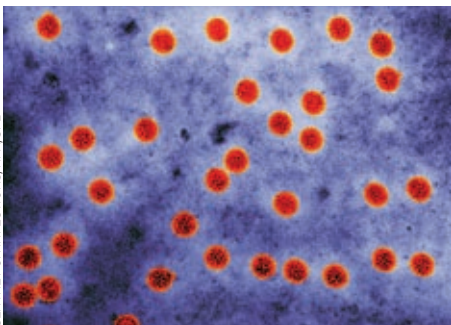


We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS



CENTRE FOR INFECTIONS/HPA/SPL

HUMAN PAPILLOMAVIRUS VACCINATION

Paradox of vaccination in cervical cancer and screening

The development of human papillomavirus (HPV) vaccines and their potential for reducing cervical cancer incidence and mortality are generally considered important steps to improve population health worldwide. For countries without well performing cervical cancer screening programmes and lack of treatment options the current epidemiological and economic models seem applicable.

However, the assumptions underlying published economic evaluations in countries with high coverage, well functioning screening programmes, such as that by Jit et al from the United Kingdom,¹ neglect an important limitation to the validity of their models. There is a non-negligible risk that a high HPV vaccine coverage in adolescents will lead to a decrease in screening uptake in later years because vaccinated women will see themselves as no longer at risk and will consequently avoid the unpleasant screening procedure.

As about 30% of cervical cancers are not caused by the current HPV vaccines against HPV types 16 and 18, there is a real risk of increased cervical cancer incidence and mortality in women who do not take up screening, counterbalancing the positive effects of the HPV vaccination. This is fuelled by health promotion material from manufacturers, cancer councils, and Cancer Research UK, all of which market the HPV vaccines as "cervical cancer vaccines." This is reflected in the general media and even in some leading scientific journals.²⁻⁵

Research investigating the potential impact of the HPV vaccines on screening uptake is urgently needed to establish the extent of this paradoxical effect on cervical cancer incidence

and mortality and to improve epidemiological and economic models to guide future policies for cervical cancer prevention.

Christian A Gericke, professor of public health policy, University of Adelaide, Adelaide, SA 5005, Australia
christian.gericke@adelaide.edu.au

Competing interests: None declared.

- 1 Jit M, Choi YH, Edmunds WJ. Economic evaluation of human papillomavirus vaccination in the United Kingdom. *BMJ* 2008;337:a769. (17 July.)
- 2 Kmietowicz Z. Opportunity was missed in choice of cervical cancer vaccine, health campaigners say. *BMJ* 2008;336:1456-7. (28 June.)
- 3 Keim B. Controversy over cervical cancer vaccine spurs safety surveillance. *Nat Med* 2007;13:392-3.
- 4 Cohen J. Public health. High hopes and dilemmas for a cervical cancer vaccine. *Science* 2005;308:618-21.
- 5 Zimet GD, Shew ML, Kahn JA. Appropriate use of cervical cancer vaccine. *Annu Rev Med* 2008;59:223-36.

Cite this as: *BMJ* 2008;337:a1049

Glimpse into the black box of HPV vaccination

We welcome an opportunity to get a glimpse into the black box underlying the recent decisions about human papillomavirus (HPV) vaccination.¹ We would like to reflect on the assumptions made. GlaxoSmithKline claims that Cervarix will provide protection longer, which would favour Cervarix. The paper by Jit et al does not reflect this (which is probably appropriate, since these claims are disputed).

The paper's assumption that those receiving fewer than three doses received no protection is conservative: two doses do provide some protection. Evaluation of the programme will allow us to assess this further.

Vaccination may allow an increased screening interval (with or without HPV testing). The paper does not seem to model the savings that might result.²

The paper's estimate of the cost of treating genital warts (£216 (€275; \$430) per successful treatment) is lower than estimates elsewhere.³ Given this, the high and increasing incidence of genital warts,^{3 4} the need for repeated treatments, and the psychosocial costs of genital warts, we wonder whether the benefits of quadrivalent Gardasil have been underestimated.

It is not clear whether discounting has taken into account the earlier benefits of wart prevention, which would tend to tip the balance more in favour of Gardasil.

HPV causes other cancers. Some data indicate that anal cancer rates in men who have

sex with men might exceed cervical cancer rates in women; and that more anal than cervical cancers might be prevented by vaccination.⁵

Consideration of other cancers would not only favour introducing the vaccine but might also tip the balance towards vaccinating boys as well as girls, thus mitigating equity issues and avoiding the impression that sexual health is only an issue for girls. Furthermore, if vaccine uptake is low, then vaccinating boys will be necessary to achieve herd immunity.

Peter M English consultant in public health medicine, professor, epidemiology of infectious diseases, epidemiology and public health, Surrey KT19 9XF
petermbenglish@gmail.com

Keith Neal University of Nottingham, NG7 2RH

Competing interests: Between them the authors have given occasional lectures for, received expenses for professional conferences from, and participated in advisory boards for various pharmaceutical companies, including GlaxoSmithKline, Sanofi Pasteur MSD, and others.

- 1 Jit M, Choi YH, Edmunds WJ. Economic evaluation of human papillomavirus vaccination in the United Kingdom. *BMJ* 2008;337:a769. (17 July.)
- 2 Franco EL, Cuzick J, Hildesheim A, de Sanjose S. Issues in planning cervical cancer screening in the era of HPV vaccination. *Vaccine* 2006;24(suppl 3):S171-7.
- 3 Lacey CJN, Lowndes CM, Shah KV. Burden and management of non-cancerous HPV-related conditions: HPV-6/11 disease. *Vaccine* 2006;24(suppl 3):S35-41.
- 4 Health Protection Agency Centre for Infections. *Sexually transmitted infections and young people in the United Kingdom: 2008 report*. London: HPA, 2008. www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1216022460726?p=1158945066450.
- 5 Parkin DM, Bray F. The burden of HPV-related cancers. *Vaccine* 2006;24(suppl 3):S11-S25.

Cite this as: *BMJ* 2008;337:a1046

PERIPHERAL INTRAVENOUS CATHETERS

It's who looks after the catheters that counts

Maki asserts that the incidence of intravenous catheter complications is greatly reduced when highly experienced nurses insert catheters.¹

The single reference provided to support this statement makes interesting reading.²

This randomised controlled trial compares complications in two main groups of patients: those who are cannulated by house doctors and followed up by ward staff and those who are under the care of the intravenous therapy team. The latter group is checked daily for complications by experienced nurses, but their cannulas are inserted by doctors and nurses in similar numbers. The intravenous therapy nurses do a sterling job it seems between 9 am and 5 pm, but in time honoured tradition it is

the house doctors who perform all intravenous cannulation between 5 pm and 9 am and at weekends.

The complication rates for patients who are subsequently followed up by the intravenous therapy nurses were slightly higher for the nurse inserted cannulas (9.3%) than the doctor inserted cannulas (6%).² The three episodes of line related sepsis in the house doctor group (not undergoing routine daily review) seem to be related to duration in situ rather than any other factor. One of these three cannulas was actually inserted by paramedics rather than the house doctors.

The paper clearly states that the maintenance and timely removal of intravenous catheters is more important than the specific personnel inserting the catheters in determining the occurrence of complications.

It is frustrating to see an editorial make a rather sweeping statement that is not supported by the relevant citation.

Steven J Kennish specialist registrar in radiology, Leeds General Infirmary, Leeds LS1 3EX
s_kennish@yahoo.co.uk

Competing interests: None declared.

- 1 Maki DG. Improving the safety of peripheral intravenous catheters. *BMJ* 2008;337:a630. (8 July.)
- 2 Soifer NE, Borzak S, Edlin BR, Weinstein RA. Prevention of peripheral venous catheter complications with an intravenous therapy team: a randomized controlled trial. *Arch Intern Med* 1998;158:473-7.

Cite this as: *BMJ* 2008;337:a1001

PROFESSIONAL CONDUCT

Confidence in child protection practice

see FEATURES pp 258, 262

The Royal College of Paediatrics and Child Health welcomes the guidance for expert witnesses produced by the General Medical Council.¹ The key points describe the rules and legislation that should be familiar to all paediatricians who attend court. It closely echoes the important statement from the Department of Health and the Department of Children, Schools, and Families.² This should protect the public and, importantly, paediatricians who have felt vulnerable when giving evidence as expert or professional witnesses. Paediatricians are particularly involved in family courts, and the GMC guidance should be read alongside the *Handbook for Expert Witnesses in Children Act Cases*.³

However, the GMC must itself look to its own procedures.

Gornall describes the GMC's withdrawal of the longstanding case, partly through, against three paediatricians⁴ (p 258). We are pleased with this decision but remain concerned about the unnecessary distress caused to doctors by



MARK THOMAS

unacceptable delays and the issues around potentially conflicted expert witnesses. We know the GMC recognises these problems, and the recent guidance describes the responsibility of experts to declare potential conflicts and the courts to decide on appropriate action.

Dyer notes that the Crown Prosecution Service's review of "secret" case files held by Dr David Southall found no evidence that any information was kept from the defence⁵ (p 263). This is a welcome and important finding and should help to restore the confidence of the public in criminal prosecution processes as well as the confidence of paediatricians who work in difficult circumstances. We know that the management of case files and proper communication are important parts of child protection processes as described by Lord Laming in the Victoria Climbié inquiry.

Paediatricians contribute to the protection of children by following clearly laid out procedures detailed in the government's document *Working Together to Safeguard Children*,⁶ and they must feel safe from unnecessary referral to the GMC or from protracted procedures. We hope this guidance will help to achieve this and the Royal College of Paediatrics and Child Health continues to have discussions with the GMC about its processes.

Patricia Hamilton president, officer for child protection
Rosalyn Proops, Royal College of Paediatrics and Child Health, London WC1X 8SH
rosalyn.proops@nnuh.nhs.uk

Competing interests: None declared.

- 1 General Medical Council. *Acting as an expert witness*. London: GMC, 2008.
- 2 Department of Children, Schools and Families; Department of Health. *Statement on the duties of doctors and other professionals in investigations of child abuse*. London: DCSF, 2007.
- 3 Wall N. *Handbook for expert witnesses in Children Act cases*. 2nd ed. Bristol: Jordan Publishing, 2007.
- 4 Gornall J. Three doctors and a GMC prosecution. *BMJ* 2008;337:a907. (24 July.)
- 5 Dyer C. Southall's secret case files show no reason to suspect miscarriages of justice. *BMJ* 2008;337:a987. (24 July.)
- 6 Working together to safeguard children—a guide to inter-agency working to safeguard and promote the welfare of children. HM Government, 2006. www.everychildmatters.gov.uk/_files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf

Cite this as: *BMJ* 2008;337:a1063

A DISCRIMINATING JUDGMENT

You cannot be serious, says GMC to observation article

In an uncharacteristically dyspeptic column, Hawkes castigates the General Medical Council over several unrelated issues.¹ Donning his suit of rusty armour and unsheathing the sword of truth and justice, he sallies forth to fight the battles of yesteryear without fear, favour, or much forethought. His points on the end of the exemption from the annual retention fee for doctors over the age of 65 cannot go unchallenged.

As an Aberdonian, I have an ingrained interest in matters fiscal. But even I have difficulty in accepting that the current fee of £390 is an "excessive" sum for a licence to practise medicine in this country. The clear advice from leading counsel was, and remains, that age related exemption from the annual retention fee is unlawful under the relevant statutory employment regulations. The council had no choice but to regularise the position as quickly as practicable. It would have been preferable to integrate this change for doctors over the age of 65 with the introduction of licences to practise towards the end of 2009. However, as the current arrangements are unlawful, this option was not open to us.

Hawkes has, I fear, misread the relevant regulation 19(1)(c), which must be read in conjunction with regulation 3. Regulation 19(1)(c) does not say that we cannot withdraw or vary the terms on which a qualification is held. Rather, it says that we cannot discriminate (on grounds of age) by withdrawing or varying the terms on which a qualification is held. The regulations are not about discrimination against elderly people, they are about discrimination on the basis of age.

The argument about national emergencies has been addressed by recent changes which empower the registrar of the GMC to grant temporary registration, without any fee, to individuals with regard to emergencies involving loss of human life or human illness.

I understand the Victor Meldrew view that standards have slipped, are continuing to slip, and that the GMC needs to do something. As ever, the truth is more complicated and less worrying—even if, along with Victor, you simply don't believe it.

Graeme Catto president, General Medical Council, London NW1 3JN
opce@gmc-uk.org

Competing interests: None declared.

- 1 Hawkes N. A discriminating judgment. *BMJ* 2008;337:a809. (14 July.)

Cite this as: *BMJ* 2008;337:a1048