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 sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Patient-centred medicine

Editor – Lewith's article on patient-centred medicine promotes notions that are debatable, to say the least (*Clin Med* June 2007 pp 250–2).[1] Lewith builds his arguments on the suggestion that NHS provision and scientific evidence are separate, largely unrelated issues. Policy is driven by political expediency and not by scientific evidence, he insists. I would counter that bad policy is driven by expediency and good policy by evidence. The fact that UK dentistry is in a mess is no reason to throw the rest of our healthcare in disarray as well. Simply because we made mistakes in the past, is no reason to justify blunders of the present or future.

Lewith states that the risks of complementary and alternative medicine (CAM) are 'exaggerated by those opposed to CAM' and they are negligible compared to the 784,000 deaths caused by adverse effects of conventional drugs. This line of argument fails to consider the concept of a risk-benefit balance. If a treatment is not more effective than a placebo, even relatively minor risks would tilt the balance. In other words, we must evaluate the risks and benefits of each form of CAM carefully. If we do this, some treatments come out as 'winners' and some as 'losers.'[2] General statements such as 'by and large CAM works'[1] are counterproductive and nonsensical.

Lewith claims the moral high ground of the 'wise physician'[1] and brands the critical analysts, 'top docs,'[1] as uncaring, arrogant scientists who are out of touch with real life. I fear that, if Lewith's views were adopted, we would not advance towards 'the best of both worlds'[1] but regress towards the quackery of pre-scientific medicine.

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References

1 Lewith G. Patient-centred medicine. *Clin Med* 2007;7:250–2.
2 Ernst E, Pittler MH, Wider B, Boddy K. The desktop guide to complementary and alternative medicine, 2nd edn. Edinburgh: Elsevier Mosby, 2006.

In response

I think it would be best for the readers of *Clinical Medicine* to decide whether they think current health policy is driven primarily by evidence or political expediency; those at the coalface of clinical practice would undoubtedly be in the best position to make this judgement. With the greatest respect I think non-clinicians who have not worked in the NHS for many years are not best placed to make judgements on this issue.

I continue to stand by the claim that processes which may alienate patients from their physician and drive complementary and integrated medicine into an 'alternative medical system' are not in the best interests of patients, medical communication or indeed medical safety. Perhaps your readership should be the judge of Professor Ernst's views.

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Normal pressure hydrocephalus

Editor – I recently wrote a report about my own case of normal pressure hydrocephalus (NPH) (*Clin Med* June 2007 pp 296–9). I described a happy ending to a long, sad story of misdiagnosis. In that report I failed to emphasise, as I intended, that incontinence is often the first clue to the diagnosis of NPH.

Over two years before the correct diagnosis of NPH was made I had developed urinary incontinence and, soon thereafter, faecal incontinence. I was referred to an urologist for the former and to a gastroenterologist for the latter. Both consultants thought my incontinence was caused by old age (76 years old).

When it presents as apraxia alone, NPH is difficult to diagnose. The appearance of incontinence in elderly patients should alert internists and surgeons, especially consultants, to the possibility of NPH, which is usually reversible. This diagnosis can be rapidly excluded by a computed tomography of the skull. Failure to think of NPH may doom such patients to prolonged, needless debilitation and death.

Normal pressure hydrocephalus is much more common than is generally believed. By word of mouth I have encountered more than 25 previously unrecognised cases in the four years since my shunt. Some of them, like me, are living healthy, productive lives.

Awareness that incontinence may be the 'breakthrough' symptom that leads to the diagnosis of NPH is an important issue. The diagnosis of NPH may make the patient's 'golden years' a bright, shining grand finale, rather than a tarnished bitter ending.

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Acute medicine CME section

Editor – We read the acute medicine CME section of the June 2007 issue with interest (*Clin Med* June 2007 pp 257–79). We were disappointed to see no mention of the role of interventional vascular radiological (IR) techniques in the contemporary management of acutely unwell medical patients. It is essential that your readers recognise the