The second message of the study is that the term persistent vegetative state is widely misused, even in recent papers.³ No clinician should accept a diagnosis of such a state within 12 months of the onset of coma. I strongly recommend use of the term "continuing vegetative state," or even the simpler term "coma," for all patients who are comatose over the first 12 months after the onset of coma. In this way clinicians and relatives will avoid drawing premature or incorrect conclusions from loosely applied diagnostic labels.

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Despite Cranford's scepticism we continue to encounter misdiagnosis of the vegetative state in our practice. Further study of patients diagnosed as being in this state, dissemination of current diagnostic criteria, and education of doctors about the difficulties of evaluation are sorely needed.

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Misdiagnosis certainly occurs

EDITOR,—It is gratifying, though alarming, that Keith Andrews and colleagues' study¹ so closely duplicates our findings regarding misdiagnosis of the vegetative state.² The accompanying editorial by Ronald Cranford, which suggests that the rate of misdiagnosis is a new finding and that Andrews and colleagues' methods were questionable, merits critical comment.³

Aside from the implication that physicians who provide rehabilitative care are scientifically suspect, Cranford shows his inexperience in the neurorehabilitation of brain injured patients when he doubts the veracity of the buzzer communication system.³ Prosthetic communication and environmental control systems, including simple on-off switching devices like the buzzer, are commonly used in rehabilitation.⁴ Obviously, the patients in Andrews and colleagues' study were showing the responsiveness required to negate a diagnosis of vegetative state before they could use a communication device with 90% consistency.

Cranford—a member of the Multi-Society Task Force on Persistent Vegetative State—says that neurodiagnostic tests have "some use in the diagnosis" of vegetative state; we find this perplexing. While the task force stated that structural and functional neuroimaging "may provide useful information when used in conjunction with clinical evaluation," it also said that "neurodiagnostic tests alone can neither confirm the diagnosis of vegetative state nor predict the potential for recovery of awareness."⁵ Contradictory statements such as these need to be reconciled. In addition, if these tests are diagnostic, as Cranford suggests, then it was the referring physicians who were remiss not Andrews and colleagues. Whether neurodiagnostic tests were used has little relevance to Andrews and colleagues since their purpose was to validate or invalidate the preadmission diagnoses.

Cranford zealously promotes the concept of "permanent vegetative state" in the face of concern that this implies unquantified finality. Yet he suggests that some patients recovered awareness under the observation and care of Andrews and colleagues. Thus the patients were not misdiagnosed: their diagnosis changed. On the basis of the Multi-Society Task Force's criteria,⁵ 70% of these patients were "permanently" vegetative. How amazing that most patients suddenly emerged from this state, and their diagnosis changed, 16 days after their admission to the Royal Hospital for Neurodisability.

Young female doctors report achieving fewer surgical skills than young male doctors

EDITOR,—In their paper on the career preferences of British doctors Trevor W Lambert and colleagues highlight the different choices of career between men and women.¹ As in the United Kingdom, in Norway the proportion of female graduates has increased in recent decades and is currently 50% (roughly 200 graduates); this change greatly influences recruitment to the different specialties. For surgery the same gender imbalance reported by Lambert and colleagues is observed in Norway, where only 27 of 973 specialists in general surgery are women. An interesting finding in Lambert and colleagues' paper is the important role of self appraisal of skills and aptitudes in the choice of a future medical career.

As part of an assessment of the Norwegian internship we sent a questionnaire to a cohort (n = 133) of Norwegian preregistration house officers who had recently finished their hospital service; 103 (77%) replied.² We asked them whether they thought they had achieved particular skills in several procedures. The female doctors reported having achieved fewer surgical skills than did their male colleagues (table 1).

Female house officers have the same potential as men to achieve surgical skills and eventually to start a surgical career. Hostile attitudes towards women have been reported among surgeons and could account for the women's limited skills, as could the absence of women in surgery.³ Because self appraisal of clinical skills is important in doctors' later choice of career, and because the

Table 1—Number (percentage) of procedures in which men and women reported having achieved skill

	Men (n = 56)	Women (n = 47)
Resuscitation (10 procedures)	109 (19)	85 (18)
Medical emergencies (11 procedures)	305 (50)	221 (43)
Laboratory procedures (8 procedures)	213 (48)	162 (43)
Surgical procedures (20 procedures)	774 (69)	556 (59)*
All procedures (n = 49)	1401 (51)	1024 (44) †

* $\chi^2 = 22.2$, 1 df, $P < 0.01$. † $\chi^2 = 21.8$, 1 df, $P < 0.01$.

recruitment of women to surgery is low, those who teach surgery at both undergraduate and postgraduate levels should address this problem.

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Advertisement for toremifene

Playing on women's fears is unethical

EDITOR,—We are concerned by the advertisement for Fareston (toremifene) published in the clinical research edition of the *BMJ* on 6 July (between p 24 and p 25) and in other clinical journals. The advertisement focuses on patients' perceived concerns about the toxicity of tamoxifen—specifically, its carcinogenic potential—and proposes toremifene as an alternative that could allay those fears. The issue of endometrial cancer and tamoxifen has stimulated much debate.¹ It should, however, be seen in context. The national surgical adjuvant breast and bowel project, a trial of adjuvant tamoxifen, showed roughly a twofold increased risk of endometrial cancer, but overall benefit far outweighed this risk.²

Whatever the concerns about tamoxifen, to use them in promoting toremifene is inappropriate. Firstly, toremifene does not have a licence for use as adjuvant treatment, the setting in which the question of endometrial cancer has been raised. Toremifene is licensed for use only in patients with advanced breast cancer. There is no evidence that the occurrence of endometrial cancer affects the outcome for this group of women treated with tamoxifen. Secondly, although there may be experimental grounds for believing that toremifene is less likely to be carcinogenic than tamoxifen, there are no clinical data to support this contention. Not surprisingly, in a randomised comparison of tamoxifen and toremifene no patient developed endometrial cancer.³ Indeed, there was no difference in either activity or adverse events between the two treatments. Thirdly, the datasheet for toremifene specifically describes "a risk of endometrial changes including hyperplasia, polyps and cancer," and toremifene is contraindicated in women with pre-existing endometrial hyperplasia. Finally, the potential risks associated with tamoxifen come with prolonged use, yet the datasheet for toremifene warns that experience of use of toremifene for more than one year is limited. By contrast, there has been more than seven million woman years of use of tamoxifen.

As clinical trialists we support the development of better treatments for women with cancer. Toremifene may find a place in the treatment of breast cancer. This advertisement, however, is unbalanced and misleading, uses preclinical data unsupported by clinical studies, and seems to contravene the Association of the British Pharmaceutical Industry's guidelines. Patients' concerns are important, but it is surely unethical to play on these concerns when there

are no clinical data showing that the use of toremifene in place of tamoxifen would reduce the incidence of endometrial cancer. Orion Pharma should rethink its marketing strategy.

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Manufacturer's reply

EDITOR,—Naturally we are concerned that Chris Twelves and Adrian Harnett take exception to our advertisement for Fareston (toremifene). Yes, the advertisement focuses on patients' concerns, but are they not relevant? It is not surprising that some women diagnosed as having breast cancer are concerned by what they have read or heard about tamoxifen. Debate in the medical press,^{1,2} sensationalism in the lay press, and the information superhighway mean that women are more aware of the issues than ever before.

Twelves and Harnett focus exclusively on endometrial cancer, and yet the advertisement makes no mention of endometrial cancer. Clearly this subject is uppermost in their thoughts because of the debate that has been stimulated on it, but what other issues concern patients? The cancer charity Tenovus has recently published a booklet entitled *Tamoxifen—the facts*.³ The publication covers the 20 questions that are most commonly asked about tamoxifen. These include "Does tamoxifen cause cancer of the womb (uterine cancer)?" and "Does tamoxifen cause liver cancer?"

Our advertisement for toremifene does not sensationalise the issue; it simply acknowledges and reflects the situation that exists. It does not make any claim for toremifene over tamoxifen with regard to endometrial cancer for the reasons outlined. The advertisement states, however, that toremifene does not cause DNA adducts and is not hepatocarcinogenic in rats—which is in total contrast to tamoxifen.⁴ The clinical relevance of this in patients is not yet determined. Nevertheless, this is an important preclinical difference between the two products that to the best of our knowledge has not been studied clinically in sufficient detail. This absence of evidence is not the same as there being no evidence of effect, and thus the experience with tamoxifen is irrelevant here.

Toremifene offers, for the first time, an alternative to tamoxifen for first line hormonal treatment of hormone dependent metastatic breast cancer in postmenopausal patients. Doctors will have to decide the most appropriate treatment, bearing in mind the principle outlined in the Calman report that "Patients, families and carers should be given clear information and assistance in a form they can understand about treatment options and outcomes available to them at all stages of treatment from diagnosis onwards."⁵

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Community pharmacists are increasingly supervising treatments

EDITOR,—Louise Sell and colleagues draw attention to the fact that community pharmacists are an underused resource in ensuring compliance in the treatment of drug dependence and tuberculosis.¹ They note that community pharmacists have expressed willingness to supervise the consumption of methadone; in Glasgow this willingness has been translated into practice. In early 1994 a fifth of the 214 community pharmacies in Glasgow were supervising the administration of methadone.² This proportion has now reached three fifths, and over 70% of all methadone dispensed in these pharmacies is now supervised. During 1995 the consumption of over 300 000 doses of methadone was supervised in the community pharmacies in Glasgow. The Royal Pharmaceutical Society of Great Britain has now produced preliminary guidelines on supervised self administration of methadone.³

Many pharmacists have expressed their willingness to extend this service to other therapeutic areas, and to our knowledge treatment with other medicines (for example, benzodiazepines and dihydrocodeine) and for other conditions (for example, Alzheimer's disease) is being supervised.

The benefits to patients as well as for pharmacists and society at large clearly point to this being an appropriate use of a valuable professional resource. We have already been contacted about this service by an appreciable number of drug treatment services throughout England, and we would welcome further contacts.

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Septic arthritis in osteoarthritic hips

Authors' interpretation of radiograph was wrong

EDITOR,—D J Knight and colleagues report the development of septic arthritis in osteoarthritic hip joints.¹ They state that the radiograph in figure 1 in their paper shows an osteoarthritic right hip and that that in figure 2 shows the subsequent changes of septic arthritis. In figure 1 the femoral head is flattened, and there is extensive destruction of subarticular bone. The joint space is narrowed, with evidence of a joint

effusion with bulging of the lateral fat plane. The acetabular roof is osteopenic, and there is erosion of the medial acetabular margin. The radiological findings are those of a septic arthritis and not osteoarthritis as stated by the authors.² The destructive process has progressed by the time of the radiograph shown in figure 2.

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- 1 Knight DJ, Gilbert FJ, Hutchinson JD. Septic arthritis in osteoarthritic hips. *BMJ* 1996;313:40-1. (6 July.)
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Authors' reply

EDITOR,—Despite D C Howlett's comments we believe that the changes in our figure 1 are compatible with a diagnosis of osteoarthritis. There is appreciable narrowing of the joint space, with deformity of the femoral head and cystic changes—all signs of osteoarthritis. Also, the second x ray film was obtained seven months after the first, and an infective process would be expected to progress more rapidly. Furthermore, we believe that the lateral fat plane sign mentioned by Howlett is unreliable as a sign of disease of the hip joint, especially in adults.¹

We believe that the basic lesson of our paper remains. The clinical picture and the x ray changes of osteoarthritis and septic arthritis overlap, and infection may be missed if it is not considered.

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- 1 Resnick D, Niwayama G. *Anatomy of individual joints. In: Diagnosis of bone and joint disorders*. 2nd ed. Philadelphia: W B Saunders, 1988:712-3.

More emergency insulin distribution projects should be set up

EDITOR,—The International Diabetes Institute and the supporters of its emergency insulin distribution project are encouraged by J Burdon's personal view detailing how this project has helped diabetic patients in rural Zaire.¹ The project obtains insulin that would otherwise be destroyed and has distributed 63 000 vials to countries in every continent.² I would encourage readers to consider establishing similar programmes, as has been done in New Zealand; those who are interested may contact me for more information. There are also many advantages in having a humanitarian medical supply project integrated with an international medical centre rather than separate from it, and we would encourage other such centres to consider adopting a similar project.

Lifesaving insulin gets destroyed because of lack of knowledge of nominal expiry dates, and no doubt this also occurs with some other medicines. Practical programmes that allow such medicines to be used would save many lives.

The emergency insulin distribution project is funded entirely by donations. With further donations we would be able to distribute more insulin that would otherwise be destroyed. We would welcome correspondence from individuals and