

speculative; however 92% of subjects presenting with newly discovered AF at the time of acute stroke continued to have this arrhythmia in a chronic or paroxysmal form suggesting that AF preceded the cerebrovascular event. Older individuals with persistent or permanent AF who are at increased risk of stroke, more commonly suffer either asymptomatic AF or AF associated with mild non-specific symptoms. Higher rates of stroke and congestive heart failure were reported in patients with silent AF in the population-based study in Olmsted County compared with symptomatic patients (17% v 13% (p=0.18) and 14% v 8% (p=0.025), respectively).<sup>9</sup>

The high prevalence and potential danger of silent AF has been emphasised by recent data from modern pacemakers and cardioverter-defibrillators: 50–60% patients may have unsuspected episodes of the arrhythmia, with almost half of these patients having paroxysms that last more than 48 hours.<sup>10</sup> Patients with episodes of fast atrial rates detected by a pacemaker in the MOST (Mode Selection Trial) study were more than twice as likely to die or have a stroke as similar patients without atrial high rate events.<sup>11</sup> Prospective studies such as ASSERT (Asymptomatic Atrial Fibrillation and Stroke Evaluation in Pacemaker Patients and the Atrial Fibrillation Reduction Atrial Pacing Trial), have now been instigated in order to clarify the implications of asymptomatic atrial tachyarrhythmias documented by implantable rhythm control devices with regard to the risk of stroke.

IRINA SAVELIEVA  
Lecturer in Cardiology

JOHN CAMM

Professor of Clinical Cardiology  
and Head of Division

Division of Cardiac and Vascular Sciences  
St George's University of London

#### References

- 1 Parkinson J, Campbell M. *Quart J Med* 1930;23:67.
- 2 Evans W, Swann P. Lone auricular fibrillation. *Am Heart J* 1953;189–94.
- 3 Kopecky SL, Gersh BJ, McGoon MD *et al*. The natural history of lone atrial fibrillation: A population-based study over three decades. *N Engl J Med* 1987;317:669–74.
- 4 Kopecky SL, Gersh BJ, McGoon MD *et al*. Lone atrial fibrillation in elderly persons: a marker for cardiovascular risk. *Arch Intern Med* 1999;159:1118–22.
- 5 Brand FN, Abbott RD, Kannel WB, Wolf PA. Characteristics and prognosis of lone atrial fibrillation: 30-year follow-up in the Framingham Study. *JAMA* 1985;254:3449–53.
- 6 Jouven X, Desnos M, Guerot C, Ducimetiere P. Idiopathic atrial fibrillation as a risk factor for mortality: the Paris Prospective Study I. *Eur Heart J* 1999;20:896–9.
- 7 Savelieva I, Camm AJ. Clinical relevance of silent atrial fibrillation: prevalence, prognosis, quality of life, and management. *J Interv Card Electrophysiol* 2000;4:369–82.
- 8 Lin HJ, Wolf PA, Benjamin EJ *et al*. Newly diagnosed atrial fibrillation and acute stroke: the Framingham study. *Stroke* 1995;26:1527–30.
- 9 Miyasaka Y, Gersh BJ, Rosales AG *et al*. Silent atrial fibrillation: an important contributor to total burden of atrial fibrillation in Olmsted County, MN (1980–1989). *J Am Coll Cardiol* 2004;43 (Abstract).
- 10 Israel CW, Grönfeld G, Ehrlich JR *et al*. Long-term risk of recurrent atrial fibrillation as documented by an implantable monitoring device: implications for optimal patient care. *J Am Coll Cardiol* 2004;43:47–52.
- 11 Glotzer TV, Hellkamp AS, Zimmerman J *et al*, for the MOST Investigators. Atrial high rate episodes detected by pacemaker diagnostics predict death and stroke: report of the atrial diagnostics ancillary study of the Mode Selection Trial (MOST). *Circulation* 2003;107:1614–9.

#### Conversation with Charles: briefing the media

The current 'Conversation with Charles' (*Clin Med* October 2007 pp 533–4) raises some valuable points and many issues relevant to the Science Media Centre (SMC). The SMC is based in the Royal Institution in London and is an independent press office for science in the news. Funded by over 70 different organisations, from small scientific societies, to larger institutions, such as the Royal Society and Medical Research Council, and pharmaceutical companies, we are in a position to provide UK national news journalists with good evidence-based experts to interview.

We agree that it is very difficult for journalists to decide whose opinion to trust and to know the difference between a good expert and a bad one. As *Coemgenus* points out, deciding whose opinion to listen to is also challenging within the scientific and

clinical community and it is understandably even harder for those who are outside the relevant discipline. It is also our experience that journalists are generally open to constructive criticism, and are often happy to be contacted by an expert offering their help if the issue comes up in the news again. Most journalists do not have an agenda – they simply want to get good information across and the greater access to evidence-based information from good experts the easier it is for them to write a fair and balanced story. A word of caution though, on balance, we find that journalists receive a large amount of criticism (often undeserved) and are rarely praised when they do justice to an issue. Most science and health journalism is of a good standard and receiving continued criticism can make the job of a journalist a thankless task. So we would encourage clinicians to also get in touch with journalists when they are pleased about the way something is covered.

The article raises concerns about whether the media is well served finding experts on clinical and medical issues. The SMC is regularly contacted on health issues and will find clinicians for journalists to interview, for example, respiratory clinicians on avian flu, or surgeons on the latest development in organ donation or the first face transplant. Though we do not have a 24-hour service all the time, if a big news story breaks we do drop everything and find good experts to work with all major news outlets – whether it happens to be Friday night, Sunday morning or even Christmas day. When a science or health story breaks we call the different programmes/journalists directly to provide them with a comprehensive list of experts. They are always delighted to hear from us as they have often been struggling to work out who is the best expert, and more importantly, how they are going to get hold of them out of hours. All UK national news outlets use the SMC including the BBC Radio 4 *Today Programme*, we answer over 800 media enquiries a year, run around 60 press briefings and issue around 120 press releases of comment and facts on the breaking news story of the day.

Despite our work on medicine and health stories, the SMC does not currently get involved in health policy issues,

including those surrounding the NHS and healthcare provision.

There have been informal discussions by some stakeholders, including the Department of Health, the King's Fund and British Medical Association, about whether there should be a health policy centre using the SMC as a model. Time will tell if this happens, or if as the SMC budget and staffing levels increase we expand into these areas.

If you are interested in being on the SMC database and would like to be involved with our work, please contact Claire Bithell on [cbithell@ri.ac.uk](mailto:cbithell@ri.ac.uk)

CLAIRE BITHELL  
Senior Press Officer  
Science Media Centre

### Patient-centred medicine

Editor – I think Lewith is correct (Letters to the Editor *Clin Med* August 2007 pp 416): clinicians currently working at the coalface of clinical practice may be best placed to judge if current health policy is driven primarily by evidence, or by political expediency (that is, what the public wants and is willing to pay for). If it is the latter, the medical profession should be alarmed and ashamed. We have a professional duty to test the efficacy treatments, however confidently we 'know' that they work.

Self-examination may be quite disconcerting, as my own experience has taught me. I obtained the MD degree with a thesis about the metabolic adaptations of severely malnourished children in a Third World country. When I returned to the UK I believed I was particularly well equipped to study the metabolic adaptations of obese adults on severe reducing diets when they mysteriously ceased to lose weight. I thought I 'knew' that, like marasmic infants, they had a severely reduced basal metabolic rate (BMR). Therefore stimulating them with a slightly supra-physiological dose of thyroxin would help them to continue losing fat.

Yes, they lost more weight on thyroxin, so the patients were pleased, and I was keen to prove that my theory was correct. Careful research showed that my theory was doubly wrong. They did not have a severely reduced BMR, and the extra

weight loss on thyroid was largely lean tissue rather than fat. So (because BMR is mainly determined by the lean body weight) when the thyroid treatment was stopped they had a lower BMR than they should have done.

I expect many scientifically inclined clinicians have similar stories to tell about beautiful theories that were destroyed by ugly facts. What they 'knew' to be good treatment may prove to be useless or even harmful to patients. I am sorry if Lewith has not had this salutary experience, so he is happy that political expediency should mainly determine his patient care. As he himself states, the practising clinician is best placed to judge the role of evidence in clinical practice. My suggestion to him is: physician, test yourself.

JOHN GARROW  
Emeritus Professor of Human Nutrition  
University of London

### Patient-centred medicine

Editor – The exchange between Ernst and Lewith (Letters to the Editor *Clin Med* August 2007 pp 416) seems to be at least in part based on semantics. Lewith stated in his original paper that, 'Patients know that CAM (complementary and alternative medicine) works...'<sup>1</sup> What does he mean by 'works'? If the statement is based on a *post hoc ergo propter hoc* scenario, then it works, and that is an assumption that patients, but I hope not Lewith, will commonly make. By 'works', I suspect that Ernst means 'demonstrated scientifically' – quite a different thing. In addition, it seems to me a misuse of the language to use the word 'know' when 'assume' would be more accurate.

While declaring the possible interest that I am one of the signatories to the letter which Lewith castigates so severely, I cannot agree that one must be a practising clinician to engage in this debate. Yet Lewith implies that those of us with a professional lifetime behind us in generating and evaluating clinical evidence are somehow unable to recognise it. Lewith made much play in the article of the value of non-specific effects, which none of us will deny.

Surely it is important for everyone, especially clinicians and most importantly

patients, to know how these can be differentiated from specific effects. How can such knowledge be a bad thing?

LESLIE B ROSE  
Director and Consultant  
Pharmavision Consulting Ltd,  
West Harnham, Salisbury

### Reference

- 1 Lewith G. Patient-centred medicine. *Clin Med* 2007;7:250–2.

---

## 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.

### Neurologists still have a role in the dementia care pathway

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) guidance regarding the identification, treatment and care of people with dementia envisages little, if any, role for physicians in general and neurologists in particular in the diagnosis of dementia, anticipating that psychiatrists, particularly old age psychiatrists, will manage the dementia care pathway in its entirety from diagnosis to end-of-life care.<sup>1</sup>

A 'single point of referral' is specified in the guidance. These recommendations apparently ignore the fact that some neurologists and geriatricians have developed significant specialist interests in dementia (the guideline development group lacked the input of a neurologist). Their exclusion from the dementia diagnostic pathway may be premature.

Referral source and diagnostic outcome of all new patients seen by one consultant neurologist in a dedicated cognitive function