UVB phototherapy for psoriasis; reply

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LETTERS

ST BARTS HOSPITAL/SPL

UVB PHOTOTHERAPY FOR PSORIASIS

Narrowband UVB phototherapy

Koek and colleagues' study should encourage others to implement supervised home ultraviolet B (UVB) phototherapy for psoriasis and other conditions.[1] We reported pilot studies of home phototherapy using narrowband UVB, which is more effective for psoriasis than broadband UVB.[2 3]

We now have over 10 years' experience of home phototherapy, with 16 home phototherapy units in almost constant use. We use a hub and spoke model for providing phototherapy and other dermatology outpatient services.[4] Our service includes three separate peripheral hospital phototherapy units and a central unit in Dundee, but home phototherapy still has a place. In 2008, 25 of the 818 (3%) courses of whole body narrowband UVB administered by our service were for home phototherapy. Most home phototherapy courses in our area are for psoriasis (155 of the previous 216 (72%)). However, with appropriate supervision, home narrowband UVB phototherapy is also useful for atopic eczema, desensitisation treatment of photodermatoses (including erythropoietic protoporphyria), and other conditions.

Appropriate selection of patients is essential. This is in keeping with Koek and colleagues' finding that only 196 patients attending 14 hospital units over three years met their study eligibility criteria.[1] Also, to ensure that the treatment is as effective and safe as hospital phototherapy, the hospital based phototherapy units must supervise patients, device testing, and dosimetry measurements. Our home phototherapy service is run within Photonet, the national managed clinical network for phototherapy (established since 2002), so treatment is given to agreed protocols and all data are gathered centrally for long term analysis. This will also allow recall of patients to monitor skin cancer if necessary.

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1 Koek MB, Buskens E, van Weelden H, Steegmans PHA, Bruijnzeel-Koomen CAFM, Vigfús Sigurdssont V, et al. Home versus outpatient ultraviolet B phototherapy for mild to severe psoriasis: pragmatic multicentre randomised controlled non-inferiority trial (PLUTO study). *BMJ* 2009;338:b1542. (7 May.)
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Authors' reply

Cameron and Dawe suggest that careful selection of patients is essential to maintain and safeguard efficacy and safety, seeming to think that patients in our trial were also specifically selected. However, our patients were a representative sample of those considered clinically eligible.[1 2]

Although only 196 patients from 14 hospitals participated in our study, the type of selection Cameron and Dawe aim at was not part of our eligibility criteria.[1 2] Only 252 patients were referred to us for participation in the trial. To keep a record of all of the reasons for non-referral was unfeasible, but from the few dermatologists who did keep a record we know that many patients were simply not willing to participate. Also sometimes dermatologists simply forgot to ask.

We noted that participants in our trial were people from all walks of life. Although we do not rule out that minimal selection has occurred, we are convinced that on average our participants adequately represent patients with psoriasis who receive (outpatient) UVB treatment. We therefore disagree with Cameron and Dawe because our trial and experience[3] show that there is little reason to select patients on the basis of presumed intelligence, competence, responsibility, reliability, or compliance.[1]

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DEPRIVATION OF LIBERTY

Liberty safeguards in hospital

The interplay of deprivation of liberty safeguards and the Mental Capacity Act is probably most complex in general hospitals.[1] People with delirium, dementia, or severe aphasia or who are in coma will lack the capacity to consent to admission or prolonged stay because of their underlying cognitive state.[2] Delirium and other neuropsychiatric disorders are often subject to chemical restraint in general hospitals, especially in adult critical care units.[3] Such restraint is done in a patient's best interest but could be regarded as deprivation of liberty under the Mental Capacity Act.

In managing a patient who has delirium in a general ward or intensive care, doctors may need to consider the use of the amended Mental Health Act 2007. However, this may not be immediately possible in an emergency—for example, the patient suddenly becoming aggressive and unmanageable. If a patient experiences repeated episodes of aggression/agitation alternating with lucid intervals, repeated use of restraint is likely to amount to deprivation.[4] The Mental Health Act 2007 could be used again, but practice may not be straightforward, especially when a hospital consultant acting in the best interest of such patients tries to ensure that they do not leave hospital before they have recovered or adequate community support has been set up.[2] Under the act the hospital consultant has to subsume the role of responsible medical officer.[2]

Hospital consultants need to be aware of these issues and work with their mental health

counterparts in drawing up guidelines (and perhaps protocols). Training and educational programmes for general hospital staff may also be appropriate.

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US HEALTHCARE REFORM

Choice and equality in health

The US aversion to a single payer system highlights a fundamental difference in mentality between the United States and the United Kingdom that the US government would do well to remember.[1] To many Americans the term single payer represents socialised medicine and government bureaucracy, while in the NHS it represents a noble ideal of use according to need but contribution according to the ability to pay. The US healthcare system is driven by the desire for choice whereas the NHS is driven by the desire for equality.

In moving to empower NHS patients with choice, the UK government is in danger of sacrificing the principle of equality on which the service was founded, for choice and equality necessarily conflict. If choice is possible then, by definition, differences exist in the quality of care being provided in the NHS and some are receiving a substandard service that an informed patient would not choose. Allowing patient choice by publicly reporting outcomes is likely to exacerbate inequality as some are better positioned to exercise choice[2]—most likely rich and well educated people.

These people are more likely to be politically active, and thus promoting choice seems an effective way of scoring political points in the guise of making the NHS fairer. The fairest approach is to foster a system in which choice is not needed by dealing with those whom no informed patient would choose.

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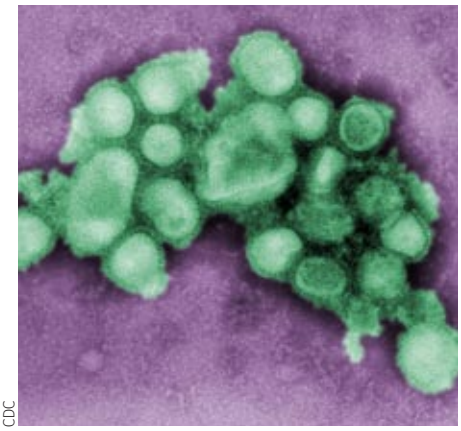
A/H1N1 FLU

NSAIDs and flu



CDC

The potentially harmful effects of non-steroidal anti-inflammatory drugs (NSAIDs) are rarely discussed in the treatment of A/H1N1 flu, which has caused high death rates in Mexico.[1 2]

Severe and fatal cases, including sudden death, are characterised by severe sepsis with multi-organ failure with findings such as fever, leucocytosis, leucopenia, acute respiratory distress syndrome (ARDS), liver impairment, renal failure, rhabdomyolysis, and hypotension.[2] NSAIDs may aggravate these syndromes, leading to multi-organ failure.[3]

Since the flu pandemics of the 20th century salicylates have been linked to Reye's syndrome and their use restricted in children. But NSAIDs such as diclofenac, mefenamic acid, and ibuprofen are still used as antipyretics in many countries, albeit less often than aspirin. Since the use of diclofenac and mefenamic acid was restricted in children in Japan in 2000, the case fatality of so called flu associated encephalopathy has fallen dramatically.[4]

Reanalysing the World Health Organization's data on A/H1N1 flu,[2] I found that the odds ratio of case fatality in adults (3.7%) and children and adolescents under 20 (0.5%) is 7.63 (95% confidence interval 3.78 to 15.85, P<0.001). Whether the people who died were treated with NSAIDs is not known. However, NSAIDs are readily available over the counter in Mexico and people commonly self treat.[5]

Case-control studies are urgently required to assess the risks of NSAIDs as antipyretics in flu.

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Aspirin in the 1918 pandemic

Aspirin may have enhanced the virulence of the flu virus in the 1918 pandemic, which has implications for A/H1N1 flu.[1]

During the 18 months of the 1918-9 pandemic, 27 million people died worldwide, mortality being highest in the second wave, October 1918, especially in the United States. Age specific mortality followed a W curve, with high death rates in healthy young adults aged 20-40 as well as in children under 5 years old and people aged 65 and over. It was wartime and young men were crowded together in military camps, but the mortality was also high in men of the same age who remained at home.[2]

In September 1918 Rupert Blue, the US surgeon general, advised that flu could be controlled "only by intelligent action of the public." He added: "During the present outbreak in foreign countries, the salts of quinine and aspirin have been most generally used during the acute attack, those of aspirin apparently with much success in the relief of the symptoms."[3]

To subdue fever 5-10 grains (324-648 mg) of aspirin tablets could be prescribed every three hours up to 7 g in 24 hours.[4] According to the same commentator on homoeopathic medicine, mortality was 1% or less without aspirin and 5-30% in patients treated with aspirin in hospitals or in the armed forces.[4]

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