Letters

Rugby union should ban contested scrums

Scrums are contested in junior rugby

DPP/REX

Editor—Bourke's statement that contested scrums are not allowed in the under 19 game is incorrect.[1] Scrums in schoolboy games are certainly contested. The differences from the senior game in terms of contesting are that the scrum cannot be wheeled more than 45° as opposed to 90°, and the scrum is not allowed to be pushed more than 1.5 m.[2]

He is also incorrect in stating that in rugby league pushing has not been allowed since 1996. It is technically still allowed according to the rule book, but it is accepted in the game that it is not done.[3]

As someone who played rugby union from a very early age and is still playing now, I disagree with the author. I have never played in a game with such an injury in over 20 years, and the scrum does not just allow a tactical advantage—games are won and lost there. I attended a rugby playing school in England, where an excellent coach taught safety at the scrum first, then competent technique. Competent refereeing is also important in keeping players safe. Most players of rugby union, a hugely popular social game in the United Kingdom, are not professional and therefore would not be covered under the Health and Safety at Work Act.

Players suffering such injuries should indeed be compensated adequately, and national union insurance policies should reflect this. Despite this, as members of their respective unions, rugby players are in a better position for such compensation than those independently undertaking such activities as horse riding and skiing or snowboarding, where the risk may be higher and any injuries sustained would be accountable only to themselves. The unfortunate events that Bourke has witnessed do not give sufficient case to change a game hundreds of thousands of people enjoy the way it is, despite knowing what could happen.

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1 Bourke JB. Rugby union should ban contested scrums. *BMJ* 2006;332:1281. (27 May.)
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Technique is important

Editor—As a retired front-row forward of over 30 years' playing experience in Wales and England I never experienced, or witnessed, any type of injury as described in Bourke's article.[1] From an early age I was taught the correct positioning of my feet, legs, neck, and back. Throughout my amateur career I kept comparatively fit and as a nurse never experienced any back problems, even before the current "no lifting" environment. I firmly believe that my sport allowed me to lift correctly, without putting any undue strain on my back.

The scrum in rugby union allows players of different shapes (tall and thin, fat and short) to participate in the game and to remove its competitive edge would turn the game into one that would severely restrict the attraction to many young people. Scrummaging was what I did well (I was very, very good at it) and what got me into many teams that normally wouldn't have touched me as I wasn't a speed merchant or particularly good in open play. I hated uncontested scrums, and I am sure that if you polled front-row forwards they would say exactly the same. We know the risks and are mindful of these when competing.

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Reality check is needed

Editor—I write with reference to Bourke's personal view.[1] There is no doubt that paraplegia is absolutely devastating. However, let's get things in proportion—based on Bourke's numbers, the risk of contracting a spinal injury is tiny. Bourke states he attends 25 home matches per season and has done so for 30 years; that makes 750 matches. I assume there are roughly the same number of away matches, making 1500 games in 30 years. A typical game may expect a scrummage every five minutes or so, say eight per half or 16 per match. That's 24 000. And in those, two consenting adults—fully aware of the risk—have suffered lifelong injury: a rate of 0.000083 for Nottingham Rugby Football Club. Still devastating, I agree.

But on the basis of this, is Bourke really suggesting we should stop a fantastic sport enjoyed by so many? If that's the case, horse riding needs to be banned completely immediately, and cycling should only occur on designated, off-road facilities when wearing Kevlar coveralls. If we really want to do something helpful let's look carefully at the road; there are more unnecessary deaths and severe injuries here in the United Kingdom than anywhere else.

I'm not saying we can ignore rugby injuries; the English Rugby Football Union has been mindful of these risks for a long time and the International Rugby Board referees' manual has clear guidance on minimising injury. We need to keep the balance of risks and benefits in proportion; scrummaging is an integral part of the union game and should not be lost as technical ability here may be one of the sporting skills that decides between great teams. Also, players have a choice, if they don't want to scrummage then they can play rugby league, where skills are just as important but strong in different aspects of the game.

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Engage, don't ban

Editor—With reference to Bourke's personal view,[1] I caution relying on personal experience rather than systematic study of the risk from contested scrums in rugby. In my six years in rehabilitation medicine, I have encountered six people with spinal cord injuries from playing rugby, one of whom was rugby league, and only one was injured in a scrum. At various times since their injury, not one regretted having played rugby and just felt they were the "unlucky" ones.

During my comparatively short career I have encountered hundreds of people with

spinal injuries from road traffic crashes, many who regret the risks they took at the time. Although it is difficult to draw direct risk comparisons between the two, I will be much more concerned when my children want to start driving than when they want to play rugby, even in a scrum. If there is a risk with the scrum, it does seem to be with the engagement and perhaps reviewing this aspect, yet still allowing the scrum to be contested, might lower the risk without loss of "the essence" of the sport?

However, ongoing study of the risks of spinal cord and other injuries from various activities needs to be routine, not just restricted to high level participants, as is the current practice of the Rugby Football Union. Only with accurate data can we inform those involved of the risks and how they might be minimised without losing the benefits and attractions of such activities. The call for a ban on contested scrums by Bourke also raises the issue of the role of the medical profession in the regulation of sports, which remains controversial even in combative sports such as boxing.[2]

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Protecting the heart may not protect the public health

Editor—Britton raises the profile of what will continue to be an informed debate over the role of alcohol in protecting the heart from vascular disease.[1] However, the picture is not complete and, as she points out, the media could take a rather skewed view of the benefits of drinking.

In older people the harmful effects of alcohol may manifest themselves in ways other than cardiac events. For example, 50% of older people with alcohol misuse present to secondary care services with falls.[2] The cardioprotective message is also clouded by the lack of any clear evidence that alcohol is beneficial to older people's health in general.

The prevalence of alcohol misuse in older people has risen steeply in the UK over the past 20 years, by 50% in men and by 100% in women. Coupled with a projected rise in over 65s of 50% between 2001 and 2031, there is a risk of a greater public health burden in years to come.

There may be alternatives to reducing cardiovascular risk other than the use of a psychoactive drug with the potential for adverse non-cardiac effects. Furthermore, for the public health, the "prevention paradox" suggests that older people drinking at moderate levels may pose the greatest public health burden.[3] The media, government, and drinks industry would do well to consider the bigger picture of alcohol related burden in people approaching their 60s before potentially misinforming the public of the benefits of alcohol.

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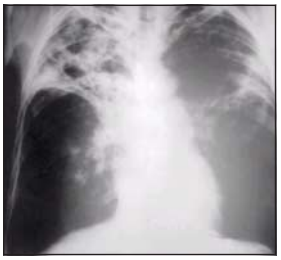
Pulmonary tuberculosis

Chest radiograph can appear normal in immunocompromised patients

Editor—Campbell and Bah-Sow describe the varied patterns of abnormality in chest radiographs in patients with pulmonary tuberculosis, appearances often being less specific in immunocompromised patients.[1] We agree that a high index of suspicion is necessary in such patients and highlight the inadequacy of a chest radiograph in excluding pulmonary tuberculosis.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Our hospital is in a major suburban town in Greater London and has an ethnically diverse and unusually mobile population. In the past 12 months, 16% of cases of pulmonary tuberculosis (excluding mediastinal lymphadenitis and pleural disease) had co-infection with HIV. In one such case the chest radiograph was completely normal while sputum was smear positive.

This occurs more often than we expected: in 2004 a paper from Addis Ababa showed that 9.2% of patients with HIV and culture proved pulmonary tuberculosis had a normal chest radiograph.[2] An earlier paper from Rome showed that 9% of patients who were HIV positive and sputum culture positive had a normal chest radiograph and were sputum smear negative. Although these patients were no different in demographic characteristics, degree of immunosuppression, or *Mycobacterium tuberculosis* drug susceptibility pattern, they had an increased risk of death and shorter median survival.[3] In a series from New York, 14% of patients with coinfection (HIV or culture positive for tuberculosis) had a normal chest radiograph, and this rose to 21% when patients with low CD4 counts were considered (<200).[4]

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Management in children has special considerations

Editor—The review of tuberculosis management by Campbell and Bah-Sow understates the importance of tuberculosis in children.[1] An estimated 1.3 million new cases occur annually in children aged 15 or younger,[2] and one third of the 1.7 million annual deaths occur in children.[3] The distinction between latent tuberculosis infection and tuberculosis disease is of particular importance in children. Younger infants have a greatly increased risk of progression from latent infection to disease, possibly as high as 40% (compared with a 10% lifetime risk in adults), with a much higher incidence of extrapulmonary tuberculosis, including tuberculous meningitis.[4]

Most paediatric tuberculosis in developed countries is in children born overseas. The diagnosis and prompt treatment of latent infection, particularly in immigrant and refugee children, is therefore of considerable importance. Admittedly, the diagnosis of tuberculosis disease in children is difficult, with at least half of children with the disease being asymptomatic at presentation.[5] Immunological investigations (Mantoux testing and blood based assays) may be comparatively insensitive, especially in younger children, and are currently unavailable in many endemic regions. Early morning gastric washings (to isolate mycobacteria from sputum swallowed overnight) is a key diagnostic investigation in younger children in high incidence areas, with a culture yield of more than 50%.[4] Similarly, induced sputum samples have a higher yield (80%) in older children. Laryngeal swabs are, however, poorly tolerated, less well studied, and rarely helpful.[1]

Classically a case of childhood tuberculosis is a sentinel event that should precipitate contact tracing for an infectious adult in the household. However, many cases in developed countries are in children who have spent protracted periods in refugee camps, where transmission outwith the household is common. Tuberculosis should be considered in children with supporting epidemiological or clinical features, even if the microbiological

or immunological investigations are non-confirmatory.

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Competing interests: DB is part of a research group that has received research funding support from Oxford Immunotec.

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Ethnic differences in risks of adverse reactions

Is personalised drug treatment better with pharmacokinetic modelling?

Editor—McDowell et al conclude that patients from different ethnic groups have different risks for important adverse drug reactions on the basis of a meta-analysis of adverse reactions due to drugs used in cardiovascular medicine.[1] Data are sparse, and regulators should ask for better data before licensing.

The use of pharmacokinetic and pharmacodynamic modelling would greatly facilitate this process. The European Commission sponsored a workshop to facilitate the incorporation of such modelling studies into drug development. Data from 1997 on naratriptan, a serotonin agonist treatment for acute migraine, used a population approach and Bayesian predictions to examine the pharmacokinetic and pharmacodynamic relations for oral naratriptan during phase II clinical trials.[2] Hepatic clearance of naratriptan declined with age and use of hormone contraception, potentially increasing the likelihood of adverse events leading to product labelling restrictions for elderly patients and leading to higher efficacy in women.[3] In tobacco smokers and black patients the hepatic clearance was increased, leading to lower exposure to naratriptan.

A population based, pharmacokinetic and pharmacodynamic approach as exemplified by naratriptan should be encouraged as a routine component of early human drug development, which could predict the need for special precautions and potential adverse events arising from differing circulating drug concentrations arising from environmental factors (such as smoking), ageing, and ethnicity.

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Competing interests: None declared.

1 McDowell SE, Coleman JJ, Ferner RE. Systematic review and meta-analysis of ethnic differences in risks of adverse reactions to drugs used in cardiovascular medicine. *BMJ* 2006;332:1177-80. (20 May.)
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Biomedical approach is insufficient to explain ethnic differences

Editor—McDowell et al conclude that ethnic group may be one determinant of harms of a given treatment in an individual patient.[1] Genomics is insufficient to explain ethnic differences. The authors did not tackle compliance with pharmacological agents prescribed to patients by doctors including the subject of the doctor-patient relationship. Most studies of adverse drug reactions and encounters between patients and doctors were carried out in Europe and North America, with fewer doctors from ethnic minority groups.

Biopsychosocial and cultural research has shown that compliance with treatment cannot be ignored if doctors are to appreciate the "effects" of the agents they prescribe to patients. A quantitative study of antihypertensive drug treatment among Caribbean hypertensive subjects found that when symptoms such as headaches and feeling hot were absent, dosages were skipped.[2] The drugs were not taken on these days because of the patient's lay and cultural beliefs about blood pressure, not because of adverse reactions. An earlier qualitative study reached similar conclusions.[3]

There is insufficient reporting and recording of adverse drug reactions even in the United Kingdom, let alone the zero reporting in many developing countries. This fact as well as the ethnic lay beliefs and cultural factors may determine whether a drug is taken. It then becomes easy to conclude and advance the hypothesis that the explanation is adverse drug reactions.

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WHO perspective on preventing avoidable harm from medicines

Editor—The *BMJ* news item on adverse drug reactions is important.[1] The estimated annual expenditure of $870m towards issues related to such effects would be hard on any economy; such figures could seriously cripple countries with lesser resources.

The cost factor should then be at least one of the reasons for all developing countries to promote pharmacovigilance. Started in 1968, the World Health Organization's programme for international drug monitoring has, to date, 79 countries as full members; only six of them are from sub-Saharan Africa, where pharmacovigilance is often still seen as a luxury. Yet in many of these countries, treatment programmes are being expanded rapidly after substantial funding has been released for procuring medicines for treating malaria, tuberculosis, and HIV/AIDS.

Not uncommonly, several disease control initiatives, including the administration of several drugs, are carried out among the same population, with little or no understanding of how these various medicines could interact.[2] Moreover, the conditions and populations in which many of these medicines were tested often differ radically from the conditions and populations of large scale treatment programmes.[3] WHO is now seeking to roll out a programme of disease driven pharmacovigilance; disease programme managers are being trained to monitor and manage adverse reactions to medicines in specific public health programmes as a first step towards introducing pharmacovigilance into countries.

WHO is also working with the Forum for Collaborative HIV Research to coordinate cohort studies throughout the developing world to collect data on adverse drug reactions resulting from antiretroviral treatment (www.hivforum.org). Another aspect of work in WHO is to help member states when there is a crisis, such as the recent cluster of adverse drug reactions to one of the antimalarials used in Ghana. No one can afford to ignore pharmacovigilance because, if access to medicines is a human right, then preventing avoidable harm from medicines is a professional and moral obligation.

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NICE work

Nice try

EDITOR—The reviews of NICE's (the National Institute for Health and Clinical Excellence) work[1] and its frustrations[2] miss the point: NICE has failed the objective of having "a leading role in healthcare priorities" because it cannot do otherwise.

The evidence of failure is bioeconomic: because new drugs risk physical and financial harm, recently shown dramatically with an immune stimulant, the pharmaceutical industry now mostly produces timid variants of existing drugs. Even when novelty is sought but fails, the high cost of production ensures that a poor drug is taken to market instead of being scrapped. Since most new drugs therefore have little or no advantage over those already available, NICE's acceptance of 80%[1] is clear evidence of failure; success would be rejection.

The reason NICE cannot but fail is biosocial—societies won't allow definition of a worthwhile level of benefit, let alone cost benefit: to the sick patient, one chance in a million, one extra life saved, even one extra day's health, are all equally desirable—try anything, regardless of its worth or cost, for the dubious reason that "worth" can only be personal and "anything is better than nothing." From these absurdities, it follows that anything becomes desirable, regardless of cost and quality.

If the government's objective had been therapeutic quality, NICE might have helped educate society about the infinite uselessness of the infinite statistic, although the great effort needed by the antismoking lobby with its very finite statistic, shows it wouldn't have been easy. Now, apart from the small cost savings of bureaucratic delay, NICE even fails in its original political purpose as a cost-cutting exercise; it's not a nice try.

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Competing interests: None declared.

1 Raftery J. Review of NICE's recommendations, 1999-2005. *BMJ* 2006;332:1266-8. (27 May.)
2 Ferner RE, McDowell SE. How NICE may be outflanked. *BMJ* 2006; 332: 1268-71. (27 May.)

Level playing field requires transparency

EDITOR—Ferner and McDowell highlight the direct marketing of product messages via the media.[1] This is important, but it is obvious, unsophisticated, and has begun to attract condemnation.[2]

"Specialist societies" and "disease interest groups" have an important role. These are often dependent on pharmaceutical sponsorship, and their leadership is heavily targeted by the marketing arm of the drugs industry. The grey market of "satellite symposia" and ad hoc promotional meetings provides fertile ground where self interest, disease promotion, and marketing combine. Opinion leaders can be provided with soft research grants, included as investigators in phase III or IV trials, or invited to author ghost written articles. Specialist societies may nominate them to provide expert submissions to NICE where discrimination between their personal interests and their professional interests may be difficult.

Guidelines are an ideal vehicle for gaining rapid market dissemination, particularly if they avoid mention of cost altogether,[3] and are well suited for providing a niche for on-patent drugs. The potential for a positive bias towards pharmacotherapy with guidelines both based on industry sponsored trials and written by those who undertake them is considerable. Considerable interaction between the pharmaceutical industry and authors of clinical guidelines has been documented.[4] Specialist society guidelines are still not invariably accompanied by a clear declaration of the nature or extent of any relevant conflicts of interest.

Journal editors are culpable when bypassing peer review through the publication of industry sponsored supplements and not rigorously enforcing disclosure of conflicts of interest in other papers. Journals are obviously subject to conflicts of interest resulting from advertising revenue and the desire for large reprint orders that are used for promotional purposes, including those for guideline statements. Ensuring the integrity of professional guidelines remains a challenge to both the medical and publishing fraternities.

Establishing a process that is open, transparent, and accountable is a major step forwards for the NHS. If the NHS is to survive, NICE will have a crucial role in ensuring that the "tragedy of the commons" does not continue to be the tragedy of the health service.

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Number of consultant posts has fallen

EDITOR—As a specialist registrar who has just obtained a certificate of completion of specialist training in rheumatology and is currently working for the final six month period of grace before becoming unemployed, I am increasingly worried about an apparent lack of new consultant posts. The general feeling among colleagues is that recruitment for new or replacement posts has been frozen in reaction to the current financial crisis in the NHS.[1]

I compared the numbers of hospital consultant posts advertised in *BMJ Careers* over the past three and six months of this year with the same period a year ago. The number of posts advertised over the past three months from 28 February 2006 to May 30 2006 was 1416. This compares to 1773 posts over the same period a year ago, a drop of 20%. The figures for the past six months from 29 November 2005 to 30 May 2006 show a drop of 16% (3497 *v* 2942 posts) compared with the previous year.

Presumably the number of national training numbers has not fallen to a similar extent, so we can expect to see both an increasing number of highly trained, but unemployed, consultant level doctors and a rapidly increasing pressure on the service with an inevitable increase in waiting times.

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1 Day M. NHS faces job cuts as financial crisis deepens. *BMJ* 2006;332:743. (1 April.)

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