

pregabalin by the European Agency for the Evaluation of Medicinal Products was based on 12 trials (eight unpublished), which showed that the drug was superior to placebo but inferior – in the only comparative trial available – to amitriptyline.² The approval of duloxetine relies on two short-term (12-week) trials with placebo as a comparator, without any formal comparison with other drugs used for the treatment of neuropathic pain.³ While the supposed superior efficacy and tolerability of these drugs over tricyclics remains to be proven, there is no doubt about their superior cost to the NHS:⁴ the incremental annual cost of the new drugs over amitriptyline (comparisons at maximum daily dosage) approaches 13 for duloxetine, 15 for pregabalin and 40 for gabapentin (although the cost of gabapentin is expected to be much reduced as soon as the generic formulation becomes available). We believe that for this money, the taxpayer, the doctor and, most importantly, the patient are surely entitled to a stronger evidence base.

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- 2 Pregabalin. Prescrire International 2005;14:203.
- 3 UK Medicine Information NHS. *Duloxetine for diabetic neuropathic pain*. August 2005. www.ukmi.nhs.uk/NewMaterial/html/docs/Duloxetine0805.pdf
- 4 Is there a place for duloxetine? *Drugs Ther Bull* 2007;45:29–32.

Neurological problems on the intensive care unit

Editor – Once again a learned article on coma (*Clin Med* April 2007 pp 148–53) fails to include cerebral malaria as a possible, and eminently treatable, cause. Several deaths from this occur annually in

Britain because no adequate travel history has been elicited and the possibility of the diagnosis has not been considered. Clinical signs may include meningism, convulsions, paralysis of conjugate gaze, extensor plantar responses and retinal haemorrhages.

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Where are you from?

Editor – I read your editorial with interest (*Clin Med* April 2007 pp 101–2). The account of a conversation with an Iraqi doctor described a healthcare system that was flourishing under Saddam Hussein until it was ruined in the aftermath of the invasion of 2003 and the subsequent lawlessness, kidnapping and murders.

I have had the good fortune to be in Baghdad twice in recent years. The first occasion was immediately after the regime change, when I spent an extended period working on public health and reconstruction with the new Iraqi Ministry of Health, which brought me into daily contact with a wide range of doctors, nurses and health officials. The second visit was for a briefer period in 2005 to discuss assistance to Iraq in updating clinical skills, which again involved frequent contact with clinicians. On neither occasion did I meet any Iraqis who shared the view put forward through the editorial that all had been well with health services before 2003.

On the contrary, I heard repeatedly of the systematic rundown of health services under Saddam and its devastating effects. Spending on health in 2001 was one-tenth of the level 10 years earlier, and I saw plenty of evidence of long-term decline with my own eyes in May 2003. I heard numerous accounts of the deliberate denial of vital drugs and equipment to sections of the population that had angered Saddam, and the memories of the distress of those who told me of the entirely preventable pain and suffering that resulted remain with me. From the time of the Iran–Iraq War, the borders were closed to most Iraqis, and accessing information from the outside world was forbidden. As a result, clinical skills stagnated as textbooks aged and

could not be replaced, conference attendance became impossible, and training became outdated. Iraqi doctors were desperate to update their knowledge and skills – the reason for the work that we have been able to initiate and that occasioned my second visit. I heard that many of the brightest Iraqis did indeed continue to enter medical training – some things are difficult to change, it seems – but on qualification the best were compulsorily drafted into the Army medical services. Another strongly persistent memory is of being taken by a young ex-Republican Guard doctor to the prison camp he had been obliged to work in, with its gruesome torture chamber and large mass graves.

As a result of many conversations in Iraq as well as my own observation, I am sure that health services in Iraq were indeed well run and extremely capable – but only before Saddam came to power. By the time he was removed, they were in a very poor state indeed, even when not perverted as another cynical instrument of state control. The great majority of individual clinicians certainly did the best they could under desperately difficult circumstances, but the idea that there was a well-managed health system for anything but the favoured minority is unsustainable.

Of course nobody would deny that the terrorism and kidnapping since 2003 have disastrously set back attempts to improve life, health and well-being for Iraqis, as well as causing widespread human misery for those affected directly and indirectly. But to suggest that life was good under Saddam, or that services were well managed and effective, at best runs counter to the evidence; at worst, it risks offence to the great majority of Iraqis, many of them no longer able to speak for themselves.

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Personal viewpoint on revalidation

Recertification for specialists in the UK will be introduced over the next couple of years and seems likely to involve knowledge-based assessments and direct observation of procedural skills (DOPS). Most consultant physicians will be daunted by the