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LETTERS

PAIN CONTROL IN HYSTEROSCOPY

Finesse, not local anaesthesia

ANTONIA REEVE/SPL

The take home message of the systematic review and meta-analysis on local anaesthesia during outpatient hysteroscopy is misleading.[1]

The conclusion, "Injectable, preferably paracervical, administration of local anaesthetic should be used for women undergoing hysteroscopy as outpatients to reduce the amount of pain experienced," is based on five randomised trials, two of which found paracervical blocks to be ineffective.[2 3] The benefit reported in the three other studies was clinically modest, two showing a one point reduction in pain on a 10 point scale. Even the authors of the study showing the largest effect (6.66 to ›1.55 on a 20 point scale with 5 being "low pain") did not support the routine use of paracervical anaesthesia when very thin hysteroscopes are used. Statistical significance must not be confused with clinical significance.

Another argument against routine paracervical blockade is the principle of first do no harm. Such injections can cause vasovagal reactions in up to a third of patients.[3]

Cooper and colleagues also recommend topical anaesthetics before applying a tenaculum. Although sensible, this ignores the fact that with narrow hysteroscopes and modern techniques such as "no touch" (vaginoscopic) hysteroscopy combined with a suitable sampling device the cervix rarely has to be held either for hysteroscopy or endometrial biopsy.[4] Many of the studies analysed by Cooper and colleagues were done more than 10 years ago and are out of date.

Narrow hysteroscopes and vaginoscopy are widely accepted as being more important to ensure patient comfort than local anaesthesia.[5] Instead of recommending anaesthesia to cover up the deficiencies of larger hysteroscopes, uncomfortable speculums, and tenaculums, we should be recommending the adoption of a minimalist approach and reliance on technical finesse rather than metal in the vagina.

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LICHEN SCLEROSUS

Biopsy to exclude malignancy

The role of biopsy in excluding malignancy as well as confirming diagnosis should be emphasised for lichen sclerosus.[1]

Although comparatively uncommon, vulval cancer is increasing in incidence, especially in younger women. In the United Kingdom in 2006 over 1000 women were diagnosed with vulval cancer, 15% of them under 50; in 1975, 6% of women were under 50.[2]

Squamous cell carcinoma of the vulva is most commonly seen secondary to chronic dermatoses such as lichen sclerosus. It may, however, be associated with human papillomavirus infection, whose increasing prevalence in the UK may account for the rising incidence of squamous cell carcinoma of the vulva, especially in younger women.[3] Malignancy of either aetiology is preceded by vulval intraepithelial neoplasia, which commonly presents as localised pruritus or "lumps" on the vulva.[4] However, because of its heterogeneous features, vulval intraepithelial neoplasia cannot be reliably distinguished clinically from squamous cell carcinoma or benign vulval dermatoses.

Similarly, anal squamous call carcinoma is preceded by anal intraepithelial neoplasia, for which there is no specific clinical presentation. Areas of anal intraepithelial neoplasia may be scaly, raised, erythematous, pigmented, or white or show no visible change.[5] White areas may be indistinguishable from lichen sclerosus by the naked eye.

Because squamous cell carcinoma and anal and vulval intraepithelial neoplasia lack pathognomonic features, white perineal plaques, even with clinical features of lichen sclerosus such as itch or soreness, cannot be assumed to be benign. A biopsy should be performed in all patients not only to confirm lichen sclerosus but more importantly to exclude malignancy.

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Competing interests: None declared.

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SPANISH TRANSPLANTATION MODEL

We need different comparisons

Why does the transplant lobby persist in quoting the rates of organ donation in numbers of organ donors per million of the population?[1] Surely we should be talking about the numbers of organ donors per 1000 brain dead patients in intensive care? Or—if we are considering donation after cardiac death—the number of organ donors per 1000 potential organ donors who are having their intensive treatment withdrawn and die within the hour?

Organ donation has nothing to do with the population of a country but everything to do with laws related to drink driving, the use of seat belts, the state of the roads, gun law, violent crime, and the excellence of the emergency services. It is affected by the availability of intensive care beds, other resources for the care of critically ill patients, and the quality of intensive care. Obviously if you

manage a severe head injury effectively you will reduce your pool of donors.

Yet again the transplant lobby tries to blame intensive care specialists for not identifying potential organ donors. Having worked in the United Kingdom and Australia, both of which have comparatively low organ donation rates per million of the population, I know this is rubbish. Clearly we have a problem if the conversion of potential to actual donors is only 50% (as it is in the UK and Australia), but this is more likely related to a vibrant multicultural richness.

I feel sympathy for my intensive care colleagues in Romania and Bulgaria for being on the receiving end of a European directive devoid of sense and irrelevant to their medical context.[1]

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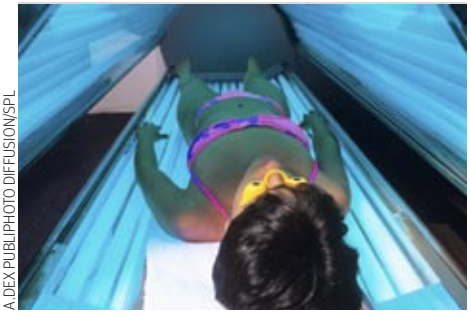
SUNBED USE IN CHILDREN

The bigger picture



A.DEX PUBLIPHOTO DIFFUSION/SPL

Historically, tones of skin colour differentiated the tanned working classes from the upper classes. Even today, in some ethnic groups, especially from Africa[1] and South Asia,[2] a fairer skin is much desired. The desirability of tanned skin in Western society has been largely attributed to the "caramel-skinned" Parisian singer Josephine Baker and the French fashion designer Coco Chanel.[3]

In not adding a ninth question asking young sunbed users why they wanted a tan, Thomson and colleagues missed the chance to provide further insight into sunbed use in children aged 11-17.[4] Much of the current trend may have its roots in the way society and the media select, promote, and popularise current role models, whose lifestyles and behaviour are copied by their followers. These society and media created notions reinforce the beliefs of younger people, providing a false boost to self esteem and a sense of fitting in.

O'Riordan et al found a significant association in adolescent females between frequent use of tanning bedsand being highly concerned about body weight, frequent dieting, laxative use and induced vomiting, binge drinking, recreational drug use, and having friends who placed a lot of importance on being thin.[5] All of these factors are strongly associated with eating disorders, body dysmorphic disorder, anxiety disorders, and depression.

Although stricter legislation or a ban may decrease sunbed use and the resultant skin disease, the wider picture must be considered. Education about health concerns is necessary not only for adolescents but also for schools and parents. The media and society have a large responsibility in portraying healthier lifestyles.

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Competing interests: None declared.

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MULTIDISCIPLINARY CANCER TEAMS

Crucial for population health

Although formal evidence on the cost benefits of clinical decision making by multidisciplinary teams in cancer may be lacking,[1] the Cancer Reform Strategy identifies such team meetings as important for collecting and validating clinical cancer data, particularly comorbidities, performance status, and stage of disease. Multidisciplinary teams also have a role in evaluating performance for populations of cancer patients by collecting accurate staging data at source and in a more timely manner than currently occurs with routine cancer registration.

Problems with collecting staging data by multidisciplinary teams include the many different data collection systems currently in operation across hospitals: some still paper based, some on bespoke locally developed spreadsheets, only a few linked to trusts' main patient administration systems. Several initiatives are tackling this issue, and the requirement for trusts to deliver data electronically to cancer registries by the end of March 2011 is also key.

Earlier diagnosis improves cancer outcomes.[2] With accurate staging data at time of diagnosis (or soon after) we can debate the true impact of delay on survival and monitor the impact of interventions to improve earlier diagnosis. Multidisciplinary teams in cancer therefore have an important role in improving the health of the population.

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NICE ON RECENT ONSET CHEST PAIN

Squaring the guideline circle

The recent guidelines from the National Institute for Health and Clinical Excellence (NICE) on the management of chest pain state that angina can be clinically diagnosed and treatment started in patients at high risk of coronary artery disease.[1] This is a welcome vindication of what used to be standard practice. They also state that exercise electrocardiography (ECG) should not be used to newly diagnose angina.

Both of these statements contradict the quality and outcomes framework (QOF) CHD2 indicator for which general practitioners are rewarded financially for ensuring that at least 90% of patients with a new diagnosis of angina are referred for exercise ECG or further specialist assessment. Other QOF indicators create perverse financial incentives for performing activities that evidence suggests is wrong—for example, reducing glycated haemoglobin in diabetic patients to below 7%, which seems to be associated with poorer outcomes.[2]

So who is going to square the circle of these contradictory guidelines? Will we still be rewarded financially for acting contrary to the NICE recommendations? General practitioners are fed up with a stick and carrot approach that fails to recognise the complexity of the science and art of medicine.

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Competing interests: None declared.

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