

Written in scholarly English, Ole Færgeman has provided us with a lively, erudite and often humorous text. It is an informed reflective study written without bias and from a variety of unusual angles. There are also two short appendices providing information on coronary disease and fats.

MICHAEL OLIVER
Professor Emeritus, University of Edinburgh

The turnstone: a doctor's story.

By Geoffrey Dean. Liverpool University Press, Liverpool
2002. 273pp. £15.

Many doctors, I suspect, aspire to writing their autobiography; a few succeed but even fewer have them published. This account of Geoffrey Dean's life, professional and private, makes compulsive reading. The son of a bank manager in Liverpool, Dean was sent to a horrid prep school and then to Ampleforth. He qualified at Liverpool Medicine School under such mentors as Henry Cohen and Robert Coope. He joined the RAF as a medical officer and came under the influence of Sir John Conybeare, the well-known consultant physician at Guy's Hospital and chief medical officer to the RAF. After the war he obtained his MRCP and took a course in tropical medicine in Liverpool. As a ship's surgeon he took passage to

South Africa. Here, initially, he was quite rightly not accepted as a consultant physician but after further training as a medical registrar started a consulting practice in Port Elizabeth.

Dean has an astute and enquiring mind. When as a young man he develops staphylococcal septicaemia, he is treated with extremely painful injections of penicillin and suggests that novocaine is given simultaneously. This was effective and widely used until the penicillin was made in a more purified form. As a registrar Dean does his first epidemiological study of dock-workers who developed unexplained paralysis. This proved to be due to contamination of the oil in which their fish and chips were cooked by orthotricresyl phosphate. His great contribution to medicine is his study of patients in South Africa with porphyria variegata, all of them descended from a common ancestor – an immigrant from Holland. His epidemiological, clinical and chemical studies of these patients in many parts of the world have made him an authoritative expert in this condition. Using similar epidemiological techniques he has studied disseminated sclerosis in many parts of the world before being appointed director of the Medico-Social Research Board in Dublin. Still alive but suffering from carcinoma of the prostate and fibrosing alveolitis, he has given a most readable and enjoyable account of his interesting life.

SIR RICHARD BAYLISS
Former Consultant in Endocrinology, Lister Hospital, London

Letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk.

Is prolonged use of computer games a risk factor for deep venous thrombosis in children?

Editor – Ng *et al* reported a fascinating case of a 12-year-old boy who developed a deep vein thrombosis affecting the left popliteal and left superficial femoral veins following a prolonged period of relative immobility

whilst playing a video game (*Clin Med* November/December 2003, pp 593–4). There was no family history of venous thromboembolism and several thrombophilic tests that they performed gave normal results.

I share the authors' view that this child's thrombosis is highly likely to have arisen from venous stasis caused by a continuous kneeling-like posture lasting four hours. Nevertheless, I would like to make two additional observations about this unusual presentation.

Firstly, current methods of thrombophilia screening suffer from a high false-negative rate. This is borne out by the fact that many families, each with a high prevalence of thromboses amongst its members, are found to be negative for various factors that can be identified by employing routinely available techniques. It is hoped that continued research in this area will reveal new entities and reliable means for their detection. For example, two novel mutations have been discovered in the factor V gene that can demonstrate activated protein C resistance (APCR),^{1,2} one of which has been described in two siblings who

both suffered venous thrombosis in the second decade of life.¹ However, as these loci are different to that associated with Factor V Leiden, they would not be identified by polymerase chain reaction (PCR) assays for its R506Q locus. This might provide an avenue of further investigation for Ng *et al* if their patient can be shown to exhibit APCR.

Secondly, with technical advances in cross-sectional imaging, there is growing recognition of anomalies affecting the inferior vena cava (IVC). One such aberration, atresia of the IVC (AIVC), is thought to predispose to thrombosis. In such individuals the supradiaphragmatic venous return is via azygos and hemiazygos collaterals into the superior vena cava (SVC). This anatomical pattern is thought to be present in 0.6% of the population³ and in those who have developed a thrombotic complication, a calculated incidence of 5.3–9.5%.⁴ This latter group of patients are generally under 40 years of age, have a negative thrombophilia screen and no recognised predisposing factors. They manifest themselves as either bilateral femoral DVT or extensive unilateral DVT.⁴ I feel computed

tomography scanning may therefore be warranted in the boy described by Dr Ng and his colleagues.

References

- 1 Mumford AD, McVey JH, Morse CV, Gomez K *et al.* Factor V 1359T: a novel mutation associated with thrombosis and resistance to activated protein C. *Br J Haematol* 2003;123(3):496–501.
- 2 Alhenc-Gelas M, Nicaud V, Gandrille S, van Dreden P *et al.* The factor V gene A4070G mutation and the risk of venous thrombosis. *Thromb Haemost* 1999;81(2):193–7.
- 3 Bass JE, Redwine MD, Kramer LA, Huynh PT, Harris JH Jr. Spectrum of congenital anomalies of the inferior vena cava: cross-sectional imaging findings. *Radiographics* 2000;20:639–52.
- 4 Bradbury M. Congenital atresia of the inferior vena cava and deep vein thrombosis. *Thrombus* 2003;7(1):7–8.

RICHARD JA MURRIN

*Specialist Registrar in Haematology
University Hospital of North Staffordshire*

Consultant appraisal: pitfalls and how to avoid them

Editor – I was interested to read Dr Waller's article on consultant appraisal (*Clin Med* November/December 2003, pp 569–72). However, I should have liked to have seen some evidence for the value of appraisal (ie clearly demonstrating its benefits to the appraisee, the Trust, or to both). In an era of evidence-based medicine, I feel that management practices new to the NHS should likewise be subjected to critical analysis before their wholesale introduction. Dr Waller assures us that 'carried out correctly, [appraisal] should be a positive, forward-looking, developmental discussion'. Perhaps so, but it is also a time-consuming activity, which seems more concerned with documenting everything than with achieving any real change.

Appraisal will, of course, be used to support revalidation. However, this is principally because it is an expedient solution to the problems of regularly re-licensing a large number of doctors, and, in itself, is no proof of the value of appraisal.

IAN R FLETCHER

*Consultant Anaesthetist
Newcastle upon Tyne Hospitals NHS Trust*

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Prescribing and dispensing by private medical practitioners in Hong Kong – a double-edged sword

We read with interest the article by Tatara¹ describing doctors prescribing and dispensing medication in Japan. Virtually all private doctors in Hong Kong, general practitioners and specialists alike, also prescribe and dispense. Here we discuss the advantages and disadvantages of doctors both prescribing and dispensing in Hong Kong, and the difficulties of separating the two activities.

Advantages of doctors dispensing medication

Getting drugs directly from the doctor is convenient, and the overall cost to the patient is likely to be lower. Also, it may reduce embarrassment for patients with psychiatric problems, sexually transmitted diseases, or erectile dysfunction, and perhaps lessen their resistance to seeking treatment. The clinic serves as a one-stop healthcare centre.

Another advantage is that the doctor can teach and check the techniques of drug administration on the spot, for example for patients on inhalation therapy. Also, in Hong Kong, most patients with sexually transmitted diseases consult private doctors.² For many sexually transmitted infections, single-dose therapy is effective, and a compliance rate of 100% can be achieved if the doctor dispenses the medication.³

Disadvantages of doctors dispensing medication

Without pharmacists checking the medication, there are risks of malpractice and drug abuse by medical practitioners and clinic staff. Also, some doctors dispense skincare products and nutritional supplements, which should be dispensed only after a consultation and for a limited time. In practice, though, some patients repeat-

edly obtain such products from the clinic for themselves or for family members who have not consulted the doctor. This reduces the role of doctor to that of corner-shop owner.

'Shopping around' for doctors is also prevalent.⁴ Hong Kong operates a dual healthcare system with 70% of primary care being provided by the private sector.⁵ There is no structural system for patients to register with a particular general practitioner,⁶ so a patient may consult several different GPs. The fact that doctors also dispense medication exacerbates this problem. For example, a patient with androgenic alopecia may phone several doctors to ask for the price of four-months supply of oral finasteride, and then attend the doctor with the lowest quotation. This seriously undermines the benefits of continuity of care, and the consultation itself is not valued if no medication is given.

Furthermore, a dispensing doctor may limit his prescriptions to the particular medications he purchases. Also, there is no regulation of the fees doctors charge for medication, so doctors working in affluent districts may prescribe expensive but unnecessary drugs. In other words, financial gain can become one of the considerations that influence clinical decision-making.

Difficulties of separating prescribing and dispensing in Hong Kong

The substantial gain from dispensing under the present system is the biggest reason for resistance to reform. One misconception by the public is that separating prescribing and dispensing will not increase costs, which is unlikely to be true. A recent opinion survey⁷ showed that 52% of respondents (patients) expected a big reduction in medical costs if prescribing and dispensing were separated, but less than 10% of doctors thought so. Also 60% of the respondents had little understanding