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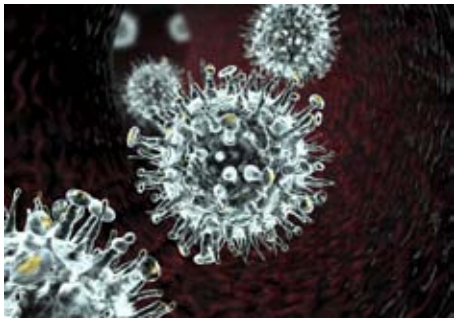
LETTERS

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 parts of England, outside London; two in 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."

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Competing interests: None declared.

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.)
2 Das G, Baglioni P, Okosieme O. Easily missed? Primary HIV infection. *BMJ* 2010;341:1159-60.
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Cite this as: *BMJ* 2011;343:d4352

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).[1] 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.[4] To maximise the diagnosis of the 26% of people living with HIV who are unaware of their status, clinicians' attitudes need to change.[5] Early diagnosis improves outcomes for the individual, public health, and the NHS purse.

These encouraging results highlight our collective professional responsibility to reduce late HIV diagnoses through normalising HIV testing.

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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.)
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Cite this as: *BMJ* 2011;343:d4358

COLLEGE OF MEDICINE

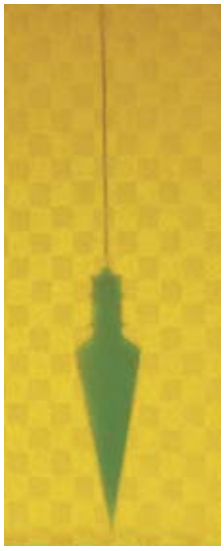
College of Medicine replies

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.

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Christine Glover council member
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Competing interests: None declared.

1 Cassidy J. The College of Medicine. *BMJ* 2011;342:d3712. (15 June.)
2 Colquhoun D. College of Medicine is Prince's Foundation reincarnated. *BMJ* 2011;343:d4368.
3 Ernst E. College of Medicine or College of Quackery? *BMJ* 2011;343:d4370.
4 May J. What is integrative health? *BMJ* 2011;343:d4372.

Cite this as: *BMJ* 2011;343:d4364

Prince's Foundation come again

There is no doubt that the College of Medicine is simply a reincarnation of the late unlamented Prince's Foundation.[1] Like its antecedent, its aim is to promote bad science and ineffective treatments by using words like "integrated," which sound good but have many meanings. In this case it means integrating things that don't work with things that do.

It has been done quite cleverly—by recruiting people like Graeme Catto and Ian Kennedy they have given themselves a veneer of respectability that the Prince's Foundation lacked. Both I and Simon Singh have talked to Catto about the problem. It is obvious that he means well, but, in my view, he has been taken in by the word play around "integrated." I think he believes that he can turn the college into something more respectable. I wish him luck, but you only have to look at their activities so far to realise that he hasn't had much success yet.

A comment signed by Catto, Kennedy, and Aidan Halligan should perhaps be taken seriously—it might be if it were not also signed by George Lewith (who prescribes homoeopathy despite having written papers that conclude it doesn't work), Christine Glover (a homoeopathic pharmacist), and David Peters (whose clinic has used dowsing as an aid to diagnosis and treatment).[2]

I am sure that Catto, Kennedy, and Halligan are sincere, but you do get judged by the company you keep.

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Competing interests: None declared.

1 Cassidy J. The College of Medicine. *BMJ* 2011;342:d3712. (15 June.)
2 Lewith GT, Catto G, Dixon M, Glover C, Halligan A, Kennedy I, et al. College of Medicine replies to its critics. *BMJ* 2011;343:d4364.

Cite this as: *BMJ* 2011;343:d4368

College of Quackery?

Cassidy mentioned that the new College of Medicine singles out projects for praise,[1] 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 homoeopathy, qigong, reflexology, and aromatherapy, which, according to an evidence based assessment, must be categorised as unproved or even disproved.[2] In one case, a therapeutic claim was made (homoeopathy is useful for asthma and eczema), which is clearly not supported by evidence.[2]

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.[3] But this is not in keeping with the known facts. The college showcases one unit that offers homoeopathy to treat patients with asthma, but the Cochrane review on this subject concluded that homoeopathy was not useful in this disease. This is not "excellence," but outright quackery, which has the potential to kill patients.

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Competing interests: None declared.

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3 Lewith GT, Catto G, Dixon M, Glover C, Halligan A, Kennedy I, et al. College of Medicine replies to its critics. *BMJ* 2011;343:d4364.

Cite this as: *BMJ* 2011;343:d4370

What is integrative health?

Is it possible that the new College of Medicine is being deliberately ambiguous about the term integrative health?[1 2]

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.

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Competing interests: None declared.

1 Cassidy J. The College of Medicine. *BMJ* 2011;342:d3712. (15 June.)
2 Lewith GT, Catto G, Dixon M, Glover C, Halligan A, Kennedy I, et al. College of Medicine replies to its critics. *BMJ* 2011;343:d4364.

Cite this as: *BMJ* 2011;343:d4372

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 over-prescription, of psychotropics to countless people at huge cost.[1]

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.[2] The book by Irving Kirsch contains information obtained from the Food and Drug Administration (FDA) under the Freedom of Information Act.[3] 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.[3]

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.

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Competing interests: None declared.

1 Wise J. Research into treatments for mental illness is under threat. *BMJ* 2011;342:d3747. (14 June.)
2 Angell M. The epidemic of mental illness. Why? *New York Review of Books* 2011;58(11):20-3.
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Cite this as: *BMJ* 2011;343:d4381

Address the causes

What lies behind the overt call for more money to fund research on psychotropic drugs?[1] 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.[1] 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.[2] 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.[3] 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?[4]

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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.)
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Cite this as: *BMJ* 2011;343:d4374

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.[1] 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,[2] and an increase in stigma that is associated with the model that mental illness is "an illness like any other illness."[3] 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.[4]

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Competing interests: None declared.

1 Wise J. Research into treatments for mental illness is under threat. *BMJ* 2011;342:d3747. (14 June.)
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Cite this as: *BMJ* 2011;343:d4377

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.[1] 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."[2 3] 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"[3] is a few percentages, not the correspondents' proposed drudge of statistics.[2-6]

The "base rate fallacy" overestimates mammogram significance[2] and contributes to spurious disease creation by screening,[5] but it is irrelevant to Rathbone's claim that doctors need the statistical "ability to calculate the probability of relative utility."[5] 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.[4] Medical advance would not have happened with that statistician mindset—think scurvy 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. Real medical advance is about certainty: medical statistics has to live in a web of uncertainty.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;343:d3975

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.[2-4] Further evidence may be helpful to make informed decisions about their correct application.

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Competing interests: None declared.

1 Taylor CC, Clarke NMP. Amputation and intraosseous access in infants. *BMJ* 2011;342:d2778. (27 May.)
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Cite this as: *BMJ* 2011;343:d4362

WART TREATMENTS

Cryotherapy was not standard

Cockayne and colleagues compared a "gentle freeze" with liquid nitrogen using a spray or probe with salicyclic 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.

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Competing interests: None declared.

1 Cockayne S, Hewitt C, Hicks K, Jayakody S, Kang'ombe AR, Stamuli E, et al on behalf of the EVerT Team. Cryotherapy versus salicylic acid for the treatment of plantar warts (verrucae): a randomised controlled trial. *BMJ* 2011;342:d3271. (7 June.)
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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.

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Competing interests: None declared.

1 Cockayne S, Hewitt C, Hicks K, Jayakody S, Kang'ombe AR, Stamuli E, et al on behalf of the EVerT Team. Cryotherapy versus salicylic acid for the treatment of plantar warts (verrucae): a randomised controlled trial. *BMJ* 2011;342:d3271. (7 June.)

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.

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Competing interests: None declared.

1 Focht DR, Spicer C, Fairchok MP. The efficacy of duct tape vs cryotherapy in the treatment of verruca vulgaris. *Arch Pediatr Adolesc Med* 2002;156:971-4.
2 Bavinck JNB, Eekhof JAH, Bruggink SC. Treatments for common and plantar warts. *BMJ* 2011;342:d3119. (7 June.)

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.

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Competing interests: None declared.

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

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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.[1]

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.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;343:d4211