Letters

All letters are subject to editing and may be shortened. Letters of no more than 400 words should be sent to the *BJGP* office by e-mail in the first instance, addressed to **jhowlett@rcgp.org.uk** (please include your postal address and job title). Alternatively, they may be sent by post (if possible, include a copy on disk). We regret that we cannot always notify authors regarding publication.

When the drugs don't work — or do they?

In response to Alec Logan's Viewpoint[1] in the Back Pages of the August issue of the *BJGP*:

The Alzheimer's Society campaigns are driven by our 25 000 members — people with dementia and their carers. On their behalf we lobby for both improved access to drugs and better care services. Donations from pharmaceutical companies in 2002–2004 totalled £68 258. This represents just over 0.1% of our £30 million income in 2003–2004. Relying on this income is not a feasible or desirable option.

We have always been careful to make clear that these drugs are not a miracle cure and we agree that where the drugs are not working they should be withdrawn. However, these drug treatments are hugely valued for the benefits they bring to people and full evidence based reviews have been completed by the *Cochrane* collaboration — all of which have concluded significant clinical benefit.

If this were not the case, the Alzheimer's Society, along with thousands of people with dementia and their carers, would not be spending so much effort trying to ensure that NICE revises its draft guidance and NHS access to these drugs is not withdrawn.

We are helping to fund research to find new treatments and possible cures, but until then, these drugs are the best treatments that people with dementia have available. There are no alternatives. We firmly believe that people with dementia deserve access to both effective drug treatments and quality social care services. It is not an either/or scenario.

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All GPs are different and some are more different than others

The causes of the wide variation in GPs' behaviour referring their patients to specialists is an under-researched subject, but is likely to become more scrutinised with the advent of cost conscious NHS initiatives like 'practice-based commissioning' and 'payment by results'. O'Sullivan *et al*'s study[1] showed that most of the variation in referrals remains unexplained, and suggests that 30% is attributable to differences in morbidity.

This study was dependent on the choice of diagnostic codes by GPs. Is this a important flaw in the study? There is a widespread belief that GPs often choose the diagnostic label after they decide how to manage a patient, and the diagnostic label will support the action (such as referral to specialist care) that they have already determined. In the absence of objective diagnostic codes for all clinical encounters, information derived from these codes informs us more about variation in GPs' behaviour than patient morbidity. Future research should focus on why GPs seem to manage similar problems very differently.

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1. O'Sullivan C, Ozmar RZ, Ambler G, Majeed A. Case mix and variation in specialist referral in general practice. *Br J Gen Pract* 2005; **55:** 529–533.

The 'bulging fontanelle' to be included in primary care algorithms

Major changes have taken place in the delivery of out-of-hours primary care. There is a growing trend towards help-lines and drop in centres. Many patients will often first speak to a nurse, who will triage the calls with or without the help of guidelines or algorithms. The concern arises as to whether this is safe. In the last few years of my training, I have come across two children whose parents mentioned a 'bulging fontanelle' as part of their concerns, and who were falsely reassured over the phone.

Both infants presented with a non-specific febrile illness. They contacted NHS Direct in one case, and a local nurse-led call centre of the local GP cooperative in the other. This last centre used the same guidelines/algorithms as NHS Direct. In both cases, parents mentioned the protruding soft spot during the structured interview. Neither nurse nor protocol picked up on this significant

finding, and parents were reassured and advised to give paracetamol and ensure adequate fluid intake. After presentation to the hospital, one child turned out to have a viral illness, while the other had pneumococcal meningitis and required a prolonged hospital stay. The helplines have since addressed the issue by updating their protocol and providing further training for their nurses.

In both these cases an important sign, that is the bulging fontanelle, was missed, and parents were falsely reassured. In medical school, presentation of meningitis in children is well-rehearsed, including all rare and non-specific presentations, to ensure this disastrous condition is recognised early. I doubt that any doctor would have missed this sign. I would encourage all primary care trusts to review their out-of-hours service, and to review protocols and guidelines they hold on children presenting with non-specific febrile illness, and in particular, include this subtle but important sign. I would like to advocate a low threshold for babies and infants to be reviewed by a doctor in any case.

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An observational study of escalator ambulation

In an age of increasing overweight and obesity it is important that we perform purposeful exercise and promote it to our patients. I attended the American College of Cardiology meeting in Orlando held over 6–9 March 2005. To see if physicians would 'practice what they preach', I sat at the bottom of an escalator and recorded the activity of attenders on the escalator over a 1 hour period of time (11:47 am to 12:47pm 8 March 2005). Two-thirds of the 234 users of the escalators made no movement other than getting on or off the escalator despite there being no obvious impediment to them doing so. We ask our patients to change their lifestyles and yet clearly fail to do so ourselves.

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Homeopathy — a response

I hope I may be allowed to reply to the several letters[1–4] commenting on my deliberately provocative personal column on homeopathy.[5] All four authors assert their belief that homeopathy 'works', two of them making the claim that the fact that it works in babies and animals proves that this is more than a placebo effect. None of them cites any objective source of evidence for their beliefs, nor do they address the main point of my piece, which was to try to lay out the extraordinary, and to me still literally incredible, rationale that lies at the heart of homeopathic practice.

I agree wholeheartedly with Peter Hanrath and Andrew Hillam regarding the direction of much of our current target- and contract-driven practice, as I hope my more recent piece on statins illustrates.[6] I have no quarrel with the use of complementary therapies per se, but I do think that such therapies should be subject to the same scientific scrutiny as is now expected of conventional therapies. As a novice in acupuncture I am well aware that much of its benefit is likely to be due to non-specific effects, and I don't agonise too much over its probable additional specific, neurologically-mediated mechanisms — but I welcome research that explores both these areas. It is my firm belief that the scientific approach can be brought to bear on the still mystifying power of such factors as suggestion, the personality of both doctor and patient, the nature of the relationship between them and so on.

Nigel Williams (in his letter)[1] mentions a meta-analysis[7] in the *Lancet* in 1997. More recently *Bandolier*[8] published a 'systematic review of systematic reviews' of homeopathy and concluded as follows: 'Much of the argument about homeopathy ends up being about trivial differences of little or no clinical relevance. Until large well-conducted trials tell us differently, the conclusion is that homeopathy does not work …'. A search of the *Bandolier* website[9] leads to a number of commentaries on trials of homeopathy, not one of them showing any clear evidence of benefit. *Clinical Evidence*[10] contains only one reference, that being a negative report of two RCTs for homeopathic treatment of warts. The *Cochrane* collaboration[11] adds nothing further.

Finally — and hot off the press — Shang *et al* from Switzerland[12] report on a comparison of 110 homeopathy trials and 110 matched trials of conventional treatments. They found insignificant evidence for a specific effect of homeopathic remedies, and strong evidence for specific effects of conventional interventions. They conclude that, 'This finding is compatible with the notion that the effects of homeopathy are placebo effects'.

It is this absence of evidence for any specific effect of homeopathic remedies that led me to use the word 'deception' in the title of my column; it is the absence of harm, and the apparent non-specific beneficial effects of the homeopathic approach that made me qualify it as 'benign'. None of your correspondents has convinced me that this is an unfair description.

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2. Hanrath P. Letter: Homeopathy — a benign deception? *Br J Gen Pract* 2005; **55:** 556.
3. Doney D. Letter: Homeopathy. *Br J Gen Pract* 2005; **55:** 638.
4. Hillam A. Letter: The merits of homeopathy. *Br J Gen Pract* 2005; **55:** 716.