Epley's procedure should be used to treat benign positional vertigo

EDITOR,—In response to our review on the treatment of benign positional vertigo¹ Graeme M Weiner advocates Cawthorne-Cooksey exercises as the superior choice for this condition.² We are aware that this reflects widespread practice in Britain, but the published evidence justifying it is weak.

Cawthorne-Cooksey exercises were devised to promote central compensation of stable unilateral vestibular deficits, and they serve this purpose well. Only one study, however, has evaluated the efficacy of such exercises for benign positional vertigo; it found that 32% of patients were cured after one week.³ This compares unfavourably with the 60-80% rate of immediate success after just one application of Epley's procedure as shown in several open studies cited in our review. The efficacy of this technique, which aims to clear the posterior semicircular canal of mobile particles, has been substantiated further by two recent studies.^{4,5} Patients appreciate the physician's support through a quick and effective manoeuvre as an alternative to repeated self inflicted attacks of the condition as occur with Cawthorne-Cooksey exercises. The 20% of patients who experience frequent recurrences can be taught an adapted version of Epley's procedure for self treatment at home.

We would invite Weiner to try Epley's manoeuvre himself because it was the grateful response of patients that ultimately defeated our initial scepticism.

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Correct technique is important in cardioversion of atrial fibrillation

EDITOR,—We are concerned that Gregory Y H Lip and colleagues' article on cardioversion of atrial fibrillation omits important information about the technique of cardioversion.¹ Direct current external cardioversion is the method most widely used to restore sinus rhythm in patients with atrial fibrillation. However, meticulous attention to detail is necessary if the technique is to have optimal results, and we take issue with the authors' guidelines for direct current cardioversion.

It has long been established that optimal results are achieved with an anterior-posterior arrangement of the paddles instead of the more usual anterior-apical approach.² The anterior-posterior approach incorporates a greater proportion of atrial tissue in the defibrillation field than the standard approach. Such a position also minimises the distance between electrodes and the quantity of lung tissue between the defibrillating electrodes.³ It also seems appropriate to start direct current cardioversion with a higher level of energy as delivery of 100 J will result in successful cardioversion in only around

half of patients.⁴ Most authorities suggest a single shock of 200 J before one of 360 J, although it is our practice to start with a 360 J shock with the anterior-posterior arrangement of the paddles.

In our institution almost all patients who present with atrial fibrillation of unknown duration are offered direct current cardioversion after an appropriate period of anticoagulation in an attempt to restore sinus rhythm. Should this be unsuccessful then selected patients are offered internal atrial cardioversion⁵ before the atrial fibrillation is finally accepted as being chronic. Failure to use the correct technique may unnecessarily condemn patients to chronic or prolonged atrial fibrillation with all the haemodynamic and thromboembolic disadvantages for the patients and the economic consequences for the NHS.

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Children and sport

De-emphasise team sport

EDITOR,—The report *Raising the Game*¹ is, as Helen Tripp notes,² a start. Unfortunately it is a start down the wrong path. The report places the emphasis firmly on developing competitive team sport at the centre of physical education. In doing so it intensifies the connection between healthy exercise and vigorous sport. The evidence shows that vigorous exercise is neither necessary to provide a health benefit nor suitable for all people in society.

Competitive sport is not liked by a sizeable number of children, particularly girls. As children get older, they tend to stop participating in sports outside school. For boys, participation in soccer outside school drops from 59% in 11 year olds to 42% in 16 year olds, and similar falls are seen in sports such as rugby and cricket. For girls, the participation in netball decreases from 19% to 6% between ages 11 and 16. This fall continues as people age, and *Social Trends* identifies that at 45-59 participation in team sports is 11%.³

As has been shown by a number of surveys, such as the Allied Dunbar National Fitness Survey,⁴ as a nation we are not taking enough exercise. Though team sport can be a beneficial source of exercise for some individuals, it is a minority interest. It would not be physically possible to increase the use and provision of facilities to allow the nation to get its exercise from team sports. Concentration on team sport at school will also confirm the link between exercise and health with sport and make the message of increasing moderate activity more difficult. It will alienate the substantial number of children who for one reason or another dislike sports and will reduce the time available for wider activities, such as dancing, walking, or cycling.

Policies must be developed that take the range of activities that will provide healthy exercise into account, and action developed to ensure that these occur. In a recent report from the Royal Society of Health we set out several recommendations for action in various settings to encourage an increase in activity.⁵ These settings included the family, the community or local authority, schools, the workplace, and health bodies. It is by developing a wide range of measures to encourage and facilitate moderate exercise such as cycling and walking that we will be able to achieve a healthier nation.

Increasing the emphasis on competitive sport ignores those who do not enjoy it or cannot participate and alienates them from all forms of exercise. We should pay attention to the World Health Organisation and the International Federation of Sports Medicine, which noted that "daily physical activity would be accepted as the cornerstone of a healthy lifestyle. Physical activity should be re-integrated into the routine of everyday living. An obvious first step would be the use of the stairs instead of lifts, and walking or cycling for short journeys."⁶

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Physicians must not be misled by arguments against screening with densitometry

EDITOR,—As the person chiefly responsible for the development of bone densitometry, I wish to reply to the unreasonable arguments of Trevor A Sheldon and colleagues that the reply by David Barlow and colleagues does not address.¹ Critics mistakenly dispute the use of densitometry for assessing risk by questioning its sensitivity in diagnosing fracture. Using densitometry to diagnose a fracture is comparable to diagnostic use of blood pressure for stroke or lipid concentrations for infarction. Bone density indicates the risk, not the presence of a morbid event. The gradient of risk associated with bone density is high compared with that associated with blood pressure or lipid concentrations: a 12% decrease in the density of the femur triples the risk of hip fracture.² Bone density, like blood pressure and lipid concentrations, shows overlapping distributions in patients and controls, but the overlap is much less for bone density.

Critics also question the use of densitometry for monitoring treatment because peripheral density increases by only 1% a year, which equals the precision error. Antiresorptive treatments (such as bisphosphonates and oestrogens) and stimulators (such as fluoride) increase spinal density by over 3% annually. Increases in spinal density are significant in 80% of patients after one year, since they are three to five times larger than the precision error. The clinical strategy for monitoring registered treatments, however, is not to prove their efficacy but to assess their failure.³ The failure to maintain femur density (which occurs in 10-30% of treated patients) after one year is a good indicator of either non-compliance or non-response.

The Advisory Group on Osteoporosis was correct in its opposition to screening for osteoporosis in the absence of symptoms or indications, even

though screening is demonstrably cost effective.⁴ Foremost among the unresolved questions is the ability of physicians to treat bone disease once it is detected. The number of knowledgeable physicians is increasing, but not enough for them to manage the 100-fold increase in caseload that could result from population screening. Today less than 5% of patients with fracture undergo densitometry, and less than one third of the potential patients with indications (for example, those taking corticosteroids or with malabsorption or hyperparathyroidism) are symptomatic. Barlow and colleagues note that critics confuse clinical densitometry in patients showing symptoms or indications with screening.¹ Physicians must become educated about bone disease so that they can manage effectively the increased caseload that will result from justified use of densitometry, and they must not be misled by disingenuous arguments against screening.

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Women need to be fully informed about risks of hormone replacement therapy

EDITOR,—As women doctors, we were surprised by A J Isaacs and colleagues' suggestion that women doctors are in favour of using hormone replacement therapy themselves and that this predicts wider use by the general population.¹ Their statistics hardly support this assertion: of 1514 doctors written to, only 344 confirmed that they currently took such treatment. Women doctors, in common with other women, are subjected to considerable pressure to use hormone replacement therapy, and the risk of serious side effects may be overlooked.

A 50% increase in the risk of breast cancer is associated with current use of hormone replacement therapy for more than five years.² Given the already high and rising incidence of this disease in Western populations, this is more frightening to most women than heart disease or osteoporosis, for which hormone replacement therapy is claimed to be beneficial. (The possibility that postmenopausal women taking hormone replacement therapy who develop breast cancer have a better prognosis than those not taking hormone replacement therapy should not be an argument for mass treatment.)

Suicide has been found to occur in more women taking hormone replacement therapy than expected; not all of these women had a psychiatric history.³ The mood swings of women taking hormone replacement therapy have been analysed⁴ but may still not be recognised as side effects of a mood altering and possibly addictive drug. This can have implications not only for the women themselves but for those people associated with them, including their families and work colleagues.

The possible cardiovascular benefits of hormone replacement therapy, which have been frequently quoted, have been questioned.⁵ Safer

ways of decreasing the risk of both heart disease and osteoporosis involve changes in lifestyle, including taking more exercise and having a healthier diet. These should be vigorously advocated, as should stopping smoking.

The menopause is a normal physiological state, not a disease. Drug treatment should not be given to the general population. Women wishing to make informed choices about hormone replacement therapy, balancing the possible benefits against the dangers and side effects, remain confused by much contradictory information. Those who are concerned about the risks should contact a new organisation, DASH (Doctors Against Abuse from Steroid Sex Hormones), for an alternative approach to the widespread promotion of hormone replacement therapy. The secretary is Dr E Grant, 20 Coombe Ridings, Kingston upon Thames, Surrey KT2 7JU.

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Education for educating surgeons

Training for trainers does exist in Britain

EDITOR,—Christopher Bulstrode and Gareth Holsgrove rightly point out the need for those people who are responsible for the day to day education and training of young doctors to be sufficiently well versed in educational techniques to undertake their tasks effectively.¹ However, their assertion that "no such training for trainers currently exists in Britain" disregards:

- The long tradition of mandatory educational training for trainers in general practice—for instance, there are about 150 accredited and reaccredited trainers in general practice in Devon and Cornwall
- Several regional initiatives in "educating the educators"—for example, the south and west scheme for consultants organised through the postgraduate deans
- The distance learning approach to medical education—including an MSc—taken by Dundee University, which has seen over 50 hospital doctors complete courses
- The MSc and diploma in medical education from the University of Wales College of Medicine. This course, established in 1987, is constructed on a modular basis and requires a commitment of 19 days a year for two years. Eighty three students, 53 of whom are British doctors, have completed or are completing this course.

Clinical staff who have taken opportunities for in depth education of this sort are able to be the source of a cascade of education to a wide range of clinical colleagues in their locality and are a cost effective means of promoting good educational experience for doctors in training.

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- 1 Bulstrode C, Holsgrove G. Education for educating surgeons. *BMJ* 1996;312:326-7. (10 February.)

Surgeons' knowledge base needs to be increased

EDITOR,—We share Christopher Bulstrode and Gareth Holsgrove's concerns about and approach towards the education of surgeons¹ but would suggest that in addition to addressing surgeons' attitudes and behaviour we should increase their knowledge base. This would mean incorporating disciplines such as clinical epidemiology into training programmes. We adopted this approach in our recently established MSc in clinical orthopaedics at the University of Teesside and introduced didactic and small group teaching of clinical epidemiology and biostatistics. Students gain further experience while completing their compulsory research based dissertation.

At our first workshop on evidence based orthopaedic surgery in Middlesbrough last November, all students found such teaching useful for their practice and research projects. They also wanted more, and accordingly we are now exploring the possibility of ward rounds and journal clubs with the involvement of educators and clinical epidemiologists. A copy of the proceedings of the workshop is available on request.

We have two concerns. Firstly, because our MSc course has attracted only visiting doctors, local career trainees are not benefitting, although we are targeting them through the regional training programme. Secondly, there are limited opportunities for the trainees to practise what they have learnt because their seniors may not have received such training and may find their questioning challenging. It is in this latter respect that the initiatives described by Bulstrode and Holsgrove will be useful.

We would be pleased to hear from others embarked on similar programmes to share experiences and collaborate with them to promote evidence based orthopaedic surgery.

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College has found strong demand for training programmes

EDITOR,—As Chris Bulstrode and Gareth Holsgrove emphasise, consultant surgeons need to be educated in the principles and methods of teaching while undertaking clinical work.¹ Indeed, it is important that they are educated in these principles and methods so that they can apply them to any educational opportunity and thereby maximise the efficiency of their teaching.

At the Royal College of Surgeons of England we have been running a "training the trainers" programme since May 1994 and have found that there is a strong demand for our courses. The two day course was initially designed for consultants who teach on various courses on practical skills, including minimal access and basic surgical skills. We soon found, however, that we were receiving requests from many other surgeons, whose main concern was teaching juniors in the workplace. We therefore vary the emphasis of our courses to take account of the needs of the particular participants who are attending. Over 200 surgeons have now taken part in these courses, and we expect that number to have more than doubled by the end of this year: 35 courses are planned, and they are fully subscribed until September.

The training the trainers project is a major development within the Raven department of