are coded as E980-983, codes used when it has not been determined whether the poisoning was accidental, suicidal, or homicidal—a circumstance corresponding to coroners’ open verdicts. They do not, however, seem to have accounted for another situation—that coroners can ascribe deaths to drug misuse or drug dependence. These deaths are coded as 304-305, codes that take precedence over E850-869 in statistics from the Office for National Statistics; 304-305 can be used even if terms such as drug misuse, or various synonyms, do not appear on the coroner’s death certificate but merely appear in accompanying detail provided by the coroner.

Our experience of studying deaths related to methadone² indicates that most deaths in subjects in methadone maintenance programmes occur in ways appropriately regarded as “accidental” or “misadventure,” but many of these deaths, and deaths from various other causes in known drug misusers, are likely to be coded as 304-305; they will therefore not appear in Roberts et al’s figures. It may well be that correction of this minor oversight will not change their conclusions, but we think it important that this assumption should be confirmed; at the very least, it will enhance comparison with other similar studies.³

Ian Roberts *Lecturer in pathology*

Emyr Benbow *Senior lecturer in pathology*
University of Manchester, Manchester M13 9PT

Alison Cairns *Specialist registrar in pathology*
Leeds General Infirmary, Leeds LS1 3EX

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MRI is best technique for imaging acute osteomyelitis

EDITOR—We are surprised that Wilkinson does not find magnetic resonance imaging helpful in the diagnosis of acute osteomyelitis.¹ This technique is particularly suited to the evaluation of osteomyelitis because of its superior soft tissue contrast and multiplanar imaging. Anatomical detail is much better than with isotope studies, and subtle abnormalities are more easily appreciated than with computed tomography or radiography.^{2,3} Isotope bone scanning is often not helpful, particularly in the early stages of infection. One comparative study quoted sensitivities and specificities of 88% and 93% respectively for magnetic resonance imaging, as compared with 61% and 33% respectively for isotope bone scanning.⁴ Magnetic resonance imaging also has the advantage of not subjecting the patient to ionising radiation.

Ultrasonography can give only limited information about the bones and soft tissues. We would therefore support the position of Smith⁵ and suggest that all children suspected of having acute osteomyelitis should have magnetic resonance imaging and that isotope bone scanning should be considered obsolete for this indication. When making a diagnosis it is surely best to use the diagnostic test that is known to be the most sensitive and specific and has the best positive predictive value. We believe that there is an overwhelming body of evidence that magnetic resonance imaging is the best diagnostic test in acute osteomyelitis.

Philip T McAndrew *Consultant radiologist*
Caroline Clark *Consultant radiologist*
Radiology Department, Kirkcaldy Acute Hospitals
NHS Trust, Kirkcaldy, Fife KY2 5AH

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Cognitive behaviour therapy has role in treatment of medically unexplained physical symptoms

EDITOR—As a general practitioner and cognitive behavioural therapist, I was encouraged by the message in Mayou and Sharpe’s editorial on treating medically unexplained physical symptoms.¹ Training doctors to extend themselves beyond the classical medical model and to think simultaneously in physical, psychological, and social terms has been central to vocational training in general practice from its inception. Identifying physical problems is the main part of our job; most doctors are sensitive to the

importance of social factors, while social interventions, when appropriate, consist largely of delegation to other professionals. Intervening at a psychological level, however, has been far more problematic, largely because the theoretical models and techniques available have simply not been adequate in terms of time, efficiency, and effectiveness.

Cognitive behavioural approaches are proved not only in the management of unexplained physical symptoms but in many other clinically relevant areas.² In addition, many developments in consultation technique already contain a cognitive element.^{3,4} Perhaps most importantly, cognitive behavioural interventions can fit within the time frame of a “normal” consultation in general practice.⁵

As Mayou and Sharpe describe, an essential strength of the cognitive behavioural model is its integrative approach, constructing an overall meaning from the patient’s distress simultaneously in physiological, behavioural, affective, and cognitive terms, all within a social context. This contrasts with the traditional approach, in which both doctors and patients have been driven to seek isolated causes, framed in dualistic terms and 19th century concepts, derived from the success of the germ theory of disease.

The authors make suggestions for the implementation of this approach and outline the obstacles. These obstacles should not be underestimated for they represent a major paradigm shift in our thinking and attitudes. However, the potential benefits that may be derived from introducing and integrating a cognitive approach into our clinical practice—in terms of reduced distress for the patient and the doctor, reduced costs, and prevention of iatrogenic damage—are enormous. I look forward to the consequences.

Steve Williams *General practitioner*
The Garth Surgery, Westgate, Guisborough,
Cleveland TS14 6AT

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Trial of breast cancer screening in younger women is necessary

EDITOR—Baum has written an interesting letter¹ in response to Fletcher’s editorial pointing out the numerical value of screening under the age of 50.² He may, however, have misinterpreted Fletcher’s slant on the “wisdom of the organisers of the British trial.”

My reading of the editorial suggested that the wisdom was in undertaking a trial rather than deciding on screening without a trial. I think it highly likely that his mathematics and