HIV TESTING

Don’t forget the over 60s

White reported routine offers of HIV tests at an accident and emergency department,1 while Das and colleagues discussed primary HIV infection as “easily missed.”2 Our recent experience with three older people suggests that opportunistic offers of HIV testing should be more widespread.

All three were repeat blood donors aged over 64 years who had seroconverted since their last donation. Careful history taking during discussion of the positive result uncovered an illness compatible with primary HIV infection. Two donors had visited their GP; the third was admitted to hospital for lymph node biopsy. The final diagnosis was “a viral infection” for two and gastrointestinal infection in the other. Two told us of a new sexual partner shortly before onset of illness—no sexual history had been taken in one, despite a history of sexually transmitted infection, and in the second a history had been taken but HIV testing was not suggested. The third donor had a clearly identifiable lifestyle risk.

None of our donors was recognised as having a primary HIV infection. Their infections would probably have gone unnoticed for years had they not been donors. They lived in different rural areas. The two oldest had given multiple donations (77 and 92) and might have been considered “low risk.” They may also have considered themselves low risk.

Late diagnosis of HIV in the over 50s has recently been described,3 and our experience supports the concern that risk of HIV infection, and HIV seroconversion illness, is not being recognised or even considered in this age group. Lifestyle risks should be explored more readily and a high index of suspicion maintained in all cases of “non-specific viral infection.”

We need to SHARPen up

White highlights initiatives to increase HIV testing in accident and emergency settings in high prevalence areas (0.2% population diagnosed).3 Such initiatives are a step towards normalising HIV testing.

The UK national HIV testing guideline advocates screening of medical admissions and primary care registrants in high prevalence areas, and diagnostic testing of patients with clinical indicator conditions.2 Slough has a diagnosed HIV prevalence of 0.35%. The SHARP Project (screening for HIV as routine practice) is a local initiative aimed at identifying HIV diagnoses in non-genitourinary medicine healthcare settings, through targeted education of clinicians; 129 local clinicians have received training.

A pre-training survey found that 70% (of 74 respondents) did not request HIV tests because of “clinician barriers,” such as “no time for pre-test discussion” or “patient has no HIV risk factors.” These reasons are no longer relevant; however, when HIV is diagnosed early and managed appropriately, life expectancy approaches that of the general population,3 negating the need for in-depth discussion and HIV risk assessment.

Six months after the launch of SHARP training, nine new HIV diagnoses were identified (376 tests outside of genitourinary medicine). In the preceding six months, two of 274 tests were positive.

Department of Health pilots show high rates of patient acceptability and uptake of HIV testing in non-traditional settings.5 To maximise the diagnosis of the 26% of people living with HIV who are unaware of their status, clinicians’ attitudes need to change.1 Early diagnosis improves outcomes for the individual, public health, and the NHS purse.

We encourage results highlight our collective professional responsibility to reduce late HIV diagnoses through normalising HIV testing.

Leena Sathia consultant in genitourinary medicine and HIV, Royal Free Hospital, London, UK

leena.sathia@nhs.net

Sarah Duncan specialty registrar in genitourinary medicine, Garden Clinic, Slough, UK On behalf of the SHARP Project Team

Competing interests: The SHARP Project was supported by a grant from Gilead Sciences UK and Ireland Fellowship.

1 White C. London hospital says it will continue to offer HIV tests to all accident and emergency patients after trial. BMJ 2011;342:d3705. (13 June.)


College of Medicine

College of Medicine replies

Cassidy’s article and the rapid responses contain errors and misunderstandings.1,4

The college aims to promote a more politically and professionally transparent, patient centred, and sustainable approach to healthcare, using whatever social or therapeutic approaches are safe, effective, and empowering for patients. The college is calling for a more compassionate NHS, where practice based on good evidence has its foundations in health promotion, resilience, and vocation. The widespread “scandals of caring” show how urgently we need to rediscover the ethic of service. A combination of management changes and evidence based medicine has failed to provide the solution.

We believe that all registered clinicians wish to provide value and excellence to their patients. Membership is open to all UK registered clinicians and medical scientists because we accept a wide range of properly trained and regulated professionals, not because we...
uncritically endorse any particular therapy. We wish to attract clinicians and scientists who will work as a team to promote high quality care and not professional self interest. Our innovations network includes examples of excellence in primary care, children’s health, and community development in deprived areas and NHS complementary therapy services. We do not promote any specific intervention.

The college believes that the patient’s voice must become a powerful component of policy making, so, unlike other medical colleges, our patient members have real executive power within our council. We believe that the dispossessed have a right to good healthcare—our faculty for homeless care is creating a dialogue that will hopefully lead to improvements in serving these needs at a time of financial crisis.

A thoughtful discussion of the crisis within medicine is needed, so that together we can achieve the patient centred, values based, team approaches that our patients, clinicians, and healthcare system desperately need. George T Lewith professor, Peninsula Medical School, Exeter, UK edzard.ernst@pms.ac.uk

### Competing interests:
None declared.

### College of Quackery?
Cassidy mentioned that the new College of Medicine singles out projects for praise, so I looked at the initiatives listed on the college’s website. The information indicates that these projects offer a wide range of treatments, including homeopathy, qigong, reflexology, and aromatherapy, which, according to an evidence based assessment, must be categorised as unproved or even disproved. In one case, a therapeutic claim was made (homeopathy is useful for asthma and eczema), which is clearly not supported by evidence.

Quackery can be defined as the promotion of unproved medical practices. On the basis of this definition, I think there is little doubt that this college is a college of quackery.

Lewith and colleagues claim that we misunderstand what this strange new institution is about and try to convince us that it aims for clinical excellence. But this is not in keeping with the known facts. The college showcases one unit that offers homeopathy to treat patients with asthma, but the Cochrane review on this subject concluded that homeopathy was not useful in this disease. This is not “excellence,” but outright quackery, which has the potential to kill patients.

Edzard Ernst professor, Peninsula Medical School, Exeter, UK edzard.ernst@pms.ac.uk

### Competing interests:
None declared.

### What is integrative health?
Is it possible that the new College of Medicine is being deliberately ambiguous about the term integrative health? I would be interested to meet any doctor who would not support the underlying philosophy of taking into account patients’ beliefs and personal circumstances and helping patients look after their own health. Of course this fundamental principle of good medicine needs nurturing and encouraging at every opportunity.

The college, however, seems to interpret this philosophy to mean the promotion of unproved complementary treatments.

These are very different agendas and should not be confused. All good doctors should support the first and reject the second. If this college is an attempt to smuggle in the second agenda under the guise of the first, then good doctors should indeed be wary.

James May general practitioner, Lambeth Walk Group Practice, London SE11 6SP, UK james.may@nhs.net

### Competing interests:
None declared.

### MENTAL ILLNESS TREATMENTS
Drug evidence is flawed

The loss of research into drug treatments for mental illness is ironic when more doubt is being expressed about the reliability of research that has encouraged the prescription, or overprescription, of psychotropics to countless people at huge cost.

Marcia Angell, an editor of the New England Journal of Medicine for many years, recently reviewed three books that discuss the role of psychiatry and psychotropic drugs in the perceived “epidemic of mental illness” that has struck the United States. The book by Irving Kirsch contains information obtained from the Food and Drug Administration (FDA) under the Freedom of Information Act. Angell writes: Drug companies make very sure that that their positive studies are published in medical journals and doctors know about them, while the negative ones often languish unseen
within the FDA. This practice greatly biases the medical literature, medical education, and treatment decisions.

Kirsch obtained details of 42 trials of the six most widely used antidepressants approved between 1987 and 1999:

- Most of them were negative. Overall, placebos were 82% as effective as the drugs, as measured by the Hamilton Depression Scale (HAM-D), a widely used score of symptoms of depression. The average difference between drug and placebo was only 1.8 points on the HAM-D, a difference that, while statistically significant, was clinically meaningless. The results were much the same for all six drugs; they were all equally unimpressive. Yet because the positive studies were extensively publicised, while the negative ones were hidden, the public and medical profession came to believe that these drugs were highly effective antidepressants.

These findings and comments will come as no surprise to the many doctors who have viewed these drugs with suspicion for decades, but the damage continues.

Noel Thomas, general practitioner, Maesteg, Bridgend, UK
nithomas@doctors.org.uk

Competing interests: None declared.

1 Wise J. Research into treatments for mental illness is under threat. BMJ 2011;342:d3747. (14 June.)
3 Kirsch I. The emperor’s new drugs: exploding the antidepressant myth. Bodley Head, 2009.

Cite this as: BMJ 2011;343:d3891

Address the causes

What lies behind the overt call for more money to fund research on psychotropic drugs? The sad reality is that across psychiatric practice there is no treatment, pharmacological or psychological, that suits all patients in all circumstances, even for the single, common diagnosis of depression used by Professor Nutt as an example. In other words, there are no “broad spectrum” treatments. For the foreseeable future, we will have to struggle to pick and mix for individuals some acceptable interventions that work for them, for now.

So what is really the critical shortage of research funding? The UK Clinical Research Collaboration found that the UK spends the tiniest proportion of its resources for health research on prevention. Prevention of mental illness is especially under-researched, even though the latest evidence suggests this type of “upstream” intervention could bring huge social and economic benefits to the UK. For example, from childhood to old age, we already know how to prevent many new cases of depression—if there was a political consensus on intervening. BMA members have taken a leading role in addressing the “causes of causes” that are antecedent to, for example, type 2 diabetes, coronary heart disease, and stroke. Can the health research community decide to address the determinants of mental illness, with determination?

Woody Caan
professor of public health, Anglia Ruskin University, Cambridge CB1 1PT, UK
woody.caan@anglia.ac.uk

Competing interests: WC is editor of the Journal of Public Mental Health.

1 Wise J. Research into treatments for mental illness is under threat. BMJ 2011;342:d3747. (14 June.)

Cite this as: BMJ 2011;342:d3747

Concentrate on human factors

Drug companies losing interest in psychiatry is great news for psychiatry and mental health services but most of all for patients. Other research funding sources may also recognise that a focus on the brain is not a credible, evidence based choice likely to contribute to better care for those who have mental distress. Drug companies have found mental health highly lucrative, with multibillion pound blockbuster drugs such as the misnamed (for marketing purposes) antidepressants and antipsychotics. Sooner or later it would become apparent that the evidence based cupboard was empty—that all of the drugs were of dubious effectiveness, had varying degrees of neurotoxicity, created abnormal mental states (which can be lifesaving for some at certain points in their distress) rather than corrected them, and were different from illicit drugs only through who provides them and how they are subsequently used rather than because of discoveries of some particular therapeutic potency.

In biological psychiatry a reliance on psychotropic drugs has encouraged some remarkable developments such as an increase in the numbers and a worsening of the long term prognosis for those categorised as mentally ill, and an increase in stigma that is associated with the model that mental illness is “an illness like any other illness.” Freed from the corrupting shackles of the pharmaceutical industry we can put money into better understanding the factors that have the biggest effects on outcome: social factors outside of treatment and the therapeutic relationship within treatment.

Sami Timimi
consultant child and adolescent psychiatrist, NHS Lincolnshire, Lincoln, UK
stimimi@talk21.com

Competing interests: None declared.

1 Wise J. Research into treatments for mental illness is under threat. BMJ 2011;342:d3747. (14 June.)
4 Timimi S. Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSIDS). 2011. Available at:www.criticalpsychiatry.net/?p=527.

Cite this as: BMJ 2011;343:d4374

RISK ILLITERACY AGAIN

Put statistics back in its bottle

In a previous letter I argued that the pressure on doctors to learn more statistics is unjustified: statistics must be put back in its bottle for occasional ancillary use. Five letters countered that we need more statistics for interpretation because “medical science just has not delivered” yes/no tests, and the search for them “is probably futile.” 1 2 Really? What about tests for pregnancy, paternity, DNA fingerprinting, arrhythmias, and immunodiagnostics, to name a few? Until more such tests are found all that is needed to interpret the “current imperfect tests” is a few percentages, not the correspondents’ proposed drudge of statistics. 3 4 The “base rate fallacy” overestimates mammogram significance 5 and contributes to spurious disease creation by screening, 6 but it is irrelevant to Rathbone’s claim that doctors need the statistical “ability to calculate the probability of relative utility,” 7 8 All you need to know is that only 1 in 10 positive mammograms reveals a cancer.

Pharoah’s idea that modern medicine would not exist had we stuck to tests and interventions with straight yes or no results because it is all about balancing probabilities is nonsense. 9 Medical advance would not have happened with that statistician mindset—think scurry and vitamin C, rickets and vitamin D; diabetes and insulin, thyroxine and myxoedema, drugs and receptors, microbiology, and so on. Balance of probabilities be damned. Medical real advance is about certainty: medical statistics has to live in a web of uncertainty.

Sam Shuster emeritus professor of dermatology, University of Newcastle on Tyne. Newcastle on Tyne, UK
sam@shuster.eclipse.co.uk

Competing interests: None declared.

1 Shuster S. The real problem is the biomedical ignorance of statisticians. BMJ 2011;342:d3579. (21 April.)
2 Hemming K. Let’s work together. BMJ 2011;342:d3030. (17 May.)
4 Pharoah PDP. Balancing probabilities. BMJ 2011;342:d3048. (17 May.)
5 Rathbone P. Role of cognitive bias. BMJ 2011;342:d3047. (17 May.)
6 Barrachlough K. Come clean if you don’t know. BMJ 2011;342:d3046. (17 May.)

Cite this as: BMJ 2011;343:d3975

111
INTRAOSSEOUS ACCESS IN INFANTS

Safety of power driven devices

Taylor and Clarke report amputation secondary to compartment syndrome after power driven intraosseous needle insertion in two infants.1 We know of another case; the three children in these cases were all under 2 years old.

To our knowledge, the power assisted devices use weight adjusted needles. However, the smallest and shortest needle with one device is designed for children weighing between 3 kg and 39 kg. With the 50th centile of a male growth chart as reference, this needle could be used for children from the newborn period to 12 years of age and may be too long for smaller children.

Young children may be vulnerable to compartment syndrome and amputation owing to factors such as bone size and biomechanics, the needle penetrating through the tibia and leading to extravasation. Obtaining intraosseous access can be life saving, but inserting intraosseous needles manually may be safer in younger children.

The number of young children included in studies of power driven devices, including paediatric studies, is small.2 3 Further evidence may be helpful to make informed decisions about their correct application.

Ashley Reece consultant paediatrician ashleyreece@nhs.net
Anthony Cohn consultant paediatrician, Department of Paediatrics, Wadford General Hospital, Wadford, Herefordshire WR18 0HB, UK

Competing interests: None declared.

Cite this as: BMJ 2011;343:d4354

Study ignored patient views

I am surprised that Cockayne and colleagues overlooked patient satisfaction in the discussion and conclusion of their randomised controlled trial of cryotherapy and salicylic acid for plantar warts.1 The only significant results were better patient satisfaction with cryotherapy, across all timeframes.

Why measure and report this and then ignore it in recommendations? When treatment effects were equal, patients preferred cryotherapy, perhaps because it demanded less of them on a daily basis. Cost is an important factor in recommendations, but satisfaction matters and is linked to acceptability and adherence.

Bridget Hamilton senior lecturer, University of Melbourne, Melbourne, VIC 3053, Australia bh@unimelb.edu.au

Competing interests: None declared.

Cite this as: BMJ 2011;343:d4356

Try duct tape

Only one randomised study has investigated duct tape for treating warts,1 but duct tape seems to be better than cryotherapy.2 It has no adverse effects and is cheap and readily available without prescription.

Richard G Henderson consultant radiologist, Darlington Memorial Hospital, Darlington, County Durham DL3 6HX, UK richard.henderson@cdcfht.nhs.uk

Competing interests: None declared.

Cite this as: BMJ 2011;343:d4349

HPV vaccine may have role

Another worthy line of investigation for wart treatment is human papillomavirus (HPV) vaccine.1 I correctly predicted the possible eradication of verrucae in a young relative within weeks of the first injection. It would be very interesting if general practitioners in the UK and family doctors further afield have noticed a similar curative response in vaccinated girls.

Given the misery and cost surrounding ineffective verruca treatments, the HPV vaccine might prove to be even more cost effective and worth while extending to adolescent boys.

Winston A Martin consultant radiologist, Darent Valley Hospital, Dartford, Kent DA2 8DA, UK winston.martin@nhs.net

Competing interests: None declared.

1 Bavinck JNB, Eklof JAH, Bruggink SC. Treatments for common and plantar warts. BMJ 2011;342:d3119. (7 June.)

Cite this as: BMJ 2011;343:d4351

DOCTORS AND TERRORISTS

We shouldn’t identify terrorists

Occasionally, patients are clearly delusional and dangerous, and they should be picked up by existing systems. If, however, we as doctors agree to the current demands to help identify people at risk of becoming terrorists, we may be agreeing to report patients because of our vague suspicions.

The most likely outcomes of this will be a further loss of patients’ confidence in doctors and confidentiality, and more accusations of racism against doctors who report patients they’re concerned about. I doubt that there will be any noticeably improved detection of terrorists.

It is also likely that in the very rare instances in which people do become terrorists, our agreeing to report suspicious behaviour—and then having “failed” to report behaviour that was suspicious only in retrospect—will be used as a stick with which to beat individual doctors and the medical profession.

Peter M English public health consultant, Surrey, UK petermenglish@gmail.com

Competing interests: None declared.

1 Dyer C. Doctors will be asked to help identify people at risk of becoming terrorists. BMJ 2011;342:d3627. (8 June.)

Cite this as: BMJ 2011;343:d4211

WART TREATMENTS

Cryotherapy was not standard

Cockayne and colleagues compared a “gentle freeze” with liquid nitrogen using a spray or probe with salicylic acid for treating plantar warts.1 This haphazard application of liquid nitrogen cannot be considered cryotherapy.

One of the problems with cryotherapy is that no specific training is required before using the equipment, and therefore poor practice and technique, as seems to have been encouraged in this study, are tolerated. The parameters for delivering cryotherapy in a reliable and reproducible manner are well defined and should have formed the basis of the study.2 5 As it stands, the only conclusion can be that uncontrolled freezing of plantar warts in various health settings is no more effective than patient administered salicylic acid. This says more about the clinics than the techniques.

Richard J Motley dermatologist, Welsh Institute of Dermatology, University Hospital of Wales, Cardiff CF14 4AW, UK Richard.Motley@Wales.nhs.uk

Competing interests: None declared.


Cite this as: BMJ 2011;343:d4354

Cite this as: BMJ 2011;342:d3271. (7 June.)

Cite this as: BMJ 2011;342:d3271. (7 June.)

Cite this as: BMJ 2011;343:d4349

Cite this as: BMJ 2011;343:d4349

Cite this as: BMJ 2011;343:d3119. (7 June.)

Cite this as: BMJ 2011;343:d4356

Cite this as: BMJ 2011;343:d4362