

Letters to the Editor

THE MEDIA DOCTOR

Sir, Dr Persaud's thoughtful appraisal¹ of the relations between the medical profession and the media is most welcome and might act as a stimulus for the Royal Colleges in Scotland to establish a joint medical advisory group with the BBC and other media companies.

Between 1978 and 1985 such a group existed, although not related to the Colleges, and was responsible for a weekly BBC broadcast. At its height, in the region of 1.3 million listeners were recorded in Scotland and north-east England. The group was allocated four and a half minutes from 08.25 each Monday morning - a peak time for car drivers. The speakers were two general practitioners - one with a gentle Glasgow voice and the other a reassuring East coast accent. They alternated, and were unpaid. The little organising committee met with the directors of the BBC once a month and selected one specific subject, such as asthma or headache or blood pressure or breast feeding, for each broadcast.

The doctors remained in full-time practice and did not, so far as I know, suffer any opprobrium from their medical colleagues or untoward publicity. They enjoyed the broadcasts and became very skilled in communicating the message. Judging by the many letters received, the public seemed enthusiastic (I recall only six adverse letters all relating to the programmes on contraception). These simple broadcasts increased the public's knowledge and trust in the profession.

All went well for seven years and Lord Swann, then Governor of the BBC, gave his full backing to this project. But for reasons of internal policy, the BBC closed the programme - to the disappointment of many.

MF Oliver, Chairman BBC Medical Advisory Committee
1978-85

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OBESITY, AN OVERVIEW

Sir, In their review of obesity McNulty and Williams support the use of vertical banded gastroplasty, but quickly dismiss jaw wiring because 'it is readily bypassed by determined patients with ingenuity. We feel, like many in the field, that this method achieves little in the long term and is dangerous and obsolete.' No literature is cited to support this opinion.

Jaw wiring for the treatment of obesity does not require a general anaesthetic or in-patient admission to hospital, and to my knowledge has zero mortality. It should be

performed by an experienced faciomaxillary surgeon, and the patient needs long-term management by an interested physician, but these requirements are certainly no greater than those for vertical banded gastroplasty. To maintain weight loss after the jaw wires are removed, it is helpful to fit a waist cord: with a combination of jaw wiring and waist cord we observed a mean (sd) weight loss of 42.4 (7.4) kg at three years follow-up,^{2,3} which compares well with the gastroplasty results, and is, an order of magnitude greater than that achieved by drug therapy.

I am curious to know why 'many in the field' think jaw wiring achieves little and is dangerous and obsolete. I believe that for many patients it is a safer and less expensive alternative to gastroplasty, which can also be 'bypassed by determined patients'. I have experience of a patient who, after gastroplasty, had such determination to override the surgically-produced stenosis that he ruptured his staple line and sadly died. This is not a danger which a patient need face after jaw wiring and the fitting of a waist cord.

Does not jaw wiring at least deserve a randomised trial versus gastroplasty?

JS Garrow, Emeritus Professor of Human Nutrition

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³ Garrow JS. The management of obesity. Another view. *Int J Obes* 1992; **16**(suppl 2):S59-S63.

Sir, We read with interest the response of Professor Garrow to our review article. We stand by our rather negative view of jaw wiring, but accept that the evidence both for and against it is neither as extensive nor as detailed as would be needed to make a truly valid assessment. The technique is certainly obsolete - at least, we no longer see patients being managed in this way, which suggests that they and their doctors have voted with their pliers, if not their feet. We would suggest that the maintenance of long-term weight loss following jaw wiring, in patients who then used a weight cord, is more a result of the latter, and that it would be seen with any treatment that achieved initial weight loss. We were sorry to hear about Professor Garrow's patent whose gastroplasty went so tragically wrong, but do not believe that a clinical anecdote - no matter how dramatic - should be allowed to demolish a steadily accumulating body of experience and evidence of clinical efficacy for this procedure.

We agree with Professor Garrow that jaw wiring should perhaps be tried in a formal setting against gastroplasty, but are not necessarily convinced that this motive alone would

be enough to resuscitate this approach. Moreover, the use of jaw wiring as a therapeutic approach runs counter to all our attempts to remove the visible and psychological stigmata of obesity.

G Williams, Professor of Medicine
SJ McNulty, Clinical Research Fellow in Diabetes

SIR HENRY DUNCAN LITTLEJOHN

Sir, The excellent paper by Bain, Bentley and Squire in the Proceedings of July 1999¹ was incorrect in one respect.

The Board of Supervision which had been the central authority for the Poor Law in Scotland since 1845 became the central authority for Public Health from 1867, and not from 1873 as stated on p250. This new responsibility was given to the Board under the terms of the Public Health (Scotland) Act 1867.²

Prior to 1867 the Board had limited powers under legislation dealing with nuisances. These enabled them to commission Dr Littlejohn on an ad hoc basis to investigate several outbreaks of infectious diseases. The wider and better defined powers given to the Board in 1867 led them to decide in the early 1870s to put Dr Littlejohn's services on a more regular basis. In 1873 they appointed him a part-time medical officer.

The year 1873 was therefore important in Sir Henry Littlejohn's career. It might also be noted that he was the first medical officer appointed on a continuing basis to advise the central government agency responsible for public health in Scotland.

IS Macdonald, Retired Civil Service Medical Officer

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HIV AND LIVER TRANSPLANTATION

Sir, I was disappointed to see that HIV infection is listed as a contraindication to liver transplantation in Simpson and Garden's recent article.¹ I had hoped we had moved on from the time when the powerful stigma of HIV used to pervade all logical medical thinking and could paralyse scalpels in mid-stroke. Do the authors feel HIV patients might not live for very long anyway, or that they might do badly post-transplant because of additional immunosuppression?

Neither supposition is true. HIV infection is a chronic infection with reasonable life expectancy (over 20 years and increasing) and patients usually enjoy a good quality of life and near-normal general immunity. The introduction of highly active antiretroviral therapy (HAART) in the last three to four years has revolutionised the lives of people with HIV. It is important that other medical specialists recognise this fact and cease to base their ideas about HIV survival on outdated misconceptions.

Many successful liver transplants have taken place in

HIV patients.^{2,3} It is true that some such patients have fared less well,⁴ but most of the studies in this area were completed prior to the introduction of HAART or in patients who had transplants up to 10 years ago. Today even better survival is expected given the improvements in the outcome of both HIV and transplantation.

It would obviously be inappropriate to attempt a transplant in someone with end-stage HIV disease who has extremely limited life expectancy, but it would be equally unjust to deny patients the benefits of an organ transplant simply because of their seropositive HIV status. Simpson and Gardner¹ discuss ethical considerations and discrimination in selection of patients for transplant - they themselves should not advocate discrimination against those with HIV. Physicians should move away from generating rigid lists of absolute contraindications for medical interventions as these can lead to failure to refer for assessment what could be suitable cases. Few things are 'absolute' in medicine, particularly in rapidly changing fields like transplant medicine and HIV infection.

PJ Flegg, Consultant Physician, Blackpool Victoria Hospital

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- 3 Tzakis A, Cooper M, Dummer J *et al*. Transplantation in HIV+ patients. *Transplantation* 1990; **49**:354-8.
- 4 Gordon FH, Mistry PK, Sabin CA, Lee CA. Outcome of orthopaedic liver transplantation in patients with haemophilia. *Gut* 1997; **42**:744-9.

Sir, We are grateful for Dr Flegg pointing out a significant omission in our review of the indications and implications of liver transplantation. Not to have discussed in more detail our current thinking regarding transplantation in HIV positive patients invited his criticism. However, the tone of his letter suggests to us that after reading our article, Flegg rushed to pen his response without adequately considering the evidence which he misquotes in his letter. Far from the scalpel being paralysed in mid stroke, our inclusion of HIV positive as an absolute contraindication is a considerable response to the available data. To suggest that we are discriminating against patients with HIV is complete nonsense.

Flegg quotes two papers to advance that 'many successful liver transplants have been undertaken in HIV positive patients.' In fact the paper from King's College, London, UK describes four patients with haemophilia and hepatitis C infection, only one of whom was also infected with HIV.¹ In contrast to the original report, this patient was later reported to have died 15 months post-transplant, from an AIDS-related illness.² A more recent report from the same group described HIV positive patients with related chronic liver disease, all of whom died within two years of transplantation. A further patient presenting with acute liver failure due to HIV infection is alive 20 months post-transplant.³ The other study cited by Flegg, from Pittsburgh, USA, describes 11 HIV positive patients receiving liver transplants, but only three of these patients were known to be HIV positive pre-transplant.⁴ The others were identified

in a look-back study.⁵ Of these 11 patients, only seven underwent liver transplantation and five out of died, 4-42 months post-transplant. Three of these five deaths were AIDS-related. In a more recent publication reviewing the results of liver transplantation in patients with haemophilia also cited by Flegg, only one other institution had reported transplanting a patient who was also infected with HIV.³ This patient died from AIDS, 27 months post-transplant. The survival of patients with haemophilia following liver transplantation was 90% at one year and 83% at three years in the non-HIV infected group compared with 67% and 23% in HIV infected patients. These poor survival figures include some patients treated with zidovudine and/or saquinavir. Further review of the literature identified very few other reports of liver transplantation in HIV positive patients. In one, the patient developed fulminant Kaposi's sarcoma and died eight months post-transplant,⁶ and in another a patient treated with protease inhibitors developed severe Tacrolimus toxicity.⁷ Furthermore the unfortunate patients infected with HIV either by their transplanted organ or the peri-operative blood transfusions, progress to AIDS quicker than a non-transplanted control group.⁴ Because of a worse prognosis post-transplant, HIV positive patients with renal failure are best maintained on dialysis.⁸ While some of the studies discussed above made much of the poor life expectancy of the patients pre-transplant and the improvement in their quality of life post-transplant, liver transplant in HIV positive patients is associated with an unacceptably poor survival rate at the present time. Our view that HIV positivity is an absolute contraindication to transplantation is currently supported by the vast majority of liver transplant programmes in the United Kingdom, United States and Canada.

The discussion regarding transplantation in patients with HIV infection raises the more general question of how we should develop and expand the indications for liver transplantation. In the past, when there were more donor organs than potential recipients, 'experimenting' with a certain group of patients could be defended. Such an approach is difficult to sustain when there are more potential recipients than donors, and many of our patients die while waiting for a suitable organ. Furthermore the donor pool is contracting with the impact of seatbelt regulations and improvement in neurological ICU care. We have a national system for the allocation of donated livers covering the UK and Eire. It is possible, for example, that use of an organ in Edinburgh may deprive a patient in Birmingham or King's College a life-saving operation. Therefore it is not tenable for one transplant unit to attempt to develop a further indication without the agreement of all transplant units in the system. Although Flegg makes the case for HIV patients, what of others, perhaps not blessed with such vociferous proponents, such as the elderly, young patients dying from alcoholic hepatitis, or those whose life expectancy following transplant is known to be inferior than for the 'traditional' indications.

The stark reality of the present equation; too many recipients minus too few donors equals more patients dying on the waiting list, suggests to us that this is the fundamental problem that requires to be addressed. A solution cannot come from the transplant centres or the medical profession alone but urgently needs wider discussion by society as a whole. In addition we should not underestimate the general public view about the advances in the indications for liver

transplantation, many of which do not appear to be supported by the medical profession or society as a whole.⁸

KJ Simpson, Senior Lecturer in Hematology
OJ Garden, Professor of Hepatobiliary Surgery

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NON-PHARMACOLOGICAL MANAGEMENT OF CARDIAC ARRHYTHMIAS

Sir, Although it is commonly assumed that 'the potential benefits of restoration of sinus rhythm...are presumed but not proven',¹ the merits of restoration of sinus rhythm relative to long-term anticoagulation are more clear-cut. Anticoagulation without restoration of sinus rhythm is like walking a tightrope poised between the haemorrhagic risk of over anti-coagulation and the embolic risk of undercoagulation; this is a double-edged risk which does not diminish with time. With restoration of sinus rhythm using amiodarone, the competing risks are drug side-effects and the possibility of relapse into atrial fibrillation, but the latter (though unproven) might diminish with time, since it is possible that 'sinus rhythm might beget sinus rhythm' in a manner analogous to the truism about atrial fibrillation. With restoration of sinus rhythm, the 'Scylla vs Charibdis' equation might progressively be less disadvantageous for the patient.

OMP Jolobe, Tameside General Hospita, Ashton-under-Lyne

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