Possible benefits of low molecular weight heparins

EDITOR.—Consideration of the main end points used in the studies included in A Leizorovicz and colleagues' meta-analysis of the possible merits of low molecular weight heparin¹ illustrates certain difficulties in persuading the uninitiated of the validity of this form of pooled analysis of different groups' data. The three studies that used clinical end points (the authors' references 30, 32, and 34) account for more than one third (751/2015) of the subjects. They all favoured low molecular weight heparin (the authors' figure 1). They also account for most of the differences in recurrent thromboembolic events, short term haemorrhage, thrombus extension, and total mortality (one of these studies (reference 30) did not cover thrombus extension but is the main source of differences in short term haemorrhage (authors' table II)). How reliable are clinical end points in the assessment of deep venous thrombosis?

In contrast, the venographic studies (authors' references 22, 24–29, 35, and 38) divide as follows: two in favour of, six against, and one undecided about low molecular weight heparin (authors' figure 1). Furthermore, when the experience of a single group of workers over time is looked at (Lockner's group published papers in 1985, 1990, and 1993 (references 25, 24, and 38 respectively)) it is clear that there was little difference in recurrent thromboembolic events, short term haemorrhage, and total mortality between the groups in the various studies but that less thrombus extension was observed in the groups given low molecular weight heparin (7/186 v 13/192; authors' table II). The three plethysmographically monitored studies (references 33, 36, and 37) were also divided in their opinion (two for and one against low molecular weight heparin).

A more detailed explanation of how the authors arrived at the relative weightings given to the individual studies in their table II would have been helpful. Nevertheless, with such diverse and apparently contradictory conclusions from studies with various end points, and given the clinical importance in terms of morbidity, mortality, and numbers of cases, the large scale trial urged by Leizorovicz and colleagues seems a priority.

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Future of inpatient adolescent psychiatric units

EDITOR.—We are concerned about the future of inpatient adolescent psychiatric units. It proved difficult to find adolescent psychiatrists to staff our regional adolescent unit at Hill End Hospital, Hertfordshire, after the retirement of the consultant in July, and the unit closed in August. Nationally, the situation is also uncertain: indications from some units suggest that, because of the purchaser-provider split, levels of funding are not assured and so beds may be closed. Concern of this kind has already been expressed for an adolescent unit in Somerset.¹

Numerous reports, consistent with clinicians' views, have acknowledged that there should be adequate provision of inpatient services for adolescents. The Royal College of Psychiatrists has estimated that four to six beds are needed for adolescents up to the age of 16 for a total popu-

lation of 250 000.² Provision is far less than this in many parts of Britain and looks set to fall further.

The problem seems to lie in the purchaser-provider split, as provider units do not need whole adolescent units for their own populations. Purchasers seem to find it difficult to recognise need, mobilise resources, and coordinate the planning of services. Furthermore, provider units with provision for inpatients may be hesitant about developing it even when purchasers collectively have an overview of need. The situation seems to be compounded by the abolition of regional boundaries and the diminution of regional responsibilities. Against this background, the provision of private services seems to be increasing. This has the implication of weakening training and research opportunities in the specialty.

Within the existing NHS structure the way forward may well lie in increased responsibility and leadership for lead purchasers, including the ability to mobilise the necessary resources.

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Acanthamoeba keratitis

EDITOR.—Recent reports of acanthamoeba keratitis in people who wear soft contact lenses in India¹² highlight the likely consequences of increased wear of such lenses in Asia without associated rigorous attention to their cleaning and disinfection. This may lead to more patients developing acanthamoeba keratitis, as has been recorded in Europe and the United States since 1975.

The similarity in presentation between acanthamoeba keratitis and keratitis with a herpetic or possible fungal aetiology is well known, but the correct diagnosis is often missed; acanthamoeba keratitis should always be considered in young adults who wear contact lenses. The infection initially presents as epithelial disease, including dendritiform lesions, together with excessive pain. This is due to invasion of corneal nerves, which can be seen with a slit lamp after several weeks.

Despite claims to the contrary, water that is not sterile should never be used to clean contact lenses. Like Sarman Singh and M P S Sachdeva,¹ we have seen patients with acanthamoeba keratitis after they used tap water to clean their contact lenses. Acanthamoeba can be found in mains and tank fed water supplies and had been identified in storage cases for contact lenses, which had probably become wet.²

Chlorine concentrations in tap water in Britain are well below the concentration necessary to inactivate the resistant cyst form of the protozoan. Similarly, commercially available tablets that generate chlorine for cleaning contact lenses are not effective against acanthamoeba cysts.⁴ Chlorine is not used in this context in the United States.

Only systems that contain hydrogen peroxide or chlorhexidine and that use sterile diluent are reliable acanthamoebicides; thiomersal products are also acanthamoebicidal but may induce delayed type hypersensitivity. Storage cases for contact lenses should be kept dry when not in use and sterilised daily.

If unrecognised, acanthamoeba keratitis may

be sight threatening. To avoid keratoplasty, the infection must be diagnosed early and antiprotozoal chemotherapy started.³ In our institute treatment is initially topical 0.02% (200 µg/ml) chlorhexidine and 0.1% propamidine, applied hourly.³ Chlorhexidine is the most effective drug in vitro, killing trophozoites and cysts, and in vivo is most effective in combination with propamidine.

The need for hygiene and disinfection must be emphasised to people who wear contact lenses. Careful control of the lenses selected and regulation of disinfecting solutions are needed in both established and developing markets to reduce the risks of acanthamoeba keratitis.

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Improving patient confidentiality

EDITOR.—The moves by the BMA and others to push for legislation to improve patient confidentiality are welcome but slightly hypocritical.¹ There are two types of situation in which the medical profession itself is technically guilty of large scale breaches of confidentiality, and perhaps it should examine its own practice and guidelines before tackling the government. The first situation concerns adult, mentally competent patients found to have a serious illness; it still seems to be common practice to inform the patient's next of kin of the diagnosis before informing the patient, if indeed the patient is informed at all. The justification usually given is that such information might harm the patient, and it is therefore in his or her best interests not to be told, at least until the relatives have been consulted. The ethical grounds for such paternalism are dubious,² and the General Medical Council's "blue book" makes clear that such unauthorised disclosure should occur only in exceptional circumstances.³

The second frequent breach occurs in the case of adult patients who present acutely with confusion or coma due to head injury, stroke, metabolic disturbance, or some such organic cause. The attending medical staff almost always obtain consent for invasive or surgical procedures from the patient's relatives, which inevitably means that they impart detailed medical information about the patient. Since such consent has no legal validity⁴ and the legal principle of necessity allows non-consensual urgent treatment to proceed, extensive and detailed (and possibly confidential) information about the patient does not need to be given. The medical staff no doubt assume that the patient would wish his or her next of kin to be informed, and this may often be the case. Neither the General Medical Council's guidelines nor the BMA's *Handbook of Medical Ethics*, however, regards assumed consent to disclosure as a valid reason for breaching confidentiality. The Scottish Law Commission recognises that for relatives to be fully informed in these circumstances a change in the rules relating to confidentiality would be required.⁵

Until the profession clarifies its own position on deliberately imparting medical information to a