Conference Report

Wartime practice and modern medicine in a Jersey spring

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Over 80 doctors and their families judged the prospect of Jersey in the spring and two days of informative medical lectures a sufficiently entertaining combination to bring them to the Grand Hotel, St Helier, on 27 April.

Reminders of Jersey's grim five year occupation by the Germans during the second world war were never far away on the island, and appropriately the BMA's biennial scientific meeting was opened on Wednesday afternoon by a historical review of the occupation by Dr J E Lewis, who had not only worked through it but written a book of his experiences. Now in his 80s he told how stress and the common

For those in his packed audience who later visited the German underground hospital, built with slave labour, his words provided an evocative context for the exhibits.

Balance between private and public sector medicine

Next morning modern Jersey's medical services were explained by Dr G J Ince, a general practitioner in St Helier. The island's 80 000 population does not have a national health service like that of mainland Britain. Instead the States of Jersey—a title that goes back to Norman times—provide a free tax financed hospital service combined with partial reimbursement for a private, item of service style general practice. Jersey seems to have struck a balance between private and state medicine that might provoke a gleam in Prime Minister Margaret Thatcher's eye.

Dr Ince explained how the island's mixed system provided patients with a choice of general practitioner, a "market" link that encouraged effective doctoring, and an excellent standard of free hospital care—with a private wing to the main St Helier hospital for those who wanted private care. General practitioners had no formal lists but patient loyalty was strong, and a mutually agreed list of drugs was funded by the states, with all patients (no exemptions) paying a flat rate 50p per item prescribed.

Challenged by one questioner to disclose how much doctors earned and to explain the number of medically owned Rolls Royces, Dr Ince diplomatically ducked the first question and sidestepped the second by suggesting that as parking was difficult in St Helier it was probably the same Rolls Royce seeking a space.

Call for more clinical research into pain

The morning had opened with Dr P J Nash calling for clinical research into pain being accorded priority. Pain was affected by culture, learned behavioural responses, fear, and personality. The Christian ethic often implied that suffering improved the soul and that sin required punishment. Such an attitude, warned Dr Nash, a consultant anaesthetist at Basingstoke Hospital, could be counter-productive, particularly when imposed by the therapist. Fear played an important part because the cause of pain might not be understood and the patient worried about what would happen. He suggested that the more prone the patient was to anxiety or depression the greater would be the level of pain experienced because, although the threshold of pain varied little among individuals, tolerance to it did—and that was affected by anxiety and depression.

Experience in pain clinics—most were a one man service with long waiting lists—showed that counselling was vital, indeed, its effectiveness emphasised the value of clinics, which should, he urged, work closely with general practitioners and other clinicians. Dr Nash advised that better results were obtained by using analgesic drugs regularly and treating side effects such as constipation before they developed. Sometimes mechanical aids, surgery, and radio-therapy might also be helpful. Numerous non-specific treatments

The president of the BMA, Mr D E Bolt; Dr J E Lewis; and the governor of Jersey, His Excellency, Admiral Sir William Pillar.

cold had virtually disappeared during the occupation, and how despite the meagre diet imposed by rationing fertility had increased, with mothers producing large babies. People had been too concerned with staying alive to get depressed. His recollections of rationing struck a chord among the more senior members of his audience, but the sparse diet and enforced exercise had had their advantages. Several obese patients had lost weight with, Dr Lewis recalled, women regaining their girlish figures but lacking the dresses and make up to show them off.

such as heat and cold (controllable by the patient), vibration, acupuncture, hypnosis, and biofeedback could also relieve pain. But often all that patients required was reassurance that they could still lead normal lives despite the persistence of pain.

Mastectomy fear deters women from breast screening

Why did women fail to use a free breast screening service when there were 14 000 deaths from the disease each year? Fear of mastectomy was one reason, according to Mr J Meirion Thomas, consultant surgeon in oncology at the Westminster Hospital, London. But if mammography, which showed up a tumour before it was palpable, was widely used there would be a 30% reduction in mortality and a greater chance of the victim's breast being preserved. The recommendations in the Forrest report for mass screening every three years for women aged 50 to 65 coupled with improvements in imaging methods would, Mr Thomas said, lead to a pick up rate of about four affected women per 1000. This was the age group with the greatest risk, yet only 60-70% of women in it came for mammography. If the 40 to 50 age group was included about four cases in 10 000 would be identified.

As to self examination, he said that there was no evidence that it reduced mortality. By the time lumps were palpable they might well be 2 to 4 cm in size. Concluding by arguing in favour of aspiration cytology as an invaluable investigation, Mr Thomas also criticised the principle that all breast lumps should be removed by biopsy. In his view such investigation was no longer tenable.

Good results in angioplasty study

Intervention cardiology had belatedly reached the United Kingdom, reported Dr D E Jewitt, consultant cardiologist at King's College Hospital, London. But it was now a mainstay in treating patients with coronary artery disease as well as those with stenotic lesions of the aortic, mitral, and pulmonary valves. With the latest fine diameter flexible wires and balloons coronary angioplasty had improved dramatically and was now the treatment of choice for many lesions. At King's in the past four years angioplasty had been performed in 525 patients, with 640 vessels being treated. The primary success rate had been 90%; in the 57 unsuccessful interventions either the balloon wire would not cross the lesion in the artery lumen or the surgeon had been unhappy about the relief of the stenosis. There had been only three deaths, but 14 patients had been referred for urgent coronary surgery and 18 patients had subsequently had elective surgery.

A high success rate had been achieved in patients with stable and unstable angina, but what, he asked, of the long term success rate? The rate of restenosis in 1987 over the first 12 months had been about 20%, but once the technique had been used successfully it could usually be repeated, and the second angioplasty seemed to last much longer. Dr Jewitt declined, however, to forecast whether angioplasty could prolong a patient's survival.

Advice for general practitioners

In the wake of the recent brain tissue transplants in patients with Parkinson's disease the next subject inevitably attracted close attention from the media table. Dr F G Gibberd, a neurologist from the Westminster Hospital, resisted any temptation to speculate on the prospects for such transplants, telling a questioner that the technique had yet to be evaluated. His presentation remained down to earth, proffering advice on helping patients with the disease to remain independent. His exposition on how and when to start anticholinergic and dopaminergic drugs and when to intervene with physiotherapy and equipment provided general practitioners with some clear guidelines. Warning his audience never to encourage patients to retire, he said that the aim was for patients to continue with normal activities for as long as possible. Dr Gibberd also had a word on the importance of consulting and supporting the carers.

"The carer with an ulcer on the foot could cause more problems than the same ulcer on the foot of the patient"—a sentiment applicable well beyond the care of patients with Parkinson's disease.

Also of particular interest to general practitioners was an excursion from the pharmaceutical industry piloted by Dr A J Martin, director of Duphar Laboratories. His report on a study of the demography of affective disorders in general practice was the mid-afternoon presentation. General practitioners are familiar with the "fat file" patient presenting with a variety of complaints for which no organic cause can be found. A contribution to learning more about such chronic attenders came from a three year series of clinical trials on a new psychoactive agent: these had provided information on the presenting features of nearly 6000 patients seeing their general practitioners. The studies confirmed that somatic symptoms were the common presenting features of patients with affective disorders. Patients might be of any age group, were three times more likely to be women than men, complained of one or more somatic features (often headaches and asthenia), had been treated with drugs (commonly anxiolytics and hypnotics), and almost half of the episodes had had an identifiable precipitating factor. Over a quarter of the patients surveyed had taken psychotropic drugs. Dr Martin suggested that, although initially, the use of rating scales required more of the doctors' time, in the long run time would be saved by the "recognition and correct treatment of the patient."

Four of the speakers—Mr J Meirion Thomas, Dr P J Nash, Dr D E Jewitt, and Dr G J Ince who chairs the Jersey division of the BMA.

Food allergy—fact or fiction?

Dr P J Kumar, senior lecturer and consultant physician at St Bartholomew's Hospital, was in no doubt that food allergy existed. She admitted, however, that the prevalence was unknown, the symptoms were vague, the tests were imprecise, and the diagnostic procedures difficult. Such an uncertain catalogue no doubt explained her cautious approach to the subject. People who suffered from urticaria after eating strawberries or from gastrointestinal upsets after eating shellfish were no problem: they avoided the offending food. But whether symptoms such as depression, headaches, tiredness, panic attacks, or other non-specific features were related to a true food allergy was questionable. In such patients the reactions were often delayed beyond 48 hours and it was hard to establish the cause and effect between the offending agent and the symptoms.

Dr Kumar's contribution ended Thursday's sessions, and any member of the audience with incipient food allergy would have had an opportunity for some discreet testing at the hospitable evening visit to the Jersey Wildlife Preservation Trust, where the chief

veterinary officer, Mr Tony Allchurch, explained the trust's work in improving the survival rates of threatened animal species.

Too much sun; too much alcohol

On Friday morning the audience was left in no doubt that too much sun sharply raised the risk of white people developing skin cancer. Dr R C D Staughton, a consultant dermatologist at the Westminster Hospital, London, blamed the Western passion for a sun tan for the increase in skin cancers. Although they were increasing faster than other cancers—in Connecticut the incidence of melanomas had increased 500% in the past four decades—Dr Staughton's message was that they were preventable and curable if detected early. Melanomas were less common (only 1-2% of all neoplasms) but more dangerous than basal or squamous cell carcinomas; their precise relationship to sun exposure was, however, not clear. There were, however, several risk groups: people who had long sunny holidays in childhood, those who had intermittent but intense exposure to the sun—for example, urban office workers taking their annual sunbathing holiday—those with a history of severe sunburn, and people with pale skin which did not readily tan.

The incidence of malignant melanomas per 100 000 of white people increased the nearer they lived to the equator. The highest known incidence was in Queensland, Australia, at 40 new cases a year per 100 000 population, whereas England's figures were just over two for men and over four for women, with Scotland, curiously, rather higher. Dr Staughton was convinced, however, that the public increasingly realised the need to seek medical advice if they had unusual moles and patches.

The serious hazards of alcohol to the physical and mental health of people of all ages is a message that bears repeating and repeating. In Jersey the message was brought from the Charing Cross Hospital in London by Dr I M Murray Lyon. Though a gastroenterologist, he was warning the meeting about the manifold and long known dangers of alcohol for the fetus. The incidence of fetal alcohol syndrome—growth deficiency, central nervous system defects, distinctive facial features, and congenital abnormalities in the offspring of mothers consuming over 80 g of alcohol (over a bottle of wine a day) was 1 in 600 in Sweden and 1 in 750 in Seattle (United States), but probably much lower in most of the United Kingdom. Even more moderate consumption still increased the rates of spontaneous abortion, stillbirth, and damage to the fetus.

Gleam of optimism on AIDS

Dr Peter Smart, recently the honorary secretary of the BMA's Jersey division, coordinated the local input at the Jersey meeting—

and the social side of the meeting was much appreciated—while Dr Brian Gazzard, consultant physician at St Stephen's Hospital, London, once again advised the association on possible subjects and speakers. On this occasion Dr Gazzard also wound up the session with a tour de force titled "AIDS—are we winning?" Introducing him, Dr John Marks, who chaired the final session, told the still full hall that Dr Gazzard had treated Britain's first victim of AIDS, subsequently looking after 400 sufferers from the spreading disease.

Though packed with information his address, as Dr Gazzard admitted, failed to answer the title. Even so, he made some arresting points. Among them were:

- The exponential rise of affected patients at St Stephen's, with the 220 admissions in the first three months of 1988 representing a 30% increase on the total numbers of admissions for 1986
- The rise (to around 170 a week) in the number of tests for the human immunodeficiency virus at St Stephen's since the government's 1986-7 publicity campaign has not been matched by the increase in seropositive results, reflecting a hard to treat cohort of the "worried well"
- An extrapolation from clinical experience at St Stephen's Hospital suggested 15 years as the median time for developing AIDS after HIV infection
- Evidence pointed to a cumulative incidence of AIDS in 95% of those infected by the virus
- The impressive array of scientific and medical talent being applied to AIDS had meant that within five years of discovery the complex HIV was the best understood plant or animal virus
- Infected lymphocytes were probably the transmission vehicle for the virus, hence the high infectivity of blood and serum from seropositive individuals
- The positive response of the homosexual community to health education
- The high rate of heterosexual infection among citizens of some African cities—40% of all women patients at one city hospital
- The Western world was hovering on the borderline of a heterosexual epidemic.

Dr Gazzard reported that about 15 potential vaccines were being developed world wide—an American one was shortly to be tested on 24 volunteers at his hospital—but the big ethical question—and one the BMA should study—was whether human volunteers should be used to test a vaccine's efficacy, given the lack of an animal model for testing.

Forecasting that a vaccine could take five or more years to develop, Dr Gazzard nevertheless offered a gleam of optimism by suggesting that "a small shift in sexual behaviour could be enough to avert an epidemic."

Can the diagnosis and management of giant cell arteritis be safely based on plasma viscosity assessment, and is it safe to abandon estimating the erythrocyte sedimentation rate altogether?

The measurement of plasma viscosity is now a well standardised technique reliably reflecting changes in plasma proteins, mainly globulin and fibrinogen. It is probably a more accurate measure of plasma protein abnormality than is the erythrocyte sedimentation rate, which may be falsified by changes in red cells. Although a viscometer is expensive, it can give rapid results within minutes after centrifugation of the sample whereas the measurement of the erythrocyte sedimentation rate takes at least an hour.

The erythrocyte sedimentation rate is widely used as a measure of disease activity in giant cell arteritis and is valuable both in diagnosis and as a guide to treatment. In chronic giant cell arteritis the erythrocyte sedimentation rate may remain abnormal after the viscosity has returned to normal, and this may indicate the need for continued steroid treatment.¹ This may not be important, however, since symptoms and not the erythrocyte sedimentation rate are the best guide for deciding when to discontinue treatment.²

If you already have a viscometer why not use it? If not, continue with the

valuable, inexpensive, and well tried measurement.—R W ROSS RUSSELL, consultant physician, London.

1 Harkness J. In: Lowe GDO, Barbenel JC, Forbes CD, eds. *Clinical aspects of blood viscosity and cell deformability*. Berlin: Springer-Verlag, 1981:79-87.

2 Graham E, Holland A, Avery A, Ross Russell RW. Prognosis in giant-cell arteritis. *Br Med J* 1981;282:269-71.

Correction

Dr Gee cleared of serious professional misconduct

An error occurred in our account of Dr Sidney Gee's appearance before the General Medical Council (16 April, p 1108). The last sentence in the first paragraph of the section headed "Side effects of the drugs" should have read: "Dexamphetamine increased heart rate and could cause sleeplessness; atropine, which Dr Gee had also given his patients, caused blurring of vision and made the passing of urine more difficult." The impression was erroneously given that these side effects had been attributed to thyroid extract.