Case 1—A 76 year old woman received the treatment for multifocal motor neuropathy. One week after treatment she developed a widespread erythematous, exfoliating rash, which was diagnosed after skin biopsy as being severe erythroderma. This required three months of intensive and predominantly inpatient dermatological care. The neuropathy initially responded to the intravenous immunoglobulin but then relapsed. After extensive patch testing with various brands of intravenous immunoglobulin, none of which resulted in a positive reaction, she was given a further course covered by oral steroids, but within six hours of the first dose the rash returned.

Case 2—A 66 year old man with inclusion body myositis developed itchy skin eruptions six days after receiving the Scottish preparation of intravenous immunoglobulin. Skin biopsy suggested an allergic aetiology. He had a further six courses of the same preparation at monthly intervals with oral steroid cover. No further complications developed.

Case 3—A 48 year old man with multifocal motor neuropathy developed a widespread eczematous rash 10 days after treatment with intravenous immunoglobulin. He was admitted to hospital after failure of outpatient treatment. Skin biopsy showed perivascular inflammation, hyperkeratosis, and parakeratosis without evidence of vasculitis.

Case 4—A 55 year old man received intravenous immunoglobulin for multifocal motor neuropathy. One week after treatment he developed widespread itchy, scaly eruptions, mainly on the arms and legs, which persisted for four weeks. Recovery was spontaneous and uneventful.

Serious side effects of intravenous immunoglobulin are rare. There are only a few reports of skin reactions in the literature²; although rarely life threatening, they may cause considerable distress (as they did in cases 1 and 3). A patient has been successfully treated with intravenous immunoglobulin and steroid cover after developing eczema,³ and the combination of intravenous immunoglobulin and steroid has been evaluated recently.⁴ This may well be optimal treatment, if only because the side effects of the immunoglobulin are lessened, but our experience is that the skin condition may recur despite such treatment.

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Products with low IgA content may be used in patients with total IgA deficiency

EDITOR—R A C Hughes emphasises that, on the basis of the results of recent randomised studies, intravenous immunoglobulin is as efficacious as plasmapheresis in the treatment of the Guillain-

Barré syndrome.¹ In view of the practical difficulties associated with plasmapheresis, intravenous immunoglobulin is increasingly likely to be preferred as first line treatment.

In this context Hughes states that intravenous immunoglobulin should be avoided in patients with IgA deficiency. This may mislead clinicians who are unfamiliar with immunoglobulin treatment and may result in them needlessly withholding treatment from all IgA deficient patients. Although it is true that anaphylaxis remains an important risk in some patients with selective IgA deficiency, this is virtually confined to those with the combination of severe or absolute IgA deficiency (<0.05 g/l) and high levels of antibodies to IgA.² Even in these patients the risk of anaphylaxis can be greatly reduced by the cautious use of an IgA depleted immunoglobulin product. Immunodeficient patients with high levels of antibodies to IgA (1 in 200 to 1 in 7000) have been maintained on regular replacement with an IgA depleted product with no serious adverse effects over a six year period.³

Table 1 shows the IgA content of immunoglobulin preparations currently available in Britain. Because measurement of the level of antibodies to IgA is available in only a few immunology laboratories in Britain it would be unwise to delay emergency treatment of the Guillain-Barré syndrome until the results of such measurement are available. It would be sensible to treat patients known to be totally IgA deficient, and those in whom any doubt exists, with an immunoglobulin product with a low IgA content.

Table 1—Approximate IgA content of immunoglobulin preparations

Product	IgA (mg/l)
Alphaglobin	24*
Endobulin	10-50†
Gammagard-SD	0.4-1.9*
Gamimune-N	270*
Sandoglobulin	720*
SNBTS intravenous immunoglobulin	920†
Vigam S	5†

SNBTS = Scottish National Blood Transfusion Service.

*Data from reference 4.

†Data provided by manufacturer.

Hughes's statement that intravenous immunoglobulin should be avoided in patients with renal failure also requires clarification. Temporary reversible deterioration in renal function (ranging from an asymptomatic increase in the serum creatinine concentration to anuric renal failure) associated with the use of high dose intravenous immunoglobulin (2 g/kg) is likely to be related to the toxic effect of a high sugar load on renal tubules.⁵ While the use of a single dose of 2 g/kg should be avoided in patients with pre-existing renal impairment, it may be possible to infuse lower doses at a slower rate safely in such patients.⁵ Hence, rather than renal failure being viewed as an absolute contraindication to intravenous immunoglobulin therapy, each case should be assessed on its individual merits.

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Impact factors need to be improved

EDITOR—Because the number of citations per article is widely used to rank journals, institutions, papers, and scientists we should welcome Eugene Garfield's suggestions for improving the validity of this simple ratio.¹ The final sentence of the summary of Garfield's article, however, hardly fits the title and finds little support in the rest of the article. While good attracts good (Nobel prizewinners work with Nobel prizewinners), we would expect citations to attract citations. Yet this circular argument is reminiscent of the explanation of why the higher echelons of the civil service in Britain continue to find their most suitable recruits to be graduates of Oxford and Cambridge universities. This circular argument is barely scientific and potentially invidious.

Many factors contribute to the number of citations per paper, including the science; the nature of the research; the style of the communication (papers vary in the number of references they include, from none to over 100); editorial policy (several journals ration the number of references per article); circulation and readership (more readers equals more citations); citation bias (comparable to submission bias and publication bias); conformism (scientists often cite those papers that are currently cited); authors' tendency to cite their own work; and referees' self promotion (referees' tendency to recommend inclusion of references to their work).

A "scientific" evaluation of the citation ratio as a measure of the quality of an article might include assessments of prior agreed criteria of quality; the value added to scientific knowledge at the time that the paper was submitted for publication (not necessarily the time it was published); whether the article is deemed correct with the wisdom of hindsight—say, 30 years after publication (because many scientific observations follow a current popular paradigm or consensus); and blind scoring by a panel of judges.

One wonders whether, if independent external criteria were used, some popular articles in widely read weekly journals would still turn out to be 30 or 40 times more valuable to science than those in monthly or quarterly specialist journals, and whether the *Lancet* really is twice as good as the *BMJ*.

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- 1 Garfield E. How can impact factors be improved? *BMJ* 1996;313:411-3. (17 August.)

Non-fatal overdosing is related to polydrug use in Glasgow

EDITOR—Michael Gossop and colleagues found that 9% of 438 heroin users in London reported at least one non-fatal overdose in the previous year, and they state that the use of heroin in combination with other drugs may be a critical risk factor.¹ In our study of 1018 drug injectors recruited in Glasgow during 1993-4, 276 (27%) reported at least one non-fatal overdose requiring medical attention during the previous year.

Table 1—Self reported drug use and non-fatal overdose among 1018 drug injectors interviewed in Glasgow, 1993-4

Drug used or injected in six months before interview	No (%) using drug	No (%) reporting overdose	Relative risk (95% confidence interval) compared with rest of sample
Injected heroin only	241 (24)	52 (22)	0.7 (0.5 to 0.9)
Injected heroin and other drugs	661 (65)	213 (32)	2.2 (1.6 to 3.0)
Injected drugs excluding heroin	116 (11)	11 (9)	0.3 (0.1 to 0.5)
Methadone	453 (44)	132 (29)	1.2 (0.9 to 1.6)*
Buprenorphine	413 (41)	109 (26)	0.9 (0.7 to 1.2)*
Temazepam	793 (78)	244 (31)	2.7 (1.8 to 4.0)
Cocaine	179 (18)	67 (37)	1.8 (1.3 to 2.5)
Ecstasy	258 (25)	99 (38)	2.0 (1.5 to 2.8)

*Not significant.

Preliminary observation suggests that non-fatal overdosing is linearly related to polydrug use; among the 298 subjects who had injected only one drug 57 (19%) had taken an overdose, compared with 29 (40%) of the 72 who reported injecting six or more drugs. Among the 116 using multiple drugs excluding heroin, however, only 10% reported overdosing, compared with 22% of the 241 who had injected only heroin and 32% of the 661 who had injected heroin plus other drugs (table 1).

It is important to note that the drugs shown in table 1 do not relate specifically to overdoses; they relate to general patterns of drug use in the six months before interview. Use of temazepam, cocaine, and ecstasy was associated with an increased risk of overdose. In contrast, use of methadone was not associated with overdosing, although we are currently conducting a more detailed study of overdosing among drug users who have been prescribed methadone as a part of a city-wide scheme initiated in January 1994.

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1 Gossop M, Griffiths P, Powis B, Williamson S, Strang J. Frequency of non-fatal heroin overdose: survey of heroin users recruited in non-clinical settings. *BMJ* 1996;313:402. (17 August.)

Private practice

Offering preferential NHS treatment to doctors is embarrassing

EDITOR,—I entirely agree with David Currie's personal view about private health insurance: I would not allow myself or my family to be treated anywhere other than in NHS hospitals, because for all its difficulties the NHS provides a full range of health care in an accountable manner.¹ But I have had private insurance since I was a senior house officer. Why? Because I am embarrassed by the preferential treatment and queue jumping that my colleagues (and I myself) offer to doctors and their families. By taking myself and my family into the private sector I am not pushing someone else down the list; I am not making staff equally uncomfortable about treating us differently or treating us the same.

What I would not contemplate is treatment in a private hospital—without access to full medical records, dedicated nursing staff led by people interested in quality and progress, highly selected junior doctors with structured supervision of their postgraduate education, and a range of consultants to consult if all is not simple and straightforward.

Readers may laugh at that description of an NHS hospital: I would have to agree that it is not quite like that, but it is our aim.

Do I engage in private practice? Yes, occasionally, if people are insured and are also eligible for NHS treatment so that I never have to give a lesser service. And only in the private ward of an NHS hospital. What do I think patients get out of "going private"? Self esteem, their own bathroom, and quiet nights. What do they lose? The context in which to judge the severity of their condition and progress, camaraderie with staff and patients engaged in making the NHS work, and the privilege of training the new generation of professionals.

People should not give up on an organisation that is imperfect: only from the inside—whether it be as a BMA member, an NHS consultant, a recognised BUPA specialist, or a patient—can they influence it.

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1 Currie D. BUPA subscription? That will do nicely. *BMJ* 1996;313:431. (17 August.)

Same standards of staffing and equipment should apply in NHS and private sector

EDITOR,—I endorse everything that David Currie writes in his personal view about private practice.¹ Some 40 years ago I joined a long established practice in north London. "We try not to send patients in privately," explained one of the partners; "we find too many come out feet first." Nothing that happened over the subsequent years changed my view. In fact, so convinced am I that the best of health care is provided by the NHS that I have waited, sometimes in pain and unable to walk, for the three joint replacement operations I have had over the past three years. Fortunately, any complications I have had have been minor, but during my most recent admission two patients had cerebrovascular accidents one Saturday morning. Other patients and I may have felt a bit neglected, and I do not know the eventual outcome, but I do know that expert care was there immediately, on the spot.

It is not that I have any principled objection to private practice; people should be allowed to spend their money as they like, and if access to a secretary and a good wine list are important they may choose the private sector. But they must do so in the full knowledge of what they are buying. I want that fashionable concept of our age, a level playing field. Incompetent doctors who have been dismissed from the NHS should not be allowed to continue in private practice; the same standards of staffing and equipment should apply in both sectors; and the endless criticisms

of the NHS that appear in the press—often, in my experience, baseless—should be matched by similar scrutiny of private hospitals.

It is a matter for shame for the profession that so many doctors have been prepared to treat patients for money in circumstances that they knew were not satisfactory. Perhaps I should add that neither I (a general practitioner) nor my husband (a surgeon) took private patients for exactly the reasons that Currie states.

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1 Currie D. BUPA subscription? That will do nicely. *BMJ* 1996;313:431. (17 August.)

Author is lucky that his waiting list can be managed quickly

EDITOR,—It is lucky for David Currie that he works in a unit and in an area of Britain where the waiting lists can be managed quickly and personally, making private insurance less attractive.¹ It is also fortunate that he works in a field in which the need for private care is less than that in other fields and the need for first class back up in the NHS is essential and recognised as such by the NHS administration.

There are many reasons for the size and nature of any surgical specialist waiting list, and "fiddling the system," as Currie suggests, is not the main one.² In my own specialty of plastic surgery most cosmetic, non-malignant, and non-traumatic work is not covered by insurance, and, because of the continual heavy input and referrals, waiting time and waiting lists are difficult to control. Some patients elect to have private treatment and pay for it themselves, mainly for convenience and speed; in some cases they indicate that they are happy to have the freedom of choice and, by removing themselves from the NHS, allow others to take their place in the queue.

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2 McGregor JC. Can a work-load coding system be used to assess and monitor a plastic surgery waiting list? *J R Coll Surg Edinb* 1996;41:50-3.

Many reasons exist for choosing private treatment

EDITOR,—Having read David Currie's personal view about private medicine, I am not sure whether to pity him or be jealous.¹ His article must surely have been written tongue in cheek. Does he really not know the use of having a subscription for private treatment?

All of us should see a patient urgently if asked to do so. If the next clinic is not soon enough then a special arrangement can be made, such as to admit the patient directly to the ward or to send the patient to the accident and emergency department, whose remit, surely, is emergencies.

Currie is lucky indeed if the pressure of his work allows him to perform all his elective surgery within six weeks; most of us still have waiting lists that are too long. When patients mention that they are insured it is because they assume (quite correctly) that there will be a long wait for routine treatment. One must have a warped sense of values if one feels that one is being bribed. By treating such patients privately, out of NHS hours, one is making space to treat other patients more rapidly.

Currie talks of "tin pot nursing homes," but it is surely up to each practitioner to be confident that he or she practises in a safe environment.