Pregnancy and fasting during Ramadan

SIR,—Awad H Rashed¹ and Jane Reeves² have discussed fasting by pregnant women during Ramadan. I worked in the Republic of Yemen for over 10 years on various projects in both inner city slums and remote rural areas. Pregnant women often fasted during Ramadan even though they did strenuous physical activity, such as collecting water or working in the fields.

In my experience lack of knowledge about exemption from fasting during Ramadan was not the most important issue. The main problem was that the women did not want to have to make the time up later, when they would be the only member of the household fasting. They preferred to fast in Ramadan, even though it made them tired and in some cases weak, because they wanted to participate fully in the religious festival. They often expressed their dislike of having to fast when no one else in the family was fasting but were adamant in their belief that they must fast for the full four weeks. I even know of a few non-pregnant women who took the contraceptive pill for the complete month of Ramadan, without the customary seven day break, so that they would not have to stop fasting because they were menstruating.

I would be interested to know if explaining the current teaching on fasting in pregnancy to Muslim women has any effect on their practice; I remain unconvinced. I would also be interested to know what are the effects of fasting on pregnant women. In Yemen for many women the diet improved in variety and quality, especially in the poorer households, during Ramadan. The main problems cited by the women were the restriction of fluid intake during the day and, especially in the last week of Ramadan, lack of sleep.

I agree with Rashed that more thorough scientific attention should be paid to this subject to ensure that we give Muslim women sound, useful advice in accordance with their religion.

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1 Rashed AH. The fast of Ramadan. *BMJ* 1992;304:521-2. (29 February.)
2 Reeves J. Pregnancy and fasting during Ramadan. *BMJ* 1992;304:843-4. (28 March.)

Cardiac stress during transurethral prostatectomy

SIR,—Julian W H Evans and colleagues report the haemodynamic effects of transurethral resection of the prostate.¹ Their earlier study of the subject stimulated us to look at it ourselves.²

We compared the haemodynamic changes in 22 patients undergoing transurethral resection of the prostate under general or spinal anaesthesia. The patients given general anaesthesia received a standardised anaesthetic regimen. Variables recorded included heart rate, arterial blood pressure, and ascending aortic blood flow assessed with Doppler aortovelocity (Sci Med). This technique, which is analogous to the Doppler technique used by Evans and colleagues, accurately reflects trends in cardiac output as determined by other recognised techniques.³

In our patients given general anaesthesia the estimated cardiac output fell by a mean of 30% with induction of anaesthesia but returned towards the baseline value before surgical resection started. Once resection began the cardiac output fell by 5-10%, returning towards preinduction values after 40 minutes. At the beginning of resection mean arterial pressure was 10% below preinduction

values, and it remained at this level throughout resection. The heart rate before the start of resection was 25% below preinduction values and gradually returned to baseline values after 40 minutes of resection. Calculated systemic vascular resistance increased by 40% with induction of anaesthesia but returned to baseline values before resection started and remained stable thereafter.

Haemodynamic variables in the patients given spinal anaesthesia were stable throughout the resection.

Thus the only appreciable haemodynamic changes that we observed were related to induction of anaesthesia and not to prostatic resection. In our hospital irrigating fluid is warmed to body temperature, and we believe that the changes that Evans and colleagues found may simply reflect the effect of irrigating the bladder with large volumes (>11 litres per patient) of cool fluid.

Evans and colleagues conclude that cardiac stress was increased in their patients through an increase in left ventricular afterload. Left ventricular afterload is determined by left ventricular end diastolic diameter and systemic arterial pressure.⁴ Alterations in systemic vascular resistance (derived from cardiac output and blood pressure gradient) will affect left ventricular afterload only if they result in a change in arterial pressure. The only estimate of afterload in Evans and colleagues' study was the mean arterial pressure, which did not increase significantly. Also, other important determinants of cardiac work—that is, heart rate and stroke distance—both fell significantly, thus tending to reduce cardiac work. Therefore, we believe that the conclusion is unsubstantiated.

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1 Evans JWH, Singer M, Chapple CR, Macartney N, Walker JM, Milroy EJG. Haemodynamic evidence for cardiac stress during transurethral prostatectomy. *BMJ* 1992;304:666-71. (14 March.)
2 Evans JWH, Singer M, Chapple CR, Macartney N, Coppinger SWV, Milroy EJH. Haemodynamic evidence for perioperative cardiac stress during transurethral prostatectomy: a preliminary communication. *Br J Urol* 1991;67:376-80.
3 Schuster AH, Nanda NC. Doppler echocardiographic measurement of cardiac output: comparison with a non-golden standard. *Am J Cardiol* 1984;53:257-9.
4 Ross J, section ed. Mechanical performance of isolated cardiac muscle. In: West JB, ed. *Best and Taylor's physiological basis of medical practice*. 12th ed. Baltimore: Williams and Wilkins, 1990:211-21.

SIR,—Julian W H Evans and colleagues noted large increases in mean arterial pressure and systemic vascular resistance within two minutes of starting prostatic resection compared with values in controls undergoing herniorrhaphy.¹ These increases, they postulate, are secondary to the release of a vasoactive compound from the prostate.

Baseline blood pressure and aortic blood flow (oesophageal Doppler ultrasonography) were measured, and systemic vascular resistance and cardiac output calculated, after induction and before surgery, but the group having prostatectomy had been put into the Lloyd-Davies position. This would considerably increase venous return, with a compensatory inhibition of vasoconstrictor autonomic outflow via atrial and pulmonary volume receptors and baroreceptors. The study group would therefore have a lower baseline systemic vascular resistance compared with the controls and a variable baseline cardiac output depending on the response to the autotransfusion. If a vasoconstrictor stimulus is applied to both groups it may have a more profound effect on the study than the control group; certainly the two groups would not be comparable.

The authors then exclude a pressor response to surgery by saying that no lacrimation, sweating, or tachycardia was seen. These are, however, relatively coarse signs seen in response to somatic afferent stimulation. Autonomic afferent activity is involved in hormonal responses to surgery² and is not blocked without an extensive extradural technique. So a degree of vasoconstriction may occur secondary to released catecholamines, as well as in response to autonomic efferent activity, without much lacrimation or sweating. The authors suggest that these haemodynamic changes predispose to cardiac stress and difficulty tolerating irrigation loads and hypothermia.

If indeed these changes are related to increases in venous return perhaps invasive monitoring of central venous pressure should be considered more often, or even measurement of pulmonary artery pressure and cardiac output, as this would give more information than ultrasonography alone. A similar study with patients undergoing prostatectomy under extradural anaesthesia would be interesting.

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1 Evans JWH, Singer M, Chapple CR, Macartney N, Walker JM, Milroy EJG. Haemodynamic evidence for cardiac stress during transurethral prostatectomy. *BMJ* 1992;304:666-71. (14 March.)
2 Analgesia and the metabolic response to surgery [editorial]. *Lancet* 1985;i:1018-9.

AUTHORS' REPLY,—We are pleased that P M S Dobson and colleagues agree with our hypothesis that cold stress could be an important factor in causing perioperative circulatory disturbances. Indeed, we are about to submit for publication a report of a further study confirming this concept.

The changes seen in our patients having transurethral prostatectomy could be explained by a primary increase in afterload with a secondary fall in cardiac output or by primary myocardial dysfunction with compensatory vasoconstriction. As no changes were seen in the control group, who received a similar anaesthetic and had stable core temperatures, we suggested that rapid central cooling causing vasoconstriction together with increases in whole blood viscosity was the primary event.

In response to S N Gower, the legs are raised only minimally in the Lloyd-Davies position compared with the lithotomy position. Therefore increases in venous return are unlikely to be important. We did not suggest that the haemodynamic responses predispose to cardiac stress, but that they are a reflection of it.

We cannot agree with Gower's recommendation for more frequent monitoring of central venous pressure as changes in ventricular compliance and peripheral vascular tone will disrupt any relation between right ventricular end diastolic pressure and volume. Pulmonary artery catheterisation should not be regarded as a routine procedure in these patients in view of its morbidity, cost, and logistical implications.

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Psychological treatments in cancer patients

SIR,—Steven Greer and colleagues present further compelling evidence to suggest that a large proportion of patients diagnosed as having cancer suffer from psychological problems and that these problems are eminently treatable with psychological therapy.¹ Given the overwhelming

empirical evidence that psychological aspects of cancer management are important to quality of life, it is perhaps time now to ask why these practices are not being incorporated routinely into cancer treatment. Counselling is now a mandatory part of HIV testing. We should be thinking along the same lines for those people with a prospective diagnosis of cancer.

In people with advanced disease the potential for distress is obviously great. It seems, however, that a large proportion of long term survivors pay a high psychological price and continue to have problems many years after treatment has ended.² Given this, how can the problem be adequately addressed? Where physical health is concerned there can be few dissenters from the belief that prevention is better than cure, yet this principle is rarely extended to psychological health. There are many excuses as to why we should not provide this type of care as routine, ranging from assertions that “everyone will want it” through to claims that “nobody will accept it.” To an extent this latter claim acts as self fulfilling: if psychological help is offered in a judgmental and stigmatised way it is no surprise that people are reluctant to accept it. Spiegel *et al*’s group of women with metastatic breast cancer, like the Greer *et al* cohort, were shown to benefit from therapy.³ Given the groaning weight of evidence, it may be time to stop finding reasons for these aspects of care to fail and take a serious look at some not so new initiatives and how they could potentially prevent the deterioration in quality of life that seems associated with life threatening disease.

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- 1 Greer S, Moore S, Baruch JDR, Watson M, Robertson BM, Mason A, *et al*. Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. *BMJ* 1992;304: 675-80. (14 March.)
- 2 Devlen J, Maguire P, Phillips P, Crowther D, Chambers H. Psychological problems associated with diagnosis and treatment of lymphomas. I. Retrospective. *BMJ* 1987;295:953-7.
- 3 Spiegel D, Bloom JR, Yalom I. Group support for patients with metastatic cancer. *Arch Gen Psychiatry* 1981;38:527-33.

Consultants’ communications
with general practitioners

SIR,—How do I write to a general practitioner about a patient’s prognosis when it is poor? In the old days a letter to a general practitioner was confidential and I could write honestly. Now it forms a part of records to which the patient has open access, and he or she may well read it.

On the same day last week I received two telephone calls from general practitioners. To one I had written a bland letter stating that the patient had received radiotherapy and detailing its possible side effects but omitting any comment about the likely outcome. The general practitioner wanted to know what the prognosis really was so that he could decide how best to plan the patient’s care. To the other general practitioner I had written an honest letter about his patient’s gloomy prognosis. He thanked me for my honesty but wanted an alternative letter which he could more easily show to the patient.

It will be argued that patients should be told about every detail of their condition. Most, however, do not want to know absolutely everything (just as most do not want to know nothing). Telling patients about a life threatening disease is more comfortably done over several consultations, with the picture being filled in gradually. So do I write letters that give an explicit prognosis as soon as this becomes clear or do I give only as much information as I think the patient can accept at a particular time?

Results of investigations may also be seen by the patient. I would not normally disclose the presence of a shadow of dubious importance, a borderline increase in a biochemical variable, or every site of metastatic disease even if I tell the patient that the tumour has spread. It is common for a scan to fail to return to normal after radiotherapy. In the past I would have told the patient that the scan was fine, but now the patient may read that there is residual thickening or slight nodal enlargement. At the very least this requires an explanation about the nature of residual fibrosis or inactive cancer, but many patients will not be reassured without further scanning, a worrying period of waiting, or a biopsy.

Perhaps the solution is to telephone the general practitioner if there is something additional that I wish to convey (we do not have to record everything said on the telephone yet). An alternative would be to write two letters, one to the practice and another personally to the general practitioner. In the end I shall probably continue to write bland letters and hope that the general practitioner will read between the lines.

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Freeman Hospital: working to
improve services

SIR,—Sharon Kingman reports a 7% overall increase in activity at the Freeman Hospital in the current year.¹ Throughout the election campaign increased activity was used to justify the benefits of the NHS reforms. Yet we need to be very careful in accepting these figures at face value.

Contracts are set, and paid for, on the basis of completed consultant episodes (CCEs) and not admissions. If a patient is admitted under one firm and transferred to another firm the next day, one admission generates two CCEs. Because CCEs are the units for quantifying activity, and hence income, they are being much more carefully monitored than previously.

Admissions and completed consultant episodes (CCEs) in
medicine and surgery in a district general hospital,
1989-90 and 1991-2

	1989-90	1991-2	% Change
Medicine			
Admissions	6 915	7 041	1.8
CCEs	8 873	9 768	10.1
Ratio	1.28	1.39	
Surgery			
Admissions	12 256	10 095	-17.6
CCEs	16 323	14 943	-9.7
Ratio	1.33	1.46	

In my hospital, as a consequence, the ratio of CCEs to admissions has increased over the past two years (table). Thus the apparent 10.1% increase in medical activity corresponds to an extra 1.8% in admissions, and the real decrease of 17.6% in surgical admissions looks less worrying when expressed as a 9.7% decline in CCEs. Is this another example of doctors, as well as the general public, being misled by statistics quoted by managers and politicians?

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- 1 Kingman S. Freeman Hospital: working to improve services. *BMJ* 1992;304:908-9. (4 April.)

SIR,—In her report on the Freeman Hospital Sharon Kingman gives the impression that it was the first hospital in Newcastle to support local

general practitioners with a twice daily courier service for pathology requests.¹ Neither this, nor the implication that the hospital currently holds the pathology services contract for the fundholding practice referred to, is in fact the case.

It should not be assumed that fundholders and self governing hospitals have an overwhelming natural affinity. The real message is that, whatever the complexion of a hospital’s management, the role of the family doctor is central in the new NHS, and any pathology service that fails to recognise this does so at its peril.

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- 1 Kingman S. Freeman Hospital: working to improve services. *BMJ* 1992;304:907-9. (4 April.)

Checking quality of health care
records

SIR,—Lewis D Ritchie and colleagues claim, by retrospective analysis of computer records, a sustained improvement in primary and preschool immunisation in Grampian during 1990-1.¹ They conclude that as overall trends were unchanged the 1990 contract for general practitioners has had little effect. But the trend is based on data going back to 1986 (three of five figures in the paper) while the authors refer only to data analysis over the period March 1990 to September 1991. Further, their methods do not describe any quality assurance of the data. We need to know the error in the records and whether it was constant throughout the reported period before considering the authors’ conclusions.

Errors might occur if children in the target population are never registered; in recording and informing the records system of immunisations and changes in name, address, and general practitioner; and in keying the information. They may be introduced through problems with software and hardware. Sending quarterly reports of non-immunised children to each clinic is not the same as cross checking with records held by clinics and by parents.

Accepting computerised information without checking its quality is absurd. In 1984 Barker *et al* reported ethnic differences in uptake of immunisation by analysing computerised records on 5637 children with a validation that 50 records had been examined for another study and proved correct.² We have become more aware of the quality of data,³ and a 1% check on a changing dataset is insufficient. Yet in 1992 we have a report with no check on quality.

The measure of quality of health care records is a requirement for research and planning of health care. We suggest that all computer health records need regular standard quality checks. These should be organised in a set way as laboratories use the national external quality assurance scheme.⁴

It is not just children who need health care and vaccinations: we know that computer records also need checking and protection against their peculiar viruses.

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- 1 Ritchie LD, Bisset AF, Russell D, Leslie V, Thompson I. Primary and preschool immunisation in Grampian: progress and the 1990 contract. *BMJ* 1992;304:816-9. (28 March.)
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