Many deaths in known drug misusers will not have been included in study

EDITOR—We were unable to find a definition of “accidental” in Roberts et al’s report on accidental drug poisoning in teenagers.¹ We then realised that a definition was implicit because the study is restricted to deaths ascribed by the Office for National Statistics to the international classification of diseases (ninth revision) codes E850-869, but we still found it difficult to relate their findings to our experience as pathologists. In England and Wales, accidental deaths are investigated by coroners, and they make a distinction between “accidental death” and “misadventure.” In practice, truly accidental ingestion of drugs is rare. The common situation is that the drugs are ingested deliberately, but the fatal outcome was not anticipated by the subject—a circumstance regarded by coroners as “misadventure,” not “accident.” Understanding emerged only when we telephoned the Office for National Statistics for clarification, when we learnt that both misadventures and accidents are coded within E850-869.

Roberts et al have dealt with another important confounding factor by recognising that many deaths from poisoning are coded as E980-983, codes used when it has not been determined whether the poisoning was accidental, suicidal, or homicidal—a circumstance corresponding to coroners’ open verdicts. They do not, however, seem to have accounted for another situation—that coroners can ascribe deaths to drug misuse or drug dependence. These deaths are coded as 304-305, codes that take precedence over E850-869 in statistics from the Office for National Statistics; 304-305 can be used even if terms such as drug misuse, or various synonyms, do not appear on the coroner’s death certificate but merely appear in accompanying detail provided by the coroner.

Our experience of studying deaths related to methadone² indicates that most deaths in subjects in methadone maintenance programmes occur in ways appropriately regarded as “accidental” or “misadventure,” but many of these deaths, and deaths from various other causes in known drug misusers, are likely to be coded as 304-305; they will therefore not appear in Roberts et al’s figures. It may well be that correction of this minor oversight will not change their conclusions, but we think it important that this assumption should be confirmed; at the very least, it will enhance comparison with other similar studies.³

Ian Roberts *Lecturer in pathology*

Emyr Benbow *Senior lecturer in pathology*
University of Manchester, Manchester M13 9PT

Alison Cairns *Specialist registrar in pathology*
Leeds General Infirmary, Leeds LS1 3EX

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MRI is best technique for imaging acute osteomyelitis

EDITOR—We are surprised that Wilkinson does not find magnetic resonance imaging helpful in the diagnosis of acute osteomyelitis.¹ This technique is particularly suited to the evaluation of osteomyelitis because of its superior soft tissue contrast and multiplanar imaging. Anatomical detail is much better than with isotope studies, and subtle abnormalities are more easily appreciated than with computed tomography or radiography.^{2,3} Isotope bone scanning is often not helpful, particularly in the early stages of infection. One comparative study quoted sensitivities and specificities of 88% and 93% respectively for magnetic resonance imaging, as compared with 61% and 33% respectively for isotope bone scanning.⁴ Magnetic resonance imaging also has the advantage of not subjecting the patient to ionising radiation.

Ultrasonography can give only limited information about the bones and soft tissues. We would therefore support the position of Smith⁵ and suggest that all children suspected of having acute osteomyelitis should have magnetic resonance imaging and that isotope bone scanning should be considered obsolete for this indication. When making a diagnosis it is surely best to use the diagnostic test that is known to be the most sensitive and specific and has the best positive predictive value. We believe that there is an overwhelming body of evidence that magnetic resonance imaging is the best diagnostic test in acute osteomyelitis.

Philip T McAndrew *Consultant radiologist*
Caroline Clark *Consultant radiologist*
Radiology Department, Kirkcaldy Acute Hospitals
NHS Trust, Kirkcaldy, Fife KY2 5AH

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Cognitive behaviour therapy has role in treatment of medically unexplained physical symptoms

EDITOR—As a general practitioner and cognitive behavioural therapist, I was encouraged by the message in Mayou and Sharpe’s editorial on treating medically unexplained physical symptoms.¹ Training doctors to extend themselves beyond the classical medical model and to think simultaneously in physical, psychological, and social terms has been central to vocational training in general practice from its inception. Identifying physical problems is the main part of our job; most doctors are sensitive to the

importance of social factors, while social interventions, when appropriate, consist largely of delegation to other professionals. Intervening at a psychological level, however, has been far more problematic, largely because the theoretical models and techniques available have simply not been adequate in terms of time, efficiency, and effectiveness.

Cognitive behavioural approaches are proved not only in the management of unexplained physical symptoms but in many other clinically relevant areas.² In addition, many developments in consultation technique already contain a cognitive element.^{3,4} Perhaps most importantly, cognitive behavioural interventions can fit within the time frame of a “normal” consultation in general practice.⁵

As Mayou and Sharpe describe, an essential strength of the cognitive behavioural model is its integrative approach, constructing an overall meaning from the patient’s distress simultaneously in physiological, behavioural, affective, and cognitive terms, all within a social context. This contrasts with the traditional approach, in which both doctors and patients have been driven to seek isolated causes, framed in dualistic terms and 19th century concepts, derived from the success of the germ theory of disease.

The authors make suggestions for the implementation of this approach and outline the obstacles. These obstacles should not be underestimated for they represent a major paradigm shift in our thinking and attitudes. However, the potential benefits that may be derived from introducing and integrating a cognitive approach into our clinical practice—in terms of reduced distress for the patient and the doctor, reduced costs, and prevention of iatrogenic damage—are enormous. I look forward to the consequences.

Steve Williams *General practitioner*
The Garth Surgery, Westgate, Guisborough,
Cleveland TS14 6AT

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Trial of breast cancer screening in younger women is necessary

EDITOR—Baum has written an interesting letter¹ in response to Fletcher’s editorial pointing out the numerical value of screening under the age of 50.² He may, however, have misinterpreted Fletcher’s slant on the “wisdom of the organisers of the British trial.”

My reading of the editorial suggested that the wisdom was in undertaking a trial rather than deciding on screening without a trial. I think it highly likely that his mathematics and

the trial will coincide in proving that screening under the age of 50 has backing only from the emotive and from neither the scientific nor the economic communities.

MD Lewars *Consultant radiologist*

South Essex Breast Screening Service, Westcliff on Sea, Essex SS0 0SB

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Greater attempts must be made to promote positive roles for elderly people

EDITOR—It is disappointing to read that the issue of family support for China's aging population is a "bad" consequence of the country's policy of controlling fertility.¹ Population aging is an inevitable consequence of successful social and economic development (including maternal and child health programmes), which results in demographic transitions from high to low mortality and fertility.² Labelling the social consequences of such trends as "bad" adds weight to negative images of elderly people in society.

Elderly people often have a major role in child care (and also in the care of frail and disabled people), which permits younger women to take up wage earning jobs. In poorer countries many elderly people remain economically and socially productive beyond usual retirement ages. Most families—in the West, in Asia, and elsewhere—want to support their elders when they become frail. Projections of crude aged dependency ratios (ratios of the population aged ≥ 60 to that aged 15-59) give little indication of true levels of dependency (which are affected by levels of unemployment, disability, and pensions) but give a negative stereotype of all elderly people as dependent and in need of support. Furthermore, elderly people in China have an important, but currently untapped, role as the repositories of a history and culture that has gone through substantial and rapid changes over recent years.

Aging populations require policy responses, but it is clear that no single formula or solution will fit all circumstances equally well. Public and private sector pensions and legislative and cultural support for unpaid family and community support may all be required, but the balance of each will differ over time and from place to place.³ A first and essential step, however, is to view "the elderly" as people with rights and not as problems.

Ageist societies deny these possibilities for elderly people and persist in promoting stereotypes of old age that bear little relation to reality. It is a pity that researchers at the Institute of International Child Health are not more aware of these issues, which are so relevant to many of their activities. The promotion of positive roles for elderly people,

family support, and intergenerational solidarity would be improved if organisations and individuals involved in health and social development were more aware of the positive aspects of population aging. Such awareness is now increasingly pursued by international agencies such as the World Health Organisation. Efforts from the academic sector would be timely and welcome.

Shah Ebrahim *Professor of clinical epidemiology*
Department of Primary Care and Population Sciences, Royal Free Hospital School of Medicine, London NW3 2PF

Alex Kalache *Head*
Aging and Health Programme, World Health Organisation, Geneva

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Alliance between medical profession and consumers already exists in breast cancer

EDITOR—The alliance between the medical profession and consumers that Liberati calls for in his editorial¹ is already a reality in the Britain; was promoted by its chairman (me) at the exploratory meeting of the Cochrane Collaboration Breast Cancer Review Group in Sydney, Australia, in August 1995; and is collaborating with interested clinicians in Germany to set up a similar group. It has received NHS funding for a project, "Using a consumers' advisory group to increase accrual into trials," to explore a methodology through use of focus groups. The results of this activity have gone forward to help shape the national randomised trial of hormone replacement therapy in women with early stage breast cancer. I, as the chairman of the Consumers' Advisory Group for Clinical Trials, and two representatives of patients from the focus groups are on the steering committee of this ground breaking trial. The provision of suitable and adequate information is seen as crucial: its provision has been guided by the views of women obtained in a project run by the consumers' advisory group in collaboration with the patient involvement unit at Mount Vernon Hospital.

The Consumers' Advisory Group for Clinical Trials is a small working group of professionals and patients that was established in September 1994. Its formation reflected a growing recognition by the health profession of the value of input from patients into the design of clinical trials.² In 1995 it was registered as a charity and was welcomed by the health select committee in its report on breast cancer,³ and its activity is furthered by the United Kingdom Coordinating Committee for Cancer Research. It has had opportunities to provide comment on other trials—for example, the Arimidex tamoxifen alone and in combination trial.

Our main activities are to work directly with the profession on protocols, to devise and improve methodologies, and to advance public education about clinical trials. We believe that awareness of the activities of other support and information organisations, and collaboration with them and others working in breast cancer will help achieve these aims. We wish to promote a new attitude to research based on the belief that patients and the profession alike have a responsibility to further the progress of research as rapidly as possible. Our type of collaborative activity is endlessly repeatable, in other countries and other disciplines.

Hazel Thornton *Chairman, Consumers' Advisory Group for Clinical Trials*

"Saionara," 31 Regent Street, Rowhedge, Colchester CO5 7EA

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Practice in prescribing emergency contraceptives in A and E departments varies

EDITOR—The management of patients who present to accident and emergency departments requiring emergency contraception remains controversial and inconsistent. From a total of 400 consultants in accident and emergency medicine in the United Kingdom we randomly selected 130 and sent a questionnaire about prescription of the emergency contraceptive pill. Altogether 102 consultants (78.5%) replied, and the table gives their responses.

Responses of 102 accident and emergency consultants questioned about prescription of emergency contraceptive pill

Response	No
Never prescribe	39
Always prescribe	10
Prescribe only if patient can't see general practitioner within 72 hours	45
No fixed policy: at attending doctor's discretion	8

Our results show an alarming conflict of practice, which leaves patients unsure whether they will receive the required help when attending accident and emergency departments. Despite reports showing the safety of emergency contraception in all but a few situations, strong beliefs still persist among doctors that it is medically unsafe and should therefore be prescribed with great care.¹ Other studies have shown that providing women with a leaflet about emergency contraception was an effective means of communication.² Practices used by many of the respondents to our questionnaire were at variance with recommendations published recently encouraging the deregulation of the morning after pill.^{3,4}