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# LETTERS

## GYNAECOLOGICAL EXAMINATIONS

### Good not bad medicine



We read with interest Dr Spence's article "Bad medicine: gynaecological examinations" and agree with the assessment of the low sensitivity and specificity of bimanual pelvic examination and the importance of ultrasound imaging for patients with pelvic or abdominal symptoms.<sup>1</sup>

We read with great concern, however, the recommendation that speculum examination of the cervix is unwarranted in cases of painless vaginal discharge. Painless vaginal discharge is not only a common benign symptom but also a cardinal symptom of cervical cancer and genital tract malignancy. NICE guidelines for the assessment of cancers rightly recommend a speculum examination in the assessment of women with vaginal discharge.<sup>2</sup> A recent report highlighted increasing incidence and mortality from cervical cancer in England, particularly in women aged 25 to 29.<sup>3</sup> Cervical cancer survival rates in the UK are worse than in other European countries.<sup>4</sup> Late diagnosis is the major contributor to poor cancer survival in the UK and it is therefore important that healthcare professionals are vigilant to the presentation and early diagnosis of cervical cancer.<sup>5</sup>

Good medicine involves a thorough history, physical examination, and investigations, which provide not only the reassurance of common benign diagnoses, such as a physiological discharge, but also the assessment of uncommon but potentially fatal conditions. Cervical examination is neither "illogical" nor "unscientific" and should be part of the assessment of all women with vaginal discharge to improve the early diagnosis of cervical cancer.

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**Competing interests:** None declared.

- 1 Spence D. Bad medicine: gynaecological examinations. *BMJ* 2011;342:d1342. (2 March.)
- 2 National Institute for Health and Clinical Excellence (NICE). Referral for suspected cancer. 2005. [www.nice.org.uk/CG027](http://www.nice.org.uk/CG027).
- 3 Profile of cervical cancer in England: incidence, mortality and survival. National Cancer Intelligence Network Trent Cancer Registry. 2011. [www.ncin.org.uk/view.aspx?rid=496](http://www.ncin.org.uk/view.aspx?rid=496).
- 4 Abdel-Rahman M, Stockton D, Rachet B, Hakulinen T, Coleman MP. What if cancer survival in Britain were the same as in Europe: how many deaths are avoidable? *Br J Cancer* 2009;101 (suppl 2):115-24S.
- 5 Richards MA. The size of the prize for earlier diagnosis of cancer in England. *Br J Cancer* 2009;101 (suppl 2):125-9S.

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### Author's reply

Thanks for the response but I must completely disagree.<sup>1</sup> Firstly, the evidence that cervical cancer is linked to vaginal discharge is observational and case based.<sup>2</sup> There are no prospective data and I would assert that discharge is so common and non-specific as to be useless as a determining risk factor for cervical cancer.

Secondly, you are extrapolating experience from secondary care without knowledge of the prevalence of vaginal discharge in the community. Many women present to pharmacies and take empirical treatments; should they all have speculums too? Thirdly, what is the negative predictive value for inspecting the cervix? Your policy suggestion is utterly disproportionate, inflicting unnecessary, unpleasant investigations on millions of women with no scientific evidence of benefit. To limit the impact of cervical cancer in young women we should ensure better uptake of smears and human papillomavirus vaccination, as this has evidence of benefit.

Finally, my point was that so called routine speculum examination for swabs traditionally taken for endocervical sampling (the medical dogma of my education) is no longer necessary.<sup>3</sup> Clearly speculums have a role in

women with irregular bleeding, atypical and persistent discharge, but not routinely in those presenting with discharge in primary care. Practice should change, for it is bad medicine.

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**Competing interests:** None declared.

- 1 Butler J, Barton D, Shepherd J, Reynolds K, Kehoe S. Good not bad medicine. *BMJ* 2011;342:d1760.
- 2 National Institute for Health and Clinical Excellence (NICE). Referral for suspected cancer. 2005. [www.nice.org.uk/CG027](http://www.nice.org.uk/CG027).
- 3 Spence D. Bad medicine: gynaecological examinations. *BMJ* 2011;342:d1342. (2 March.)

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## OLD DRUGS, NEW TRICKS

### Use of intravenous lipids in clinical toxicology

The discovery that intravenous lipids can counter the toxicity of local anaesthetics has been tremendous for a condition that was previously associated with a high mortality.<sup>1</sup> Owing to the single mindedness of one group,<sup>2</sup> this component of parenteral nutrition has become the saviour of nerve blocks and clinical toxicology.

More recently, intravenous lipids have been used successfully in overdoses of lipid soluble drugs such as verapamil, propranolol, bupropion, and some pesticides even after prolonged cardiopulmonary resuscitation.<sup>3</sup> Although case reports provide only anecdotal evidence, they all showed a temporal association between provision of intravenous lipids and cardiovascular stability.

Readers should consider using intravenous lipids for drug overdoses in failed resuscitations, where outcomes are usually poor.

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- 1 Shaughnessy AF. Old drugs, new tricks. *BMJ* 2011;342:d741. (9 February.)
- 2 Weinburg GL, VadeBoncouer T, Ramaraju GA, Garcia-Amaro MF, Cwik MJ. Pretreatment or resuscitation with a lipid infusion shifts the dose-response to bupivacaine-induced asystole in rats. *Anesthesiology* 1998;88:1071-5.
- 3 Rothschild L, Bern S, Oswald S, Weinberg G. Intravenous lipids emulsion in clinical toxicology. *Scand J Trauma Resusc Emerg Med* 2010;18:51.

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## HOSPITAL RECONFIGURATION

## Southeast London—the unspoken problem

Palmer's report on hospital reconfiguration in southeast London omits some important points.<sup>1</sup> He notes that the substantial Private Finance Initiative (PFI) payments for several local hospitals have contributed to the massive financial problems but does not stress that any non-PFI partner in a reconfiguration will become the sacrificial lamb. Restructuring hospital payment to cover PFI costs would simply prop up a failed financial system, and exorbitant interest and service charges would continue unchecked.

My hospital can no longer deal with medical emergencies, and the withdrawal of all intensive care means that complex or high risk surgery cannot be done. I can no longer admit emergencies from outpatients, but have to ask colleagues at other sites to take them over. The use of medical beds as a "step-down" facility has led to early and inappropriate transfers from acute sites and has been bad for continuity of care and lengths of stay.

There is no guarantee that a community hub model will work. The collapse of morale has already led to a staff exodus. If commissioning bodies are cash strapped, they will not be able to take on loss making organisations, and if reconfiguration just shuffles pieces on the chess board, without removing any, hospital trusts will save nothing.

I do not believe that we are using the right "R" word. Reorganisation and reconfiguration are an irrelevance. Rationing is what we need to talk about.

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1 Wise J. Report calls for National Commissioning Board to have strategic commissioning role. *BMJ* 2011;342:d1355. (3 March.)

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## GPS AND CHILD PROTECTION

## Medical records should be shared by all

Forget communication between health workers and social care workers.<sup>1</sup> I wait for the day when GPs, health visitors, and hospital doctors (casualty and paediatric wards) have access to the same medical records. In this day and age, it is baffling why secondary care still uses paper records. Most neonatal intensive care units have electronic records that are shared across the neonatal network. Why can't we all share the same system?

The Munro report further highlights my belief that we are more concerned with the processes (ticking boxes) than the outcome.

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1 Learner S. After Baby P: can GPs follow child protection guidance? *BMJ* 2011;342:d707. (2 March.)

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## Online conferencing might be the answer

The traditional office based child protection conference is a poor use of professionals' time.<sup>1</sup> Online conferencing offers advantages—in particular, background reports from conference participants could be loaded as text before the online conference starts. This would allow participants to study the case at their own speed, and at a convenient time, and would reduce the amount of "live" discussion needed. GPs would more easily be able to spare 15-20 minutes sitting at their desks than the two to three hours typically required to attend a meeting at the local council's offices.

An important challenge to this approach is security. It should not prove impossible, however, to develop secure networks and protocols that would enable online interchange of highly sensitive information with little risk. The costs would be quickly recovered in the time saved by all the professionals involved.

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1 Learner S. After Baby P: can GPs follow child protection guidance? *BMJ* 2011;342:d707. (2 March.)

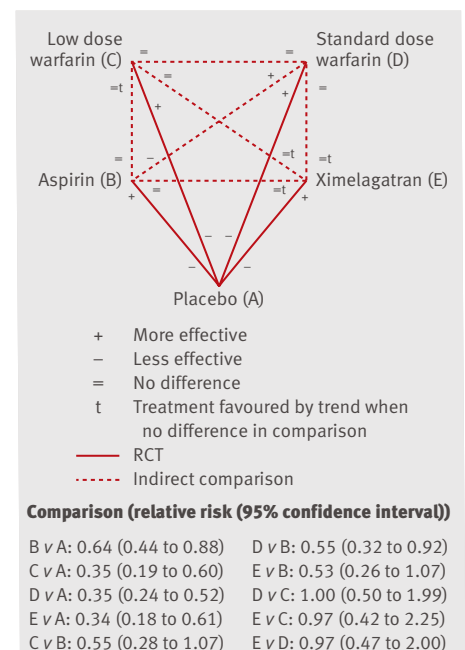
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## NETWORK META-ANALYSIS

## Results can be summarised in a simple figure

Studies based on network meta-analysis are increasingly being published,<sup>1</sup> but little attention has been paid to how the information generated is best summarised graphically. Most authors favour multiple forest plots, with some advocating the use of increasingly complex graphical methods.<sup>2</sup>

Non-specialist readers need a figure that limits the information presented to the results of individual comparisons in terms of significance. A few examples of such figures have been published,<sup>3 4</sup> and an open source program to draw them is freely available.<sup>5</sup>

Comparison of stroke prevention treatments in non-rheumatic atrial fibrillation.<sup>6</sup> RCT=randomised controlled trial

These simplified figures represent each direct comparison by a solid line and each indirect comparison by a dotted line, with the statistical results for each comparison given as relative risk (or odds ratio) and 95% confidence interval. Symbols such as + and – can be added to show the treatment favoured by the clinical result (figure).<sup>4</sup>

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- 1 Trelle S, Reichenbach S, Wandel S, Hildebrand P, Tschanen B, Villiger PM, et al. Cardiovascular safety of non-steroidal anti-inflammatory drugs: network meta-analysis. *BMJ* 2011;342:c7086. (11 January.)
- 2 Salanti G, Ades AE, Ioannidis JPA. Graphical methods and numerical summaries for presenting results from multiple-treatment meta-analysis: an overview and tutorial. *J Clin Epidemiol* 2011;64:163-71.
- 3 Phung OJ, Scholle JM, Talwar M, Coleman CI. Effect of noninsulin antidiabetic drugs added to metformin therapy on glycemic control, weight gain, and hypoglycemia in type 2 diabetes. *JAMA* 2010;303:1410-8. [http://jama.ama-assn.org/content/suppl/2010/04/09/303.14.1410.DC1/JWE05034\\_04\\_14\\_2010.pdf](http://jama.ama-assn.org/content/suppl/2010/04/09/303.14.1410.DC1/JWE05034_04_14_2010.pdf).
- 4 SIFO (Italian Society of Hospital Pharmacists) website. Simplified graph. [http://www.sifoweb.it/pdf/notizie/sifo\\_graficoatrialfibrillazione.pdf](http://www.sifoweb.it/pdf/notizie/sifo_graficoatrialfibrillazione.pdf).
- 5 SIFO (Italian Society of Hospital Pharmacists). GRNETMA. EXE. [www.osservatorioinnovazione.org](http://www.osservatorioinnovazione.org).
- 6 Cooper NJ, Sutton AJ, Lu G, Khunti K. Mixed comparison of stroke prevention treatments in individuals with nonrheumatic atrial fibrillation. *Arch Intern Med* 2006;166:1269-75.

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