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Letters

Early intervention for first episode psychosis

Secondary care must become more responsive to primary care

Editor—Shiers and Lester observe that primary and secondary care must work together and that the wider involvement of the community is the key to success.1 However, they eschew a more detailed appraisal of these important issues in favour of a finger wagging at general practice.

They base their predication on several assumptions. Firstly, they assume that general practitioners neither recognise early psychotic features nor wish for involvement in managing mental health. Secondly, they assume that people with psychotic symptoms want to see psychiatrists or wish to take medication commonly believed to have unpleasant side effects. Finally, they assume that secondary care is responsive to the concerns of primary care workers and patients alike. Little of the above holds true. As a result of recent pressure from the government (and in many cases, well before this), primary care is remarkably responsive to patients’ demands. Most general practitioners are wholly familiar with mental health problems, and so the issue is not one of training, it is about the negotiation between health professionals, patient, family, and secondary care.

The London borough of Tower Hamlets is home to large numbers of non-English speakers. A general practitioner who recognises psychotic features has to persuade the patient and his or her family that a trip to the local psychiatric hospital is in the patient’s best interests, in order to involve the community mental health team, which will not accept referrals from general practitioners unless a diagnosis of psychosis has been made. This is antediluvian practice, and, although it may be a local problem, it is essential that community mental health teams work more closely with primary and secondary care if early intervention for first episode psychosis is to be a success. The new government programme for the expansion of primary care premises is an ideal opportunity to bring psychiatric services into the community.

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Consider increasing staff at primary care level before complaining

Editor—Mach has been written regarding awareness or the lack of it in mental health issues, as a major factor in the degree of general practitioners’ involvement in the care of their patients with mental health problems. Although the article by Shiers and Lester1 rightly identifies the importance of primary care involvement, professionals in the secondary and tertiary care settings should not lose sight of the fact that, although they deal with disorders confined to a particular physiological system and eschew the need to adhere to national service frameworks and evidence based consensus guidelines, general practitioners have to deal with the entirety of the patient’s health.

The traditional health-care delivery system follows an inverted funnel distribution, with expansion of services at secondary and tertiary levels. To facilitate greater involvement of primary care professionals in mental health, consideration must be given to increase the skilled manpower at this level rather than complain of poor engagement by them. This would have the added benefit of services being available to patients within the primary care setting and reduce the stigma attached to mental illness.

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Worldwide burden of psychosis is not as severe as suggested

Editor—I found the editorial by Shiers and Lester on early intervention in psychosis insightful and practical.1 However, it contains an important error. The authors say that worldwide, the burden of psychosis is exceeded only by quadriplegia and dementia. Although there can be no doubt that schizophrenia is a disabling condition with an early onset, it does not cause the degree of global burden in terms of disability adjusted life years (DALYs) or years of life lost though illness as many chronic conditions. Psychosis ranks 22nd in the worldwide causes of disability (or 12th, if high income counties are considered alone) according to the World Health Organization’s 1999 study into the global burden of disease.2 The comparable rates for unipolar major depression are fourth and second, respectively. The figures that Shiers and Lester quote are derived from people’s perception of disease burden calculated by WHO’s Assessment Classification and Epidemiology Group.3 In this study 241 key informants (health professionals, policy makers, people with disabilities, and their carers) from 14 countries were asked to rank 17 health conditions from first to last. The result was by no means identical to the global burden of disease study.

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Paediatrics has a role too

Editor—Shiers’s and Lester’s review should have mentioned the role of acute paediatrics in picking up young people with psychosis. It is not common but occasionally we meet quite ill but puzzling teenagers who need a multidisciplinary assessment to tease out organic, social, and psychiatric factors before we can work out what precisely is the matter. This requires a team of social workers and child and adolescent psychiatrists working with the paediatric staff, as recommended in the hospital national service framework for children.2

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Helicobacter pylori
and gastro-oesophageal reflux disease

Information on underlying pathology is not given

Editor—We read with interest the article by Harvey et al on the effects of Helicobacter pylori infection on heartburn and gastro-oesophageal reflux.1 However, as the authors recognise, the mechanism by which H pylori infection might affect reflux symptoms is by altering secretion of gastric acid, due to the H pylori related antral gastritis which results in a net increase in acid secretion,2 3 Nevertheless, a number of recent studies, by combining old and new diagnostic tools (such as pH monitoring, bilimetry, and intraluminal oesophageal impedance), are providing a new and more detailed characterisation of the factors contributing to the so called gastro-oesophageal reflux disease.4 5

As Harvey et al recognise, their study has some weaknesses, due to the absence of direct information on the pathology underlying the symptoms of the patients, and one of these is that a subset of the enrolled patients might have reflux symptoms due to the occurrence of non-acid or non-liquid reflux events. This may possibly lead to an underestimation of the real role of H pylori in the pathogenesis of acid-related heartburn and gastro-oesophageal acid reflux.

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Non-smoker status should also be declared

Editor—I write with reference to the article by Chappe et al on the negative experiences of patients with lung cancer.1 I remember a campaign many years ago encouraging doctors to record on a patient's death certificate that a smoking related death was due to smoking.2 Several years ago my father was diagnosed with lung cancer. He was a non-smoker and not even a passive smoker.

In the months leading up to his death I became concerned that in years to come people seeing his death certificate in the archives would assume that he died because of smoking. This upset me.

After his death I asked the doctor providing the death certificate to state on the form that my father was a non-smoker. This was done. I had one hurdle left. I am pleased to say that the registrar of births and deaths accepted the death certificate as it was written along with the comment that my father was a non-smoker. This helped me greatly in the days after my father's death.

If doctors are to be encouraged to record on a death certificate that a patient was a smoker then I think it is only fair that the opposite can be appended as well.

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All drugs can have serious side effects

Enrrox—In their review article, Lee et al say that further evidence is required before atypical antipsychotics can be endorsed in the management of behavioural and psychological symptoms of dementia.1 Of the five randomised trials reviewed, only three contained information on adverse events, and only two of these reported on the number of serious adverse events.

Currently, no atypical antipsychotic is licensed for the treatment of behavioural disturbances in dementia. In March 2004, after analysing data from randomised placebo controlled clinical trials and finding approximately three times the risk of cerebrovascular adverse events in patients taking risperidone or olanzapine compared with placebo, the Committee on Safety of Medicines advised that risperidone or olanzapine should not be used for the treatment of behavioural symptoms of dementia.2 Perhaps this is all the evidence needed, but perhaps not. Let us not forget that all drugs can have serious side effects and that non-pharmacological interventions are important.

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Association of British Pharmaceutical Industry’s code of practice needs to be clarified

Enrrox—The article by Eaton does not adequately reflect the requirements of the Association of the British Pharmaceutical Industry’s code of practice for the pharmaceutical industry (www.abpi.org.uk).1 It is based on an editorial in the review of the code of practice from May, which reminded representatives that agreeing to give money in exchange for appointments with general practitioners would be a breach of the code. The Prescription Medicines Code of Practice Authority (which administers the code) occasionally receives reports of general practitioners’ surgeries asking for a fee to see representatives. In such circumstances the authority writes to the general practitioners concerned, asking them to bear in mind the requirements of clause 15.3 of the code that no fee should be paid or offered for an interview. The authority was also aware of a surgery requiring that pharmaceutical company representatives paid a fee for what seemed to be a social event. No indication was given that there was any educational content. Representatives can reimburse surgeries for appropriate hospitality at meetings where the prime purpose is educational. This is specifically referred to in the supplementary information to clause 15.3 of the code. Meetings organised for groups of doctors and other health professionals that are wholly or mainly of a social or sporting nature are unacceptable. The purpose of the article in May’s review of the code of practice was to remind companies of what is and what is not permitted under the code, and that unacceptable requests from health professionals can be forwarded to the authority for it to write to the surgeries concerned and ask that arrangements be changed.

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Competing interests: None declared.

1 Eaton L, GP asked not to demand payments from drug company representatives. BMJ 2004;329:72. (10 July)

The Portman Group does not represent alcohol industry

Enrrox—I write with reference to Mayor’s news item on a researcher, Robin Room, objecting to a representative from the drinks industry sitting on an alcohol research body.1 Room should check his facts before jumping to conclusions. Here are some facts.

Firstly, the Portman Group is not a trade association or lobby group. It does not represent the industry. It has no commercial purpose. Its role is to promote responsible drinking by the consumer and responsible marketing by producers.

Secondly, I was not nominated to the Alcohol Education and Research Council (AERC) by the industry or any industry related body. I was invited to apply by the Department for Culture, Media and Sport. I do not occupy one of the three places on the council that are traditionally reserved for industry nominees. This was made abundantly clear in discussions with the department and with the chairman of the council.

Thirdly, neither Robin Room nor anyone else engaged in alcohol research registered any concern when one of the industry representatives on the council was also the chairman of the Portman Group for two of the years he served on the council. His concern about the chief executive is therefore puzzling.

Fourthly, the Portman Group has co-funded a number of research projects with the Alcohol Education and Research Council in the past, at the invitation of the council, again without any apparent cause for concern.

Finally, all members of the Alcohol Education and Research Council are appointed as individuals and are committed as trustees to upholding the independence and integrity of the council. This I fully intend to do, whatever the source of any pressure.

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Competing interests: None declared.

1 Mayor S. Researcher objects to drinks industry representative sitting on alcohol research body. BMJ 2004;329:71. (10 July)

Clinical examination has important role

Enrrox—Threatened miscarriage is an excellent topic for your clinical review series,2 but it seems odd that Sotiriadis et al should almost entirely overlook the role of clinical examination, particularly in an article titled “evaluation and management.” After a brief comment that thorough physical examination is essential to differentiate between genital and extragenital causes, the review moves directly from history to sonographic evaluation and maternal serum markers.

Many women with vaginal bleeding in early pregnancy present to primary and emergency services, where many of the investigations described in this review are not immediately available. The exact role and most appropriate type of physical examination is unclear,3 and would be worthy of inclusion in an article intended for generalist readership.

To overlook physical examination as a key part of patients’ assessment is contrary to one of the fundamental principles of medicine: even if the authors think that it has a small part to play this should be clearly stated, and the issues discussed.

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