hepatitis B surface antigen, though the plasma source will have been checked for the presence of hepatitis B virus by polymerase chain reaction.

The allocation of IVIG varies from country to country. Australia, Spain and the USA on the whole use IVIG derived from plasma from donors from their own country. With the proviso that the products are otherwise similar, this decision makes good sense given the differences in endemic diseases and vaccination protocols between countries. Another significant difference is the method of collecting plasma; in the UK this has been performed on an altruistic voluntary basis while in the US donors are paid. This may result in an increase in the proportion of donors from lower socioeconomic groups in the USA. There is debate as to which method of plasma collection is safer with regard to the risk of potential transmission of infection; however, plasma from all sources is subjected to a rigorous series of checks. During the production of IVIG there are serial steps to inactivate and/or clear any viruses/transmissible agents which may be present in the plasma. The emergence of new viruses such as severe acute respiratory syndrome coronavirus and the spread of established viruses such as WNV to new geographical areas may have an impact on the selection of plasma/product to ensure that appropriate cover is provided.

In the UK, plasma is currently sourced from the USA because of directives resulting from concern regarding possible variant Creutzfeldt-Jakob disease (vCJD) transmission. At present, blood donations from those resident in the UK for three months or more between 1980 and 1996, or who received a blood transfusion or surgery in the UK, are prohibited from being used for the production of IVIG. However, current production processes have been shown to remove prions down to undetectable levels in the final IVIG product.[5] Given the current worldwide shortage of IVIG, with major problems in obtaining adequate supplies in the UK, even for indications which are both licensed and life threatening, it is vital that the ban on UK plasma is urgently revisited and that any decisions regarding risk assessment are made based on the scientific evidence base available. The current ban on the use of UK plasma is also inconsistent with the ongoing use of UK packed cells, albumin and colloid plasma substitutes produced with gelatine obtained from bovine bone products.

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Skin cancer: prevalence, prevention and treatment

Editor – Dr Sharpe's editorial on skin cancer (*Clin Med* July/August 2006 pp 333–4) is a good overview of the subject for non-dermatologists. Despite the editorial requirement for brevity, his failure to specifically mention Mohs micrographic surgery (MMS) misses an opportunity to bring this little known treatment to the attention of our general medical colleagues. This highly specialised form of cutaneous surgery has an important role in the management of selected cutaneous squamous cell carcinoma[1] and published national guidelines recognise MMS as the treatment of choice for high risk, invasive facial basal cell carcinoma.[2] Mohs surgery, in which tumours are excised under total microscopic control, was pioneered in the USA and is increasingly available in specialised dermatology units in the UK. For the most difficult lesions, it offers tumour removal with maximal preservation of normal tissue together with cure rates which surpass those offered by radiotherapy or formal excision with wide margins. Of particular interest to readers of this journal, MMS is a surgical technique exclusively practised by physicians.

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Skin cancer and surgical margins for basal cell carcinoma

Editor – I enjoyed reading Sharpe's informative editorial (*Clin Med* July/August 2006 pp 333–4) which rightly highlights the burden that skin cancer care creates in the UK with over 50,000 recorded basal cell carcinomas (BCCs). However, I feel clarification is needed regarding BCC excision as an error in marking surgical margins of just 1 mm can adversely affect cure rates. Sharpe states that the recommended minimum clearance margin is 3 mm for most BCCs.[1] However, in clinical practice, for predetermined surgical margins around BCC most surgeons would take at least 4 mm. The reason for this is that 3 mm margins will clear approximately 85% of well-defined previously untreated BCC less than 20 mm in diameter on the face, whereas 4 mm margins achieves >95% clearance.[2] If the goal of BCC excision is complete extirpation of the tumour then margins of 3 mm are

inadequate for BCC, even those BCCs with a small diameter.[3] A recent study showed that for BCCs measuring on average 6x5 mm, excision margins of 1, 2 or 3 mm resulted in positive margins of 16%, 24% and 13% respectively.[3]

Sharpe states that the recommendation for BCC at high-risk sites or morphoeic BCC is 5 mm. For morphoeic BCCs that measure 10–20 mm in diameter, a 5 mm margin achieves a clearance rate of 82%.[4] It has been shown that on average, morphoeic BCC have subclinical extensions of approximately 7 mm.[5] For this reason, Mohs micrographic surgery (where available) is the treatment of choice for high-risk or morphoeic BCCs as this form of surgery has the lowest recurrence rates and conserves as much normal skin as possible. If Mohs surgery is not selected then margins of 10 mm or more may be required to completely remove morphoeic BCC.

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Note

I have no conflicts of interest to declare although a rapid response (to Boyce DE, Shokrollahi K. Reconstructive surgery. *BMJ* 2006;332:710–2) posted on the *BMJ* website (never published in print) contains some similar themes.

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In response to Telfer and Varma

I am grateful to Dr Telfer for highlighting the role of Mohs micrographic surgery in the treatment of skin cancer. My article was written for the non-dermatologist to give an overview of the three main types of skin cancer, including treatment modalities, in a little over 1,000 words. I support Dr Telfer's comments about this specialist technique for high-risk non-melanoma tumours.

I thank Dr Varma for his comments on basal cell carcinoma (BCC) surgical margins. Tumour margins are a non-trivial procedure for both operator and pathologist, and widely discussed by specialists in the field. Within the brief of a non-specialist editorial I did not feel able to enter this debate and therefore quoted the currently accepted UK guidelines. In my article I quoted minimum margins and accept that the operator may frequently decide a wider margin is desirable. The margins required are dependent on body site and sub-type of BCC; greater margins are most commonly needed for facial lesions and morphoeic subtypes. However, I expect Dr Varma will agree that BCC margins is not an exact science and the lateral margin taken needs to be balanced against cosmetic result. Determining edge of some BCCs clinically, elasticity of skin, and histological sectioning and interpretation are just some of the variables. Dr Varma quotes two papers where a 3 mm margin gave 85% clearance in the first and 87% in the second. While surgery is usually the preferred treatment it is not the best option for all patients. For other treatment modalities within UK guidelines, such as curettage and cautery or topical treatments, there are no surgical margins. Finally, it is interesting to note that positive histological margins do not necessarily give rise to recurrence. In a five-year follow-up of 151 BCCs, recurrence occurred in 26% of those with positive margins and 14% of those with negative margins.[1] BCCs are the commonest human cancer, but are variable in type and behaviour. Thus it is important that tumours are treated by clinicians with the appropriate expertise to choose best management in each case.

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Systematic review of systematic reviews of acupuncture published 1996–2005

Editor – Derry *et al* (*Clin Med* July/August 2006 pp 381–6) conducted a 'systematic review of systematic reviews' of acupuncture, and concluded that 'double blind studies had good evidence of no benefit'. This conclusion is in direct conflict with the everyday observation throughout the world that acupuncture gives valuable relief of pain and other symptoms. How can this be? We suggest that the authors asked the wrong question, and answered it in the wrong way.

Wrong question

The most important question about acupuncture for patients in pain must be: 'Is it more effective than the usual treatments offered?' There is now a considerable amount of evidence from large, rigorous trials that the answer is yes – acupuncture was superior to usual care for migraine,[1–3] tension headache,[1] back pain,[4–6] and osteoarthritis of the knee.[7–9] In addition, there is evidence that acupuncture can be provided at a cost that is competitive with many other medial interventions,[5,6,10] and that it is cost effective for migraine and low back pain, a conclusion which is based on firmer evidence than that for many orthodox treatments.[11] Instead, Derry *et al* address the question: 'Is acupuncture more effective than sham acupuncture?' and only consider sham-controlled trials. Sham-controlled trials of acupuncture generally consist of pitting one form of treatment against another. Sham acupuncture is not an inactive placebo: two randomised controlled trials (RCTs) have compared superficial needling (administered as the true therapy) with an inert non-needle sham control, and both found the superficial needling to produce much stronger analgesic effects.[12,13] Sham-controlled trials of acupuncture cannot be interpreted in the same simplistic way as placebo-controlled trials of drugs. The authors themselves recognise this in their discussions, but not in their conclusions.