fered a myocardial infarction would be facilitated by better communication between the general practitioner who has the key role, the hospital and the doctor working in industry.

Following the symposium, a brief questionnaire completed by participants showed that more than half had changed their practice in direct response to what they had heard. The most frequently cited changes were those related to getting people back to work and their normal duties much earlier than before, certainly by six weeks after uncomplicated myocardial infarction or cardiac surgery.

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References

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2. Carson P. Activity after myocardial infarction. *Br Med J* 1984; **288:** 1–2.

How Effective is Acupuncture in the Management of Pain?

Sir,

Dr Lewith has earned our gratitude for reviewing the literature on the efficacy or otherwise of acupuncture as an analgesic, (May *Journal,* p.275). The lesson is that this subject is asking for attention.

If, however, he wishes his favourable verdict to be convincing, he must know that it is not enough to give a superficial appearance of open-mindedness; he must learn to think with as much rigour as he would expect to find in a well-designed clinical trial.

Three classical examples of sloppy thinking:

1. *Begging the question,* p.276. 'Therefore, studies using random needling are perhaps best thought of as an evaluation of acupuncture versus a less effective form of needle puncture.' Who said 'less effective'?
2. *Not comparing like with like,* p.276. 'The acupuncture group,' (compared with the placebo group,) 'had needles inserted into their tender trigger points on the back.' Acupuncture points and 'tender trigger points' only occasionally coincide. Acupuncture, unfortunately, is not defined here, but few if any of its practitioners restrict their needling to 'tender trigger points'.
3. *Non sequitur.* Dr Lewith reports his own results in the treatment of postherpetic neuralgia. 'Acupuncture resulted in improvement in 24 per cent of patients and the placebo in a 21 per cent response.' These figures are so bizarre coming from a writer who is happy to accept a 30 per cent placebo response that one wonders if there is not a misprint somewhere. They make a poor introduction to his glib first conclusion, that 'Acupuncture has an analgesic effect in approximately 60 per cent of patients suffering from chronic pain.'

As I have practised acupuncture myself, I would love to think acupuncture as effective as some claim, but faint praise is no more damning than muddled over-praise. The subject yells for unbiased attention.

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Sir,

Dr G. Lewith (May *Journal,* p.275) has pointed out how fashionable acupuncture has once again become in the last few years. He reviews the results from 20 trials that have attempted to evaluate acupuncture as a treatment for painful musculoskeletal conditions. He concludes that these studies show an analgesic effect in 60 per cent of patients suffering from chronic pain; that the effect of acupuncture was greater than that of placebo and that acupuncture was as effective for musculoskeletal pain as were more conventional treatments.

Of the 20 studies that he cites, he acknowledges that 11 of them (including his own study) showed no significant advantage of acupuncture over placebo or conventional therapy. Six studies had serious methodological flaws that cast doubt on the validity of the conclusions, or numbers so small that the likelihood of detecting a significant difference, where in truth none exists, becomes embarrassingly large. Three studies showed significant differences between the effects of acupuncture and placebo or conventional treatment.

In weighing up the conclusion to be drawn from these studies, Dr Lewith has his foot on the scales. Surely the balance doesn't swing in favour of acupuncture. His conclusions are all the more remarkable, when of the same studies, he pointed out in the *British Medical Journal* that 'These trials have not, however, convinced the sceptics. Most were poorly designed, with small numbers of patients, muddled entry criteria, short follow-up and no clear definition of success or failure.'[1] We would have to effectively suspend our critical faculties to become true believers on the evidence so far. P. Skrabanek has reviewed the literature on controlled trials in acupuncture[2] and emerged with his critical faculties intact, concluding that the claims made for acupuncture have no scientific validity.[3]

The current vogue is for fringe medicine, better known as alternative medicine, and now to be known as holistic medicine. We should leave our minds open to the claims of acupuncture, homoeopathy, transcendental meditation, chiropractic and other more exotic techniques. But not so open that our brains fall out.[4] So far, their only tangible benefit has been to make poor men richer.

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3. Skrabanek P. Acupuncture and the age of unreason. *Lancet* 1984; **i:** 1169–1171.
4. Glymour C, Stalker D. Engineers, cranks, physicians, magicians. *New Eng J Med* 1983; **308:** 960–963.

Sir,

Readers of Dr Lewith's article (May *Journal,* p.275) on acupuncture in pain management may be left with the impression that acupuncture is a single form of treatment. Acupuncture incorporates a number of widely differing diagnostic and therapeutic approaches. Therefore, in comparing it to other methods, it is vital to include some details of the approach that was used and something of the competence and experience of the practitioner.

The most common ways that acupuncture is practised in this country are:

1. The 'traditional' approach using concepts and terminology which seem archaic, foreign and scientifically unacceptable to western trained doctors.
2. Formula or 'cookbook' techniques which involve a scanty basic knowledge of acupuncture and use relatively fixed combinations of points for treatment.
3. The use of trigger points and the periosteum for needling.
4. Uneasy and irrational combinations of all three.

Whilst the traditional approach may be effective in the hands of an experienced practitioner, the other methods are often no more effective than random needling.

Based on pioneering work by Voll, Nogier and others in Germany, Austria and France, other more scientifically acceptable methods of acupuncture diagnosis and treatment are currently being used in this country. These consider acupuncture points and meridians as part of an energy system in the body which can be explained in biophysical terms. Treatment is carried out after a proper clinical assessment and subsequent careful measurements of the electrical behaviour of meridian system and acupuncture points. The resultant accurate needling combined with the use of electroacupuncture achieves effective and lasting results in painful disorders and in many conditions seen in general practice.

I agree with Dr Lewith that further competent research is badly needed but this must include a careful assessment of the acupuncture treatment system itself if it is to remain acceptable as a rational therapy to western doctors and a suitable subject for scientific investigation.

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Association of Course Organizers

Sir,

We would like to announce the formation of the Association of Course Organizers for Vocational Training in the British Isles.

The aims of the Association, supported by 80 per cent of all course organizers, are:

1. To explore and develop the role and responsibility of course organizers
2. To plan and implement regular educational opportunities for course organizers.
3. To collect and provide information on all matters relating to the work of course organizers.
4. To represent course organizers on appropriate local and national representative bodies.

The Association looks for support from the College in achieving the above aims.

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Intrauterine Devices

Sir,

I was interested to read an article in the April edition of *The Practitioner* on the use of IUDs in a North London practice.

The conclusions arrived at are well documented in that we are all aware of the small but significant risk of salpingitis and subsequent infertility caused by this method of contraception. For this reason enlightened doctors do not usually recommend IUDs for nulliparous girls.

I see in this report that 48 per cent of users were nulliparous, 5 per cent contracted salpingitis and 6 per cent became pregnant with a higher incidence of both complications in the nulliparous patients.

It is interesting that the authors commented on the distorting effect of item of service fees on surgical procedures. I understand that this is documented in the USA but not here. However, I think that we can make an educated guess as to the result.

May I suggest that one way of discouraging inappropriate IUD prescribing would be for the fee to be halved and a similar fee to be paid for the less invasive procedure of fitting a diaphragm. It would be illuminating to see the effect of this on IUD item of service claims!

Perhaps the College might interest itself in this question as it would appear to come within its brief for maintaining 'standards'.

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Ice Cream Headache

Sir,

I report a case of an unusually severe single attack of migraine or possibly cold-induced carotid vasospasm.

A thirteen year old schoolboy who had gone out to watch football returned home early. His mother noted that he was hot, sweaty and staggering and that his speech was garbled. She thought he had been glue sniffing.

The main complaints were of frontal headache, feeling sick, legs 'like jelly' and difficulty in seeing. On examination there was no evidence of glue sniffing, the boy was fully conscious and had no sign of head injury or meningeal irritation. However, his gait was unsteady and he had a moderate expressive and receptive dysphasia. Neurological examination was otherwise negative, and the signs regressed spontaneously during the course of the examination. Further information obtained at this stage indicated that the precipitating factor seemed to have been the consecutive consumption of three large ice creams. Within an hour of arriving home all the symptoms and signs had disappeared.

Raskin and Knittle, studying the incidence of ice cream headache (the brief frontal pain which results from cold food contacting the roof of the oropharynx) showed that 93 per cent of their group of migraine sufferers had had such an experience compared with 31 per cent of the control group.[1]

It would appear that this patient could have had a classical migraine attack, with an unusual and severe prodrome, the precipitating factor possibly being the prolonged exposure of the oropharynx to a low temperature. The mechanism of the trigger in this case may therefore be quite different from a postulated humoral factor where chocolate or cheese are precipitants.

I would be interested to hear of any similar case.

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Lessons from Abroad

Sir,

Your editorial (March *Journal,* p.123) concerning the 'chilling news from America' that proprietary profit-making entrepreneurs in primary care could actually benefit their patients and have room for charity, would not suit the myths required by the government practitioners of a politically organized health care monopoly.

In the free market, judgement 'on the best service possible' is made by the patient, while 'consensus on clinical policies' dictated by those who know best arbitrates for your patients. Your comment on the good intentions of the practitioners 'to review the pattern and outcome of their work carefully' suggest a divine quality missing on this side of the Atlantic where our brothers in the Law happily test our rationalizations. This helps to keep our wits sharp and our comments unpretentious.

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