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Endovascular repair is not worse than open repair of abdominal aortic aneurysms

EDITOR—The title and interpretation of the EVAR trial results in the POEM are misleading and incorrect.¹ Mortality figures were quoted both as aneurysm related and all cause deaths. The 30 day mortality was 1.7% in the EVAR group, which is significantly lower than 4.7% in the open repair group. Surprisingly, the POEM somehow interpreted 30 day mortality to be less than 1% for both groups, which is clearly an error. The confidence intervals (odds ratio 0.35, 95% confidence interval 0.16 to 0.77, $P=0.009$) make type I error unlikely. If pre-intervention deaths are added to the figures 30 day mortality was calculated at 3.5% for endovascular repair and 7.1% for open surgery.²

The advantage of endovascular repair is sustained at four years, with 4% aneurysm related deaths in the EVAR group compared with 7% in the open repair group. This confers a 3% absolute reduction in aneurysm related mortality. The all cause mortality rate was comparable in both groups at four years.

Endovascular repair offers a 30 day lower risk treatment compared with open surgery in patients who are medically fit with an abdominal aortic aneurysm. Compared with open repair, endovascular repair offers no advantage with respect to all cause mortality and health related quality of life; and is more expensive; however, it confers a 3% improved aneurysm related survival which persists at four years.

The POEM's message that endovascular repair is worse than open repair is inaccurate and not evidence based.

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¹ Endovascular repair is worse than open repair of abdominal aortic aneurysms. *BMJ* 2005;331:0-f. (24 September.)

² EVAR Trial Participants. Endovascular aneurysm repair versus open repair in patients with abdominal aortic aneurysm (EVAR trial 1): randomised controlled trial. *Lancet* 2005;365:2179-86.

Details of HPV immunisation need not delay decision

EDITOR—Lowndes and Gill are upbeat in their appraisal of the future for primary prevention of cervical cancer by immunisation.¹ But they then deliver a long list of questions that they suggest should be answered before starting human papillomavirus (HPV) vaccination. For most of their questions, this timing is not supported by recent historical precedent.

Without doubt ascertainment of the HPV types currently causing cancer, data for which are available in the United Kingdom,² is central to the modelling and cost effectiveness studies with which we must assume the Health Protection Agency and others in the UK are already engaged. Certainly, as for all recent new vaccines, cost is likely to be a key determinant. Likewise, careful evaluation of vaccine acceptability to children and parents will be important, although it should be pointed out that universal immunisation against hepatitis B, primarily a sexually transmitted disease and a cancer causing virus, is already widely established and accepted in many countries.

But the other questions need not delay implementation and have not done so for other immunisation programmes. The precise design and nature of any catch up programme is a wholly separate issue from the decision that will need to be taken as soon as possible after one or more of these vaccines become licensed and available in Europe—namely, whether to offer the vaccine to all girls before they become sexually active as a means of preventing the second most common cancer of women. It seems that this will be an important, although quite possibly expensive, public health opportunity. The case will need to be made in a clear and uncluttered way if needless loss of life is to be avoided.

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¹ Lowndes CM, Gill ON. Cervical cancer, human papillomavirus, and vaccination. *BMJ* 2005;331:915-6. (22 October.)

² Peto J, Gilham C, Deacon J, Taylor C, Evans C, Binns W et al. Cervical HPV infection and neoplasia in a large population-based prospective study: the Manchester cohort. *Br J Cancer* 2004;91:942-53.

Omitted evidence?

EDITOR—I was surprised that Alvarez-Rosete et al in their article did not discuss what is thought to be the best piece of evidence that the NHS in England has improved: performance of accident and emergency departments.¹ Then I double checked my sources.

What is clear is that English accident and emergency departments are dramatically better than they were five years ago, when more than one in four people waited more than four hours for admission or treatment. Over the past six months fewer than two in 100 have waited more than four hours in England. The situation in Scotland, which boasted about being the best in the United Kingdom in 2001,² has certainly got worse and is probably much worse than England. The current Scottish figures are hard to compare and may not be reliable as the sampling technique (a three day sample, once a year) may be both unrepresentative and gameable.³ English departments have to submit statistics on all-patient performance weekly.

I could find no site reporting useful statistics about Wales, but according to anecdotal evidence, accident and emergency performance is as poor as English performance in 2000 in some of the larger hospitals. It seems that the experience of reform in this part of health care in England is a success.

Debate is ongoing in these pages about the evidence for and against reform, and it would be ironic indeed if the evidence for elements of reform were undermined by the lack of information about what happens if you don't do it.

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¹ Alvarez-Rosete A, Bevan G, Mays N, Dixon J. Effect of diverging policy across the NHS. *BMJ* 2005;331:946-50. (22 October.)

² Scottish Executive News. *Scottish A&E departments lead UK* www.scotland.gov.uk/News/Releases/2001/11/694 (accessed 28 Oct 2005).

³ Scottish Health Statistics. Accident and emergency waiting times. www.isdscotland.org/isd/info3.jsp?pContentID=3589&p_applic=CCC&p_service=Content.show& (accessed 28 Oct 2005).

Informed consent

Talking with patients, not at them

EDITOR—"Informed consent"¹ seems to be a term that sends doctors and lawyers off into preconditioned behaviours rather than thinking about what we are really trying to achieve—probably normal behaviour for lawyers from my experience.

What we are trying to do is to help a patient make an informed choice about proceeding with the suggested treatment. Doctors are so focused on "treating" patients, and solving the problem, that they seem to forget that the patient is involved too.

"Consenting" is not something that should be done to a patient—it is something patients do when they have the information they need. For surgery or other invasive treatments, the doctor needs a consent form for their protection—but that should be after the patient has chosen—recording the fact of consent. Too often the signing of the form is viewed as the "consent"—it can still be challenged in law.

Patients need to know that there are risks and that doctors are human and make mistakes. They do not necessarily need the graphic detail, but it should be there if they either ask or appear interested.

What patients need is an effective dialogue with the doctor and the healthcare system. Leaflets may help, but listening and talking on a personal level is much more effective, but requires doctors to allow patients to direct the process.

It can go to the other extreme—last month in the accident and emergency department I had to help the doctor complete my consent form. Occasionally the patient may be better informed than the clinician.

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Competing interests: PDS was an author of the report *The Informed Patient*, produced by Cambridge University Health.

¹ Rowbotham D. Informed consent (and a flutter in Vegas). *BMJ* 2005;331:973. (22 October.)

Is frightening patients really in their best interests?

EDITOR—Rowbotham raises some issues in his article that are familiar to us as surgical trainees.¹ We are often in the position of obtaining patients' consent for operations which, although clearly in their best interests, entail the discussion of rarely occurring, but serious, risks, leaving the patient worried about rare, but serious, complications.

Unfortunately, in today's climate of ever increasing litigious activity it becomes ever more important to ensure all possible complications are mentioned, since failure to do

so could risk serious problems for the doctors involved. Many patients in our experience are keen to proceed with the procedure, and being informed of such complications does nothing but contribute to the stress already felt by many in preparing themselves for an operation. At a time when many are seeking reassurance, are we really acting in the patients' best interests?

We note the comments and suggestions of Professor John Harris mentioned in the *bmj.com* news roundup by Davies with regard



to offering patients the choice of a simple consent as an alternative option.² This would allow doctors to act in accordance with the patient's wishes, yet protect against litigation. We agree that this could offer a useful alternative. Of course, the option of fully informing patients of all possible complications would and should remain. In a society in which patients' choice is a sought after gold standard, surely it seems logical to take account of the variety of different patients'

views in the amount of information they seek and the degree of professional guidance they wish to allow. It would be refreshing to see a system in place that allowed patients' consent to be guided by patients' choice rather than the ugly fear of litigation.

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¹ Rowbotham D. Informed consent (and a flutter in Vegas). *BMJ* 2005;331:973. (22 October.)

² Davies J. Doctors should be allowed to offer patients a simplified form of consent, expert says. *BMJ* 2005;331:925 (22 October).

Danger is ahead when staff don't know what they don't know

EDITOR—The perception that many healthcare professionals fail to understand fully the law on consent seems to have been confirmed in some of the responses to Rowbotham's article.¹ An enduring right already exists for practitioners to omit information in relation to risks that they consider not in their client's best interests to hear. Practitioners have no need to repeat a long list of every potential adverse risk of treatment, unless explicitly requested to by the client: whether this is a paternalistic remnant fit to be consigned to a bygone age or not depends on the individual viewpoint. The other extreme of simply handing out leaflets is equally concerning and would most certainly expose any practitioner to claims of poor practice in the realm of consent.

Junior medical staff and other healthcare practitioners require support and guidance to ensure that they are not being railroaded into routinely frightening clients, in the pursuit of a signature on a potentially

useless piece of paper. The basic tenets of consent instruct us that clients must be informed, in possession of all their faculties, and acting voluntarily. By scaring them witless they are highly unlikely to meet any one of these three criteria.

The propagation of the spectre of litigation seems to be fostered as much by the medical fraternity itself as the media. Litigation in the realm of injuries arising from a defective consent process is comparatively rare—complaints, an apology, and a willingness to change for the better are the more usual requirements. And on the occasions where it does arise, why shouldn't someone gain a pecuniary advantage when their health is irreversibly affected? Wouldn't you expect it for yourself?

Notwithstanding, I agree that there is no need for complacency, but it is high time that the aforementioned support and guidance is provided for individual practitioners to ensure that only partly informed, and sometimes unwisely held beliefs are eradicated.

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¹ Rowbotham D. Informed consent (and a flutter in Vegas). *BMJ* 2005;331:973. (22 October.)

Are consenters representative of a target population?

EDITOR—I write with reference to the paper by Junghans et al on recruiting patients to medical research.¹ We recently published a method to determine if consenters to population surveys are representative of the target study population.²

Recently introduced data protection legislation has changed research practice in the United Kingdom, although uncertainties about the interpretation of the legislation remain.³ Methods such as searching general practice records to investigate whether non-responders are different to responders are no longer acceptable as they use information about identifiable individuals without their consent. An alternative approach to estimating the effect of non-response is to reformulate the problem as the extent to which responders are representative of the total target population. Since anonymised data may be obtained and used for the target population as a whole, this represents an indirect way of assessing the impact of non-response on representativeness. We compared consultation rates for some common conditions among responders to a headache survey⁴ who had consented to the use of their practice records for research with anonymised rates derived from the practice populations from which they were sampled.

We found that the adjusted consultation rates were similar but generally higher in the consenters group than in the population group. This shows that consenters have more morbidity than those who do not participate, not only with respect to the topic of

the survey (headache) but for other conditions also. However, the differences were not large and imply that non-response bias is unlikely to be substantial with respect to the extent and pattern of ill health.

The alternative method that we described offers one potential approach to determine whether respondents to a study are representative of the population from which they were sampled with respect to a particular set of characteristics—namely, their morbidity as measured by consultation with a general practitioner—and as such can be used as one measure of the representativeness of the responding sample.

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Competing interests: None declared.

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Mandatory reporting of all sexually active under-13s

Confidential sexual health services to young people: part of the solution or part of the problem?

EDITOR—Bastable and Sheather offer little evidence as to what would happen if limits were placed on confidential underage access to sexual health services.¹ They mention the United States without mentioning the relevant empirical data there, as for example summarised by the economist Levine in a recent analysis of US and international data on abortion.² Levine finds that parental involvement laws actually reduce abortion rates of minors by 10-20%. More importantly, there is no evidence of a concomitant increase in the rate of underage births. Teenage pregnancies either remained unchanged or even fell.

Levine et al find that US states restricting Medicaid funding for abortion during 1977-88 led to a decrease in their pregnancy rates of 7.7%.³ This too implies that increasing access to abortion increases the incidence of unprotected sex.

Another "social experiment" that contradicts the assumptions by Bastable and Sheather occurred at the time of the Gillick ruling,⁴ which restricted access for under 16 year olds to family planning in England and Wales, but not in Scotland. If Bastable and Sheather were correct, the 1984 ruling should have been associated with an increase in underage pregnancies at the time. However, the opposite occurred: no increase in England and Wales, but an increase in the underage pregnancy rate in Scotland.⁵

The explanation for these findings lies in the economic (and not just medical) model of teenage sexual activity including teenage pregnancy: easy and confidential access to family planning services (including abortion) acts essentially as an "insurance" against the unwanted risks of sexual activity.² It therefore leads to an overall increase in sexual activity, as the "risk" of sexual activity (unwanted pregnancy especially) has been reduced.

Despite free and confidential access to family planning clinics, teenage pregnancies have therefore not fallen and sexually transmitted infections have risen substantially over the past decades. Is confidentiality—at least partly—to blame?

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Competing interests: None declared.

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Reporting is a public health imperative

EDITOR—We write with reference to the editorial by Bastable and Sheather.¹ The consultation document from the Department for Education and Skills outlines the principles of sharing information about sexually active youngsters among the agencies that deal with them. Although the intentions of this proposed legislation are good, the intricacies of its application make it impractical. Some of these problems are well highlighted in the editorial. However, more importantly, it can have adverse implications for certain public health issues.

With the growing incidence of teenage pregnancy (that includes under-13s) and abortion rates in the United Kingdom,² sexually active teenagers should be encouraged by all means to attend counselling sessions and to seek medical help in times of need. Any threat to their confidentiality will certainly deter them from seeking help. In addition, delays in presentation for abortion preclude them from accessing safer medical methods. Subsequent surgical methods of termination are associated with more complications. More importance has to be given to maintaining the health of the teenagers.

Another major public health threat is the possible increase in the incidence of sexually transmitted infections and associated problems. Disclosure of information to parents and other professionals could potentially drive teenagers away from seeking medical help, promoting further transmission.³

Although, such legislation is existent in countries such as the United States, the inci-

dence of births to 15-19 year olds in America is still higher than that in the UK (61/1000 compared with 33/1000).⁴

Good communication, a good relationship with a doctor or nurse, and non-judgmental attitudes in all staff can help encourage young people to use services.⁵ We think that the legislation is being brought as a knee jerk reaction to the report on the Soham murders case, without considering all determinants of health.

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- 1 Bastable R, Sheather J. Mandatory reporting to the police of all sexually active under-13s. *BMJ* 2005;331:918-9. (22 October.)
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Author rectifies omission: health behaviour change in the developing world

EDITOR—I want to acknowledge an omission in the paper I wrote on behaviour change with colleagues with expertise in communications.¹ Our first sentence places the context for the paper in the developed world, as if the far more widespread poor health and associated behaviour problems in the developing world are of less importance. The effects of poor housing, social upheaval, and other forms of deprivation manifest themselves widely in the consulting rooms of practitioners in the developing world, placing a huge burden on them to help patients as best they can.

Having made this mistake, there is not much else that needs be said about the potential of a guiding style in behaviour change consultations in developing countries. It is clearly relevant and, I believe, adaptable across cultures. In fact, given my impression of quite widespread morale problems among overburdened practitioners in the developing world, skilfulness in using a guiding style can help them to feel less responsible for solving health behaviour problems they encounter every day. As for the listening component, I am yet to come across a practitioner from a culture or language group who does not affirm the value of listening to patients.

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Are medical schools fit for graduates?

EDITOR—James may be ready for a UK wide system of graduate entry medical education,¹ but are we sure that UK medical education is ready for graduates? Absurdities remain at all stages of the current training system—the Joint Committee on Higher Medical Training states that a three year doctorate completed before or during medical school will count less towards specialty training than, for example, a weekend of research as a senior house officer.²

What signal does this send to those engaged in BM-PhD programmes? Graduate entrants to medicine have been reported to find medical school more stressful than school leavers.³ Perhaps the suggested national quantitative assessment of knowledge (analogous to the US medical licensing exams, USMLE) would allow selection and then fast tracking of motivated students through foundation competences while still in medical school, thus avoiding the stress associated with feelings of stagnation felt by some graduates while completing a training programme designed, and paced, for school leavers.⁴

Might the current “fluid” state of Modernising Medical Careers allow the incorporation of foundation years into a five year integrated graduate entry medicine training programme? Will revised “run through” programmes for specialty training accommodate and acknowledge any post-graduate research training (especially that funded by research councils and resulting in graduate degrees) without reference to the date of medical qualification? Might such joined-up thinking even encourage more scientists into clinical training and help tackle the shortage of clinical academics?

I await the answers with interest but in the meanwhile I'm not going to stop studying for the USMLEs just yet.

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- 1 James WS. Students need education fit for professional and public life. *BMJ* 2005;331:966. (22 October.)
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Psychological impact of alopecia

Alopecia may lead to social anxiety

EDITOR—Hunt and McHale conducted an extensive clinical review about the psychological impact of alopecia.¹ Alopecia is psychologically damaging, causes intense emotional suffering, and leads to personal, social, and work related problems.^{1,2}

Although stressful life events may have an important role in triggering some episodes of alopecia,¹ the anxiety symptoms that follow its



appearance may closely resemble social anxiety disorder. Some patients with alopecia have anxiety symptoms, avoidance behaviour, and social and economic suffering similar to social anxiety disorder patients. Social anxiety disorder is characterised by the fear of humiliation or being judged negatively in social situations as well as the avoidance of such social or performance situations.³ The diagnosis of social anxiety disorder excludes patients whose social fears and avoidance are secondary to other psychiatric disorders or medical problems (for example, essential tremor or stuttering).

Patients with alopecia initially unrelated to social anxiety may begin to avoid public situations out of fear that it would be embarrassing if others observed the loss of hair, and they may experience excessive fear of being humiliated or of embarrassment when their alopecia is noticed. Identical to patients with primary social anxiety, they tend to be self conscious and self critical, and they often experience physical symptoms of anxiety, such as blushing, palpitations, sweating, and trembling. Such secondary social anxiety disorder has the same symptoms, behaviour, and consequences of the primary subtype.⁴ Patients with social anxiety disorder secondary to disfiguring or disabling medical conditions experience serious social anxiety and avoidance, and since such symptoms have been shown to respond to antidepressant drugs,⁵ controlled trials should be conducted to describe the response of secondary social anxiety and avoidance to pharmacological treatment.

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Don't forget syphilis

EDITOR—I write with reference to the article by Hunt and McHale.¹ Late syphilis can be a cause of atypical alopecia. Some 30 years ago the *BMJ* ran an article about alopecia and

syphilis.² Within a month, I saw a patient who had apparently been complaining of patchy “alopecia areata” for some time. The appearances and long history did not seem to fit any alopecia areata that I had seen. The “very long shot” serology result confirmed a specific causation, which turned out to be the unconfessed late result of an affair years previously. It was interesting that the specific treatment also cured another problem of “detergent hand dermatitis” as well as the alopecia.

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Speaking from personal experience

EDITOR—I had to respond to the article on alopecia by Hunt and McHale,¹ if only to show how attitudes have changed in the past four decades. I lost every hair on my head in 1965, when I was 17 and doing my A levels. I had two wigs, both made out of Chinese hair, which had to be cleaned from time to time. One looked a lot more like my own hair than the other.

I played a lot of hockey and netball at school so I had to wear a headband to keep the wig in place. One day, at netball practice it fell off. As far as I can remember I picked it up and put it on again—and no one said a word—I suppose they were embarrassed. I had a polystyrene head on which I used to put the wig at night.

I had ultraviolet therapy to make my hair grow back a bit quicker—so I had nice tan that year. By the time I went to university in the autumn I had a sort of fine down covering my head, which very soon looked as though I had spent a fortune getting some highlights done.

I survived the experience—and I am not sure if I am psychologically scarred or not. I still have the odd bald patch now and again—which just jogs my memory a little bit.

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- 1 Hunt N, McHale S. The psychological impact of alopecia. *BMJ* 2005;331:951-3. (22 October.)