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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1 Leizorovicz A, Simonneau G, Decousus H, Boissel JP. Comparing efficacy and safety of low molecular weight heparin and unfractionated heparin in initial treatment of deep venous thrombosis: a meta-analysis. *BMJ* 1994;309:299–304. (30 July.)

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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- 1 Welbourne J. Success does not ensure survival. *European Eating Disorders Review* 1994;2:118–9.
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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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- 1 Singh S, Sachdeva MPS. Acanthamoeba keratitis. *BMJ* 1994; 309:273. (23 July.)
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- 4 Seal DV, Hay J, Devonshire P, Kirkness CM. Acanthamoeba and contact lens disinfection: should chlorine be discontinued? *Br J Ophthalmol* 1993;77:128.
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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

patient's relatives it should not howl too loudly when non-medical staff inadvertently do the same.

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- 2 Gillon R. Confidentiality. *Philosophical medical ethics*. Chichester: John Wiley, 1986:106-12.
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- 4 Brazier M. *Medicine, patients and the law*. Harmondsworth: Penguin, 1987:67.
- 5 Scottish Law Commission. *Mentally disabled adults: legal arrangements for managing their welfare and finances*. Edinburgh: SLC, 1991:102. (Discussion paper No 94.)

Circumcision and uncircumcision

EDITOR,—In his review of a book on "uncircumcising" Roger S Kirby is doubtful whether circumcision desensitises the glans to sexual stimuli,¹ even though many men complain that this is the case, including some who have been circumcised as adults. I am not aware of any published objective studies comparing the sensitivity of the glans in circumcised and uncircumcised men. Furthermore, although there is obvious macroscopic change in the appearance of the glans after circumcision, no published studies of the histological changes associated with this have been carried out, so far as I know. Although the profession has been performing circumcision for a century, we have never looked into its anatomical or physiological consequences. It is unwise to ignore what patients are telling us.

The fact that this book has been written should alert us to the possibility that circumcision may be more harmful than we have supposed. The knowledge that some men perceive that the function and feeling of their penis have been impaired by this operation, usually carried out in childhood without their consent and often with little or no medical indication, should concern us and stimulate further research into penile function and sensory perception. If we have no objective information about the effects of circumcision after 100 years it is hardly surprising that the profession is ignorant about the effects of uncircumcision after 10. Until this subject is properly investigated we cannot dismiss what these men report as a placebo effect and should keep an open mind.

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- 1 Kirby RS. The joy of uncircumcising! Restore your birthright and maximize sexual pleasure [book review]. *BMJ* 1994;309:679. (10 September.)

Importance of awareness of religious customs

EDITOR,—Further to A R Gatrads' article on Muslim customs surrounding death,¹ it is important that all health care workers are constantly aware of all religious customs.

A 72 year old man was sent to an accident and emergency department by his nursing home as the nurses were concerned that he had not eaten or drunk for the previous five days. He spoke no English and had no relatives or next of kin. He had lived in the home for two years, and the history was obtained from the nurses there.

On examination there were no abnormal findings. Investigations including biochemistry,

haematology, chest radiography, analysis of a midstream urine specimen, and blood culture gave negative results.

The hospital staff realised that he was hungry and gave him food, which he ate with relish. It became apparent that the nurses in the home had failed to appreciate that their patient was adhering to the requirements of Ramadan. Meals at the home were served only after sunrise and before sunset, and during the month of Ramadan Muslims must fast during daylight hours. For following his religious beliefs he had been subjected to numerous investigations and an uncomfortable night in hospital. Thus not only medical staff but also staff in institutions need to be aware of religious beliefs. Carers in institutions are often the only source of information.

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- 1 Gatrads AR. Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants. *BMJ* 1994;309:521-3. (20-27 August.)

Help for sick doctors

Confidential help is available

EDITOR,—Liam J Donaldson and Claudia Court drew attention to the important matter of sick doctors.^{1,2} They both referred to the unsympathetic attitudes of colleagues and employers when the sickness is alcohol or drug misuse.

Doctors who have an alcohol problem often live in fear of drawing attention to themselves, this fear being shared by their spouses and families. They usually do not know how and where to seek fully confidential medical help that can be trusted and regarded as safe. They fear employers and colleagues, often without cause, and they commonly most fear the General Medical Council, again probably without cause. Because of these factors the sickness may continue unaddressed, to the detriment of all concerned. This situation should not and need not arise. There is a well established way of approaching these understandable fears of discovery.

It is regrettable that neither Donaldson nor Court mentioned the British Doctors and Dentists Group, the one peer group that can and does help doctors totally confidentially and without involving outsiders. It has existed for over 20 years and is composed of a large number of formerly addicted colleagues who have been helped to recovery and thence to normal lifestyle, including being able to work professionally in happy and permanent sobriety. Help and guidance are given freely to colleagues by colleagues who are themselves former sufferers and are now free of compulsive addiction to alcohol or drugs. The group does not involve anybody outside the medical and dental professions or anybody within the professions who has not been a sufferer. In gratitude for the help that they have received group members are only too willing to share their experiences and knowledge with any newcomer who chooses to seek out the group. The success rate is high and recovery is usual.

The Doctors and Dentists Group is available to any colleague nationwide who seeks it; it fulfils one of the recommendations in the Holland report,² in that it provides every worried doctor or his or her partner or spouse with access to a confidential telephone number over which private discussion can take place.

A telephone number for any of 12 geographical areas within the United Kingdom can be obtained by using in the first instance a private number. No surnames or addresses are asked for, and calls will be taken by a doctor who has made a happy and

successful recovery and identifies himself only as "James." Call him if you think you might need help on 021 353 6817. You will receive reassurance and understanding and will be given a contact number where help can be obtained in your part of the country.

- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
- 2 Court C. British study highlights stigma of sick doctors. *BMJ* 1994;309:561-2. (3 September.)

Occupational health departments can help and be trusted

EDITOR,—On the basis of my experiences in practising occupational medicine within the NHS I agree with Liam J Donaldson's assertion that many doctors perceive occupational health departments as irrelevant to them and as having too close a relationship with management.¹ This perception stems from a basic lack of understanding about the practise of occupational medicine and occupational health and also about the workings of a modern NHS occupational health department.

Most doctors come into contact with occupational health departments only when they start a new job or when they are called for vaccinations. This is despite the fact that most departments now provide a comprehensive range of services to other members of staff. Doctors' lack of contact with occupational health departments is probably because until recently they did not fully understand their management responsibilities within a multidisciplinary organisation and were oblivious to the fact that health and safety legislation applied to them.

The lack of trust in occupational health departments may stem from the origins of such departments as nurse sick bays and it may also reflect the lack of clinical status which afflicts departments without consultant occupational physicians. That information is leaked to management, however, is totally erroneous: occupational health departments go to great lengths to protect clinical confidentiality. Perhaps this fear is based on practices elsewhere in hospitals? Occupational physicians are skilled in assessing and managing ill health in the workplace. It is sad that doctors do not feel able to consult them more often.

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- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)

Value of Kleihauer test

EDITOR,—Jennifer K M Duguid and Imelda Bromilow question the reliability of the Kleihauer test,¹ while Elizabeth A Letsky and Mahes de Silva suggest that a higher dose of anti-D immunoglobulin would eliminate use of the test.² We report a case showing the danger of this proposal.

A woman who was group O RhD negative delivered a baby who was group O RhD positive in 1989 and was given the standard dose of 500 IU of anti-D immunoglobulin. In her second pregnancy in 1992 screening for antibodies yielded negative results at 16 and 32 weeks; at 35 weeks intrauterine death occurred without warning. Postmortem examination attributed death to transplacental haemorrhage secondary to placental infarction. She was given 500 IU of anti-D immunoglobulin. Kleihauer testing showed over 45 fetal cells per low power field, and an additional 6000 IU of anti-D