Letters

Evidence based diagnosis

We may need to be open to new ideas

Editor—If evidence based diagnosis is still in the dark ages, as Delamothe writes,1 then so is evidence based treatment. The doctor's job is to choose the right treatment. If the diagnosis is wrong then the treatment will be wrong. Inaccurate diagnoses will also affect clinical trials. A treatment may be “evidence based” because it has worked in a published study, but some patients who would have responded might have been left out because of diagnostic inaccuracy while some patients with no prospect of responding might have been included incorrectly.2

Evidence based diagnosis is about convincing others using shared rules of evidence that a diagnosis (and its implications in terms of treatment) should be accepted by others. Evidence is gathered from the individual's facts in addition to pointing to facts relating to that diagnosis in the literature.3

Bayes's theorem uses unconditional initial prior probabilities. Diagnostic leads are based on conditional probabilities and are used to initiate diagnostic thought processes.4 However, closely related theorems can be used to interpret diagnostic leads, which allow doctors to reason with diagnostic evidence in a more familiar way, thus reducing misunderstandings.5 So to improve evidence based diagnosis we also need to collect better data on diagnostic leads.

The published evidence given for a diagnosis and any related actions cannot realistically be assembled when actually seeing a patient. A draft evidence based rationale might be prepared in advance. It would have to be capable of being accessed in seconds to provide evidence in support of a suspected diagnosis and decision arrived at by using kindness, imagination, and common sense. It could be put into context by inserting the patient's details into the draft evidence summoned up from a computer. If we are to make progress and allow evidence based diagnosis to emerge from the dark ages then in addition to doing more of the same, we may also have to be receptive to new ideas.

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1 Delamothe T. Diagnosis—the next frontier [Editor's choice]. BMJ 2006;333:430-4. (26 August.)
2 Llewelyn DEH, Garcia-Puig J. How different urinary albumin excretion rates can predict progression to nephropathy and the effect of treatment in hypertensive diabetics. BJUM 2004;141:5.
3 Thakor-eff S. A patient's journey: our special girl. BMJ 2006;333:430-1. (26 August.)
5 Bianchi MT, Alexander BM. Evidence based diagnosis: does the language reflect the theory? BMJ 2006;333:442-5. (26 August.)

Multiple tests with multiple responses are important

Editor—Diagnostic reasoning is never carried out by using a single test alone: doctors should take a history first, do an examination, then do the tests.6 Each stage adds variables to a multivariable rather than a univariable prediction process, already well recognised in prognostic studies.7

Using log_{10} likelihood ratios and assuming independence of the predictor variables is appealing to me.8 Computer scientists would use the log, unit, the information bit. This method seems to be equivalent to the naïve bayesian classifier, used for filtering out spam mail, and is relatively easy to program.

The tests often have more than just a single purpose—for example, some recent electronic responses have argued about performing lumbar puncture for scan negative, rapid onset headache.9 It is not just for diagnosing or excluding subarachnoid haemorrhage but relevant to diagnosing meningitis. Binary outcome logistic models do not reflect clinical reality. That is why clinical medicine is harder than mathematics.

You might have to go back to the patient to clarify the history and examination in light of unusual test findings. The real diagnostic process is nowhere near as linear and directed as implied in the research protocols.

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1 Bianchi MT, Alexander BM. Evidence based diagnosis: does the language reflect the theory? BMJ 2006;333:442-5. (26 August.)

Terminology is unsatisfactory

Editor—Undoubtedly the failure of diagnostic theory to catch on is partly due to unsatisfactory terminology.10 “Sensitivity,” and to a lesser extent “specificity,” are words of multiple meanings that can be confusing in the context of test evaluation. The terms “true positive rate,” “true negative rate,” “false positive rate,” and “false negative rate” are much less ambiguous. Likelihood ratios are also more easily understood, comparing as they do the proportions of positives or negatives in the diseased with the reference population. These are the “weights of evidence” defined by Pierce.11 It can be helpful too to recall that odds ratios are the ratio of the positive and negative likelihood ratios—rationcination with a vengeance.

“Positive predictive value” is another term best discarded. “Posterior probability (or odds)” emphasises the process as well as the outcome. Nevertheless, the probabilists would do well to remember that many clinical rules of thumb include a dimension of utility. “Never diagnose a condition you can’t treat” is an irritating remark that is difficult to confute.

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Competing interests: None declared.

1 Bianchi MT, Alexander BM. Evidence based diagnosis: does the language reflect the theory? BMJ 2006;333:442-5. (26 August.)
2 Pierce R. A Bayesian account of independent evidence with applications. Philosophy of Science (Proceedings) 2001;S125-140.

Prior probability saves money, time, and possibly lives

Editor—Bayesian concepts of prior probability come to the aid of clinicians who aim to expedite diagnosis and treatment.1 In one series comprising 63 patients in whom the final diagnosis was choleodocholithiasis, four patients in whom this diagnosis was subsequently validated by endoscopic retrograde cholangiopancreatography bypassed
ultrasonography purely on the strength of the index of clinical suspicion—that is, prior probability—on the basis of their clinical and biochemical stigmata. 2 Strictly, given that ultrasonography may itself be falsely negative for stigmata such as dilatation of the common bile duct or calculi in the common bile duct. 3 Potentially life saving treatment is also expedited by bypassing potentially redundant “routine” investigations—an important issue for patients with ascending cholangitis. 1

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1 Bianchi MT, Alexander BM. Evidence based diagnosis: does the language reflect the theory? BMJ 2006;333:142-5. (26 August.)

What about the patients?

Editor—Test results are not just of interest to clinicians. Patients are commonly told, “Your blood results were absolutely normal.” Although clinicians may know exactly what this phrase is intended to mean, patients are likely to interpret it differently. The test may have been a full blood count with urea and electrolytes, but the “your blood is normal” message may be interpreted as meaning that everything in the blood is normal—possibly up to and including HIV status. Such a message may have profound healthcare implications. In an ideal world, this phrase would never be used. In reality, it is used all the time. The timely focus that Bianchi and Alexander have put on diagnosis and investigations may be an opportunity to deal with this use of terminology.

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1 Bianchi MT, Alexander BM. Evidence based diagnosis: does the language reflect the theory? BMJ 2006;333:142-5. (26 August.)

Subarachnoid haemorrhage: lumbar puncture for every negative scan? Authors’ reply

Editor—Coats suggests that a lumbar puncture should not be undertaken after a negative computed tomogram for every 2823 NSAID prescrip-
tions. 2 At least 83 patients need misoprostol prophylaxis to prevent one NSAID-related gastrointestinal bleed, although a subsequent systematic review was unable to calculate any figure from the available evidence. 3 Using Aronson’s table of what frequency qualifiers presently mean to people, we would have to say that NSAIDs “never” cause the problems described above, and the most effective prophylactic measure against these risks “never” works. Well I never.

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Strange things happen when we never qualify the frequency

Editor—Aronson illustrated that the definition of frequency qualifiers cannot be taken for granted. 1 However, we often omit them completely as we condense complex research findings into terse one liners. This can dramatically distort our perception of risk.

For example, nobody would disagree that non-steroidal anti-inflammatory drugs (NSAIDs) are an important cause of avoidable iatrogenic mortality in elderly patients, largely through ulceration and perforation of the upper gastrointestinal tract. These ideas profoundly influence prescribing: doctors may avoid their use altogether or co-prescribe prophylactic measures.

Reputable studies show that, for NSAID users over the age of 75, the annual risks for serious gastrointestinal bleed and death are 1 in 110 and 1 in 650, respectively, and that there is one episode of ulcer bleeding in every 2823 NSAID prescriptions. 4 At least 83 patients need misoprostol prophylaxis to prevent one NSAID-related gastrointestinal bleed, although a subsequent systematic review was unable to calculate any figure from the available evidence. 5

Using Aronson’s table of what frequency qualifiers presently mean to people, we would have to say that NSAIDs “never” cause the problems described above, and the most effective prophylactic measure against these risks “never” works. Well I never.

1 Aronson J. Sometimes, never. BMJ 2006;333:415. (26 August.)
Early intervention in acute renal failure

Assessing fluid status is important

Editor—Bennett-Jones suggests that doctors take a pragmatic and prompt approach to intravenous fluid replacement, based on the patient’s blood pressure, capillary refill time, and venous filling.1 Assessment of fluid status needs to be much broader and incorporate a full history of any fluid gains and losses from the patient, relatives, nurses, fluid balance charts, prescription charts, anaesthetic records, and daily weights. The patient should be assessed for symptoms of hypovolaemia, which can include postural dizziness, thirst, dry mouth, reduced urine output, feeling cold, shivering, shortness of breath, and altered mental state.

Furthermore, in examining the patient, of central importance are blood pressure, a postural fall in blood pressure, tachycardia (or rarely bradycardia with severe hypovolaemia) and postural changes in pulse rate, whereas capillary refill time is not of proved diagnostic value in adults.2 Other signs that should be sought are jugular venous pressure, pallor, peripheral perfusion, the dryness of mucous membranes, and the presence of pulmonary and peripheral oedema. If doubt about volume status remains, central venous pressure monitoring should be considered.

This careful assessment of fluid status is crucial before the instruction to give intravenous fluids, not loop diuretics to avoid a rate of fluid administration for each patient with their uraemia ratio on admission. We excluded from the analysis patients with chronic renal failure or upper gastrointestinal haemorrhage, or who were taking drugs known to affect this ratio.

Across all admissions, the volume of fluid prescribed over the first hour of treatment ranged from 85 ml to 1250 ml. The degree of correlation between rate of administration and uraemia ratio was low, with a correlation coefficient for the complete data set of only 0.23 (95% confidence interval: 0.05 to 0.40). This indicates that just 5.3% of the variation in rate of fluid administration can be explained by an association with uraemia ratio (and hence degree of intravascular volume depletion).

The most likely explanation for this finding is a failure by the admitting doctors to appropriately diagnose and treat hypovolaemia. In UK hospitals, fluid prescription is typically left to the most junior members of medical and surgical teams, among whom inadequate knowledge is common.3 Training and practice clearly need improving, and courses such as ALERT (acute life-threatening events—recognition and treatment) may be a good start.

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Evidence of inadequate intravenous fluid treatment in UK hospitals

Editor—Bennett-Jones emphasises the importance of prompt administration of intravenous fluids for early intervention in acute renal failure.1 Determining the appropriate rate of fluid administration must include an estimate of the degree of intravascular volume depletion at the start of treatment, with most aggressive volume expansion targeted at patients with the greatest deficits. To determine whether this simple principle is followed in practice, we audited intravenous fluid prescriptions for 114 consecutive acute surgical admissions to three UK centres (one teaching hospital and two district general hospitals).

A raised ratio of blood urea to creatinine is commonly used as a quantitative reference standard for the diagnosis of hypo- volaemia,2 and can be seen in patients with reduced effective intravascular volume secondary to sepsis.3 We therefore compared the initial rate of intravenous fluid administration for each patient with their uraemia ratio on admission. We excluded from the analysis patients with chronic renal failure or upper gastrointestinal haemorrhage, or who were taking drugs known to affect this ratio.

Across all admissions, the volume of fluid prescribed over the first hour of treatment ranged from 85 ml to 1250 ml. The degree of correlation between rate of administration and uraemia ratio was low, with a correlation coefficient for the complete data set of only 0.23 (95% confidence interval: 0.05 to 0.40). This indicates that just 5.3% of the variation in rate of fluid administration can be explained by an association with uraemia ratio (and hence degree of intravascular volume depletion).

The most likely explanation for this finding is a failure by the admitting doctors to appropriately diagnose and treat hypovolaemia. In UK hospitals, fluid prescription is typically left to the most junior members of medical and surgical teams, among whom inadequate knowledge is common.3 Training and practice clearly need improving, and courses such as ALERT (acute life-threatening events—recognition and treatment) may be a good start.

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Exempting mental health units from smoke-free laws

Nicolette can have beneficial effects

Editor—Campion et al argue that psychiatric units should not be exempt from smoking bans, but they do not discuss several issues.1

Nicolette can have beneficial effects on mood, anxiety, and cognition, and it ameliorates some of the side effects of psychotropic drugs. Acute nicotine withdrawal can exacerbate psychiatric symptoms and cause diagnostic difficulty. Cigarette smoke also induces the metabolism of many different psychotropic drugs.2 Therefore, enforcing acute smoking cessation in mentally unwell patients may cause serious problems, including making the patient feel worse, clouding the clinical picture, worsening the side effects of prescribed drugs, and precipitating drug toxicity. When the patient starts smoking again after discharge, the risk of relapse is increased (secondary to re-stimulation of the hepatic microsomal enzyme system and associated reduction in plasma concentrations of prescribed drugs).

To enforce a smoking ban on patients who are free to leave hospital and who stay of their own volition may be considered acceptable. However, to enforcing this on patients who are detained against their will under mental health legislation seems unreasonable, especially in Scotland where the principles of least restrictive alternative and reciprocity are recognised.3

Even in studies where motivated patients use smoking cessation aids in the absence of acute mental illness, only the minority remain abstinent in the medium to long term. Is there any clear evidence that enforcing a blanket smoking ban on acutely unwell psychiatric patients will result in longer term benefit for them in the real world?4

I would love to live and work in a smoke-free environment. However, I remain unconvinced that we are treating patients as we ourselves would wish to be treated if we ban them from smoking against their will when mentally ill. It is one thing to help smokers give up when they are well enough to make an informed choice for themselves. It is quite another to enforce a smoking ban on acutely unwell patients.

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Issue should no longer be ignored

Editor—Campion et al wrote on no longer exempting mental health units from smoke-free laws.1 By allowing smoking in psychiatric units the government will only increase stigma towards psychiatric patients when the Royal College of Psychiatrists is trying hard to reduce it.

Admission of smokers with mental illness to smoke-free psychiatric units may lead to behavioural deterioration, but some evidence from the United States refutes this argument. In 1987 the Board of Trustees of Southwest Washington Hospitals instructed
a smoking ban in all of its facilities, including general psychiatry units. The changes were introduced successfully with minimal impact on the successful function of the psychiatric service.¹ The implementation of a smoking ban, establishing a smoke-free psychiatric service and abolishing tobacco products, created minor management difficulties on a locked psychiatric unit.² The effects of prohibiting cigarette smoking on the behaviour of patients on a 25 bed psychiatric inpatient unit were assessed immediately after implementation of a smoking ban and two years later. No major behavioural disruptions were observed after the ban. The number of calls for security assistance, physical assaults, instances of leather restraints and of seclusions, and discharges against medical advice did not increase significantly immediately after the restriction on smoking or two years later.³

Signs and symptoms of nicotine withdrawal and alterations in psychopathology were evaluated among acutely ill psychiatric patients admitted to a hospital with a smoking ban. Despite subjects’ reports of feeling distressed and of experiencing nicotine withdrawal symptoms, abrupt cessation of smoking did not significantly affect either the severity or the improvement of psychopathological symptoms during admission. The authors report no compelling reasons to reverse the smoking ban.

With the growing concern for the harmful effects of cigarette smoking and passive smoking and the evidence above, exemptions for mental health units from smoke-free laws can no longer be ignored.

Letters

Three Bs, please

Don’t despise excellence

Editor—Choosing medical students is more difficult than it might seem at first glance.¹ Lowering entrance requirements for medical school is not the answer—medical school and subsequent medical practice require intellect and application. Equally important, favouring mature students with a first degree or qualification in time may lead to a situation where a pre-med qualification becomes an advantage and may discriminate against school leavers.

Perhaps the fairest way to level the playing field between state and private schools is to introduce a standardised national qualification for entry to medical school entry, in addition to A level results. In that way, problem solving skills, knowledge, and emotional intelligence could all be assessed, without fear of bias towards one group.

In the meantime, to make excuses for the failure of the state school system to achieve good A level grades, by suggesting that the private schools are “puffed up,” is not helpful. Rather, ask why state schools achieve such low results, even with recent huge increases in funding? Private schools can be academically selective, tend to have smaller classes, be better disciplined, and have more motivated pupils and parents—but why attack a system that appears to be doing the job better?

It may be socially rewarding for Spence to identify with what he sees as the underdog, but with such an important issue as this, perhaps it is time for all of us to put aside our outdated social prejudices and just try to get the best result.

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Three Bs, please

Editor—Spence’s article highlights a growing divide in the perception of who the doctors of tomorrow should be. On the one hand, we hear the cry for more students with lower grades who have “the gift of the gab, blarney, patter, or a silver tongue” (although whether there is any evidence base on which to support an association between these attributes and low grades seems dubious).

At the same time, medicine needs students of an academic bent more than ever. We need doctors who are at home in the world of primary research, who aspire to further the limits of our knowledge, who have a scientific approach to their profession, and the ability to accept uncertainty and reprise.

When As make up 24.1% of all A levels now awarded, surely to lower the requirements even further would remove an important and useful hurdle for admissions panels: are you motivated enough to achieve the necessary grades?

Interviews are the appropriate point at which to assess a student’s personality rather than when surveying his or her grades. To label all those students who want to go into medicine and were willing to work to achieve the necessary grades “neurotics” or “no-social-skills types” is too absurd to be offensive. Should Spence wish to verify the accuracy of that statement, he has an open invitation to dinner with the students in my house (who have not a B grade between us).

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¹ Spence D. Three Bs, please. BMJ 2006;333:453. (26 August)

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