

CMO's Update 4

a communication to all doctors
from the Chief Medical Officer



New national thesaurus

This autumn sees an important milestone in the development of a common computerised language for health care. Medical and nursing professions and the professions allied to medicine have worked over the last two and a half years to expand the Read Codes¹ to provide an agreed national thesaurus of health care terminology. This coding system provides a basis for computerised clinical records that can be shared across professional and organisational boundaries, subject to essential safeguards of security and confidentiality.

The projects have involved over 2,000 clinicians in the United Kingdom; 55 working groups developed terms for individual specialty areas in consultation with all other relevant groups. These terms are being integrated into version 3 of the Read Codes, the structure of which has been enhanced to accommodate the different views of specialties and to keep terms simple and understandable without the loss of fine detail. In recognition of this technical achievement and the collaboration with and involvement of such a large clinical network, the British Computer Society has chosen

the National Health Service (NHS) Centre for Coding and Classification as one of nine medal winners for their Information Technology Awards for 1994.

An announcement is expected shortly from the Conference of Medical Royal Colleges and the Joint Consultants Committee that the Read Codes should be the preferred clinical dictionary to underpin all person-based clinical systems and electronic communications in the NHS to improve patient care and for audit, research, outcomes and guidelines. It is expected that the professions allied to medicine and the nursing professions will also issue similar recommendations. The clinical terms have also attracted the full support of the Chief Medical Officer and the NHS Executive and should provide a sound base to assess outcomes of various health initiatives, including the Health of the Nation.

For further information please contact: Dr Charlie Stuart-Buttle, NHS Centre for Coding and Classification, Woodgate, Loughborough LE11 2TG.

1. Chisholm J. The Read clinical classification. *BMJ* 1990; 300: 1092.

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CMO's Update is a newsletter sent by the Chief Medical Officer of the Department of Health to all doctors in England. It will incorporate some topics that might otherwise have required an individual letter, progress reports on earlier letters, and other information from the Department of Health that should be of interest to practising doctors.

For changes in address, please contact: The Medical Mailing Company, PO Box 60, Loughborough LE11 0WP (or telephone Freephone 0800 626387).

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Adverse reactions to alternative remedies

The use of traditional medicines and food supplements has increased considerably in recent years. Many people consider such products to be safe and devoid of ill-effects because they are 'natural'. However, some of these preparations may cause adverse or toxic reactions; many are not thought of as a medicine (and therefore as a potential hazard) by consumers or by their physicians; and only a few have been tested for efficacy, safety or quality.

The Department of Health has an advisory role in a project, being carried out by the Poisons Unit at the Guy's and St Thomas' Hospital Trust, which aims to assess the frequency and severity of toxicological problems resulting from exposure to traditional medicines and food

supplements. A number of cases have already been identified in which the use of such products has had adverse effects on health, including a death from acute liver failure^{1,2}.

All doctors should be aware that their patients may be taking traditional medicines or food supplements and inquire specifically about their use. The project team would like physicians to notify them of cases where the use of such products is thought to have led to acute or chronic health problems; more detailed investigations can be suggested if required. Collation of this information is not an attempt to impose 'conventional' ideas of allopathic medicine, but is intended to minimise potential harm and to maximise potential benefits in an area where firm

data are sadly lacking; this activity has also been supported by the British Medical Association. The Project is funded by the Ministry of Agriculture, Fisheries and Food.

Further information can be obtained from: Dr Norman Lazarus, Room 510 Skipton House, 80 London Road, London SE1 6LW; or from: Guy's Poisons Unit, New Cross Hospital, Avonley Road, New Cross, London SE14 5BH.

1. Perharic-Walton L, Murray V. Toxicity of chinese herbal remedies. *Lancet* 1992; **340**: 672-4.

2. Perharic L, Shaw D, Colbridge M, et al. Toxicological problems resulting from exposure to traditional remedies and food supplements. *Drug Safety* 1994; **11**: 284-94.

Hepatitis B: NHS Injury Benefits Scheme

There has recently been some concern about compensation for health care workers whose earning ability is reduced because they acquire hepatitis B infection as a result of their work. All work-related infections, including hepatitis B, are covered by the National Health Service (NHS) Injury Benefits Scheme. The Scheme provides both temporary and permanent benefits to workers infected during the course of their NHS employment, whether symptomatic or not.

The benefits are intended to compensate for loss of earning

ability and provide a guaranteed income of up to 85% of pre-injury NHS earnings. A lump sum is also payable if employment is terminated and, where death occurs, dependants' benefits are payable.

In addition to covering all NHS employees, the Scheme also covers general medical and dental practitioners in respect of their NHS duties.

Claims should be made on form AW13, which can be obtained from the NHS employer. General medical and dental

practitioners can obtain the form from their Family Health Services Authority.

Further information on general aspects of hepatitis can be obtained from: Dr Hugh Nicholas, Room 717 Wellington House, 135-55 Waterloo Road, London SE1 8UG. Information on the NHS Injury Benefits Scheme can be obtained from Mr Chris Haworth, NHS Pensions Agency, Room 024 Hesketh House, 200-20 Broadway, Fleetwood FY7 8LG.

TOXBASE, the computerised poisons information database of the National Poisons Information Service, contains information on several thousand drugs, chemical substances, household products, cosmetics, toiletries, pesticides and plants - including their active ingredients, clinical effects by various routes of exposure and management in cases of poisoning. United Kingdom Departments of Health regard TOXBASE as the primary source of poisons information for National Health Service (NHS) staff; the database is of particular value to accident and emergency departments, drug information centres and the larger primary health care centres. Purchasers of accident and emergency services in particular should ensure access to poisons information services, and provider units with accident and emergency departments have been urged to install computer access to this database¹.

TOXBASE is available "on-line" to authorised users and

registration for access to it is free within the NHS; an inquiry costs only the price of a telephone call. The database is made available through a viewdata (videotext) system in which a dedicated viewdata terminal or a personal computer with appropriate communications software is linked to the host computer either by the national telephone system or the ISTEEL 'Infotrak' network; the latter system enables inquiries to be made at local call rates. (Two other view databases are also available on the same system - TRAVAX, which provides information on health precautions for travellers, and VADIS, which offers prescribing notes on pharmaceuticals; application for access to them may be made on the registration form for TOXBASE).

TOXBASE was developed to meet the basic information needs of health care professionals who deal with patients exposed to potential toxins. Poisons Information

Services staff can provide further advice if more detailed or specific information or clinical guidance is required: the telephone numbers of regional centres are listed in the British National Formulary.

Further information on registration can be obtained from: Ms L Gordon, National Poisons Information Service (Edinburgh Centre), Scottish Poisons Information Bureau, The Royal Infirmary NHS Trust, Edinburgh EH3 9YW (Tel [office hours]: 0131-536 2303).

Further information on general aspects of poisons information from: Dr Fraser Kennedy, Room 657C Skipton House, 80 London Road, London SE1 6LW.

1. NHS Management Executive. *National Poisons Information Service*. Heywood (Lancashire): Department of Health (Health Service Guidelines: HSG(93)18).

Supply of single-dose oral poliomyelitis vaccine

Over the last 6 months, there have been some problems with the availability of single-dose oral poliomyelitis vaccine (OPV). Improved arrangements should now ensure continuity of supply. SmithKline Beecham have recently obtained a product licence for the supply of their OPV in a single-dose presentation and supplies are already being made available to Farillon for distribution. Single-dose OPV manufactured by Wellcome, but packaged and distributed by

Evans Medical, will shortly cease to be available. Evans intend to resume supply with their own manufactured product as soon as possible, but until further notice SmithKline Beecham will be the sole supplier of OPV (both multidose and single-dose) in the United Kingdom. Single-dose OPV is supplied in a carton containing ten individual plastic monodose tubes, each of which contains the equivalent of three drops from a multidose container. It should be ordered direct from

Farillon (Tel: 0708 379000), who will deliver the vaccine, at no charge, in accordance with users' scheduled delivery arrangements for childhood vaccines.

For further information on vaccine policy, write to Dr David Salisbury, Room 707 Wellington House, 133-55 Waterloo Road, London SE1 8UG; inquiries about supply arrangements should be addressed to Mr Frederick Coleman, Room 716 Wellington House.

Management of lung cancer

Lung cancer is a major cause of death and disability throughout the world, and is the commonest malignant disease in western Europe. In England, it killed 32,000 people in 1991: although overall lung cancer mortality is falling in this country, it continues to rise in women.

With this background, the Secretary of State for Health's Standing Medical Advisory Committee (SMAC) asked a working party, chaired by Professor Michael Whitehouse, to prepare a report on the management of lung cancer. The report was published in July and has been sent to consultants likely to be involved in the diagnosis and treatment of lung cancer, and to every general practice in England. It has also been recommended to commissioning health authorities as part of the National Health Service (NHS) Executive's clinical effectiveness programme.

The report was prepared after a detailed review of published research on the epidemiology, prevention, diagnosis, and treatment (whether directed at cure or palliation) of the disease, and was then circulated widely for consultation before publication. It thus provides authoritative and widely agreed advice on good practice which should be taken into account by all who are responsible for treating or commissioning treatment for patients with lung cancer.

Prevention and early diagnosis

At least 80% of lung cancer deaths are caused by active smoking, although deaths may also occur because of other environmental and occupational factors, including passive smoking. One single lifestyle change could therefore prevent most of these deaths, and all doctors should be encouraged to play their part in reducing tobacco consumption, particularly among young people.

There is no effective practicable way of screening for lung cancer before the onset of symptoms. For those who have contracted the disease, successful treatment depends upon early diagnosis - which will usually be made by a general practitioner (GP). Smokers in particular need to be encouraged to request advice, and GPs should remain alert to the common and less common presenting signs and symptoms of the disease, and to maintain a high 'index of suspicion'. On average, a general practice with 10,000 patients will see about 5 deaths from lung cancer annually.

The report describes ways in which patients may present and makes recommendations about further investigation and referral, for which there should be clear mechanisms. Patients should ideally be seen by a specialist within one week of the diagnosis in general practice; automatic referral of patients with a radiographic diagnosis of lung cancer may reduce delays.

Assessment and treatment

Confirmation of diagnosis and further assessment, including biopsy for histology and staging, is normally done by a consultant physician specialising in chest disease, often after fibre-optic bronchoscopy. Rational treatment of lung cancer depends upon accurate histological diagnosis. For practical purposes, the disease can be divided into small-cell and non-small-cell carcinoma; although rare, it should be noted that the incidence of mesothelioma is increasing.

The purpose of assessment and staging is to determine the most appropriate management in each individual patient. Questions to be addressed are:

- Is the tumour operable? If so, there should be prompt referral to a thoracic surgeon because surgery remains the only curative treatment in common use.
- For patients with small-cell lung cancer, should chemotherapy be considered?
- If both of the above options are inappropriate, should patients, in the light of their likely prognosis, be offered radical radiotherapy or chemotherapy to attempt a cure (a few), or palliative radiotherapy and other palliative treatment (the majority)?

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Sickle cell, thalassaemia and other haemoglobinopathies

The Secretary of State for Health invited the Standing Medical Advisory Committee (SMAC) to consider various aspects of haemoglobinopathies to ensure even provision of the best possible health care for patients with these disorders. A report, drawn up by a SMAC working party was published in February¹, at the same time as a 'Patient Perception Booklet' on sickle cell anaemia was distributed².

The terms of reference for the working party were: to consider issues relating to the screening, counselling, and clinical management of people affected by sickle cell disorder, thalassaemia and other haemoglobinopathies; to advise on the information which should be provided about the haemoglobinopathies to those affected and to health professionals; and to give advice on the assessment of need, provision of facilities, treatment and measurement of outcomes.

Haemoglobinopathies are an inherited group of disorders of varying degrees of clinical severity, some of which may have potentially serious and crippling complications. Knowledge of the conditions, adequate prophylaxis, proper crisis intervention and expert management can alleviate these complications. The availability of genetic

screening enables patients and doctors to be alert to the disorders and potential parents to make informed choices in pregnancy.

Sickle cell disorder primarily affects the Afro-Caribbean population, whereas thalassaemia is mainly found in individuals from the Mediterranean and from the Indian sub-continent. Many of those at risk live in deprived inner-city areas, but many do not: all doctors should be aware of how to manage individuals with, or at risk of, haemoglobinopathies.

The report gives background information on the frequency of the haemoglobin traits (carriers) in different groups, as well as information about the distribution of various ethnic minority groups in local authority districts throughout England and Wales. Opportunistic screening (in adults who present to clinicians for reasons other than complications of haemoglobinopathy), pre-conceptional, antenatal and neonatal screening are all discussed. The important role of counsellors to ensure that patients benefit by access to all appropriate services is highlighted.

Guidance is offered on the management of sickle cell disorder and thalassaemia major, with particular emphasis on pain control in

painful sickle cell crisis and special considerations for the care of children with haemoglobinopathies. Additional chapters consider the importance of education and haemoglobinopathy cards and registers, methods to measure outcome and to ensure effective purchasing contracts, and future research trends.

Recommendations are addressed to purchasers of health care and providers of treatment, whether in hospital or general practice. Additional recommendations are also made in respect of screening and counselling services, as well as to those responsible for educational activities and patient groups.

1. Standing Medical Advisory Committee. Report of a Working Party of the Standing Medical Advisory Committee on Sickle Cell, Thalassaemia and Other Haemoglobinopathies. London: HMSO, 1993. (ISBN 0-11-321699-8, £8.95.)

2. Department of Health. Patient perception booklet: Sickle cell anaemia. Heywood (Lancashire): Department of Health, 1993 (Health Service Guidelines: HSG(94)13).

Safe use of diagnostic ultrasound

In the last few years, occasional concern has been expressed by individuals and professional bodies, and in the media, about the possible hazards of diagnostic ultrasound, against the background of the gradual increase in the output of diagnostic ultrasound equipment. In 1993, the Chief Medical Officer's Radiological Advisory Committee convened an ad-hoc meeting to advise on the safe use of diagnostic ultrasound. Nominees were invited from a range of relevant professional bodies; their advice was later ratified by the Radiological Advisory Committee and has been passed on for information to the professional groups concerned.

Seven points were emphasised. Firstly, there is no unequivocal evidence of damage from diagnostic ultrasound exposure in man, woman or fetus. Nevertheless, some diagnostic ultrasonic fields may present a biophysical hazard, although the risk to individuals would depend on the way in which they were exposed to the ultrasonic field. Therefore all ultrasound exposures should be justified, and limited to the minimum necessary for the diagnostic purpose. There was also a need for further research to investigate the biophysical effects of ultrasonic emissions.

Professional bodies relevant to the several types of health care professional who use diagnostic ultrasound apparatus should set

standards for adequate training. Such training must encompass the interpretation of ultrasonic images, because currently the greatest risk to an individual is from inaccurate interpretation of the image, rather than any physical hazard of the ultrasonic field. Finally, ultrasound equipment should be maintained according to current standards¹.

Further information on diagnostic ultrasound can be obtained from: Dr Elizabeth Wilson, Room 409 Eileen House, 80-94 Newington Causeway, London SE1 6EF.

1. Medical Devices Directorate. *Management of Medical Equipment and Devices*. London: Medical Devices Directorate, Department of Health, 1990 (Health Equipment Information no. 98).

Obstetric cholestasis

Obstetric cholestasis is a rare liver disease which is unique to pregnancy and occurs in around 1 per 1,000 pregnant women^{1,2}. Early recognition and referral to an obstetrician is needed because of an increased perinatal mortality rate.

The dominant symptom is pruritus - which may appear from around the 25th week of pregnancy, but often only after the 30th week. A late sign is mild jaundice; the liver edge may be palpable and tender. Sub-clinical steatorrhoea may impair nutritional status.

Maternal mortality is unaffected, but there have been reports of an increased rate of post-partum

haemorrhage; symptoms and signs resolve quickly after delivery. However, the perinatal mortality rate is increased by up to 500%: increased rates of premature labour, intrauterine death and intrapartum hypoxia have all been reported, although the underlying mechanisms are unclear³⁻⁵.

The cause of obstetric cholestasis is also unknown and may be multifactorial; a familial tendency has been observed and an abnormal reaction to pregnancy hormones is likely to be involved. Pruritus may be alleviated by the cautious use of cholestyramine, but the fetal prognosis points to the need for early referral to an obstetrician.

Further information can be obtained from: Dr John Modle, Room 501 Wellington House, 133-55 Waterloo Road, London SE1 8UG.

1. Reyes H. The spectrum of liver and gastrointestinal disease seen in cholestasis of pregnancy. *Gastroenterol Clin North Am* 1992; **21**: 905-11.

2. Schorr-Lesnick B, Lebovics E, Dworkin B, Rosenthal WS. Liver diseases unique to pregnancy. *Am J Gastroenterol* 1991; **86**: 659-62.

3. de Swiet M, ed. *Medical disorders in obstetric practice*. Oxford: Blackwell Scientific, 1984.

4. Johnston WG, Baskett TF. Obstetric cholestasis: a 14 year review. *Am J Obstet Gynecol* 1979; **133**: 299-301.

5. Reid R, Ivey KJ, Rencoret RH, Storey B. Fetal complications of obstetric cholestasis. *BMJ* 1976; **1**: 870-2.

HoNOS: a psychiatric thermometer

Many people who suffer from mental illnesses have problems with various aspects of their lives. Difficulty in forming social relationships or maintaining a home are at least as important as hallucinatory voices, bizarre ideas or inappropriate moods. Assessment of the success of a psychiatric service requires a simple yardstick which will measure all these aspects of mental health - a psychiatric 'thermometer'.

Until now, centrally gathered data for psychiatric outcomes have only covered administrative items and a patient's diagnosis: this information is insufficient to show whether the patient's condition has improved or deteriorated. The Health of the Nation initiative commits the National Health Service to improve the health and social functioning of mentally ill people and to develop measures to demonstrate this.

The Department of Health therefore commissioned a simple 12-item scoring system to cover all aspects of mental health. The system, HoNOS (Health of the Nation Outcome Scale), is designed to be usable by clinicians in routine clinical practice.

It would be unrealistic to expect hard-pressed doctors and nurses to undertake large-scale information gathering simply to produce a central performance indicator.

HoNOS has therefore been designed to be a helpful tool for local audit and for the management of individual patients. It will provide the information needed to supplement diagnosis for the new Healthcare Resource Group classification, which will influence purchasing contracts and local management issues (such as ensuring that the caseload for individual staff members is reasonable and appropriate).

For individual patients, the Care Programme Approach offers the opportunity to check HoNOS scores at a sensible time, in a sensible context, when all staff involved with a patient meet to review the whole spectrum of a patient's problems. Once staff become familiar with the checklist, its completion at such a review should impose very little extra work and the results will form a valuable summary of the patient's current clinical status.

HoNOS, a simple measure of a patient's condition - a sort of psychiatric thermometer - should be useful to clinicians, managers and purchasers alike, as well as forming the national information base for a major Health of the Nation target.

Further information can be obtained from: Dr Gyles Glover, Room 315 Wellington House, 135-55 Waterloo Road, London SE1 8UG.

Public Health LINK

Public Health LINK¹, the urgent communications cascade set up earlier this year to provide rapid information to doctors about important health matters, is now well established. A test exercise carried out in the summer was very encouraging and audits at District level have improved local distribution of information. The first real use of the system was in September when, in response to growing concerns about the reported

plague in India, a message was broadcast for District Directors of Public Health to cascade to all local doctors. The message contained information on the current situation in India and recommendations about travel, prophylaxis and management of suspected cases. From the feedback received, this timely provision of information was welcome. It is very reassuring to have a system in place for urgent communications with all doctors, and the

Department of Health would like to take this opportunity to thank everyone involved in the message cascade.

For further information please contact: Mrs Elizabeth Kidd, Room 3W37, Quarry House, Quarry Hill, Leeds LS2 7UE.

1. Department of Health. *Communications with the profession*. Heywood (Lancashire): Department of Health, 1994 (Professional Letter: PL/CMO(94)3).

On the State of the Public Health 1993

The Chief Medical Officer's Annual Report for 1993 was published on 21 September 1994¹. In his introduction, Dr Calman sets out the long-term strategic aims which underpin the content of his Report, summarises the state of health in England in 1993, and follows up progress on issues raised in previous Reports. He also identifies four new issues to be followed up in future reports: the health of adolescents; genetic factors and disease; changing patterns of infectious diseases; and asthma. Presenting his Report to an audience of health care professionals and managers on 31 October, Dr Calman and colleagues from the Department of Health discussed aspects of the new issues identified in his 1993 Report, as well as topics as

varied as moving mental health into outcomes, delivering public health in England, continuing medical education, and a review of 75 years of health in England (to mark the 75th anniversary of the establishment of the then Ministry of Health in 1919).

Further information about the Report (but no copies) can be obtained from: Dr Mark Powlson, Room 121 Eileen House, 80-94 Newington Causeway, London SE1 6EF.

1. Department of Health. *On the State of the Public Health: the annual report of the Chief Medical Officer of the Department of Health for the year 1993*. London: HMSO, 1994. (ISBN 0-11-321820-6, £16.25.)

Health of adolescents

The health of adolescents was highlighted by the Chief Medical Officer in his 1993 Report, and will be followed up in future Reports. Adolescence is the period between childhood and adulthood, and is a crucial period during which lifestyles, values and attitudes are established. Existing health services may not fully cater for their special needs. In general, mortality in this age-group is low: injury and poisoning account for half of all deaths, and three-quarters of all

injuries are related to road accidents. Lifestyle issues in this age-group that may set patterns for future life and have long-term effects on health include physical activity, diet, cigarette smoking, alcohol consumption, substance misuse and sexual behaviour. Continuing care for those with chronic diseases (such as cancer, arthritis, diabetes mellitus, asthma or cystic fibrosis), for which treatment begins in childhood but needs to continue in later life, is also of particular concern.

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Management of lung cancer

The report emphasises the range of clinical disciplines that are needed to provide high quality care for patients with lung cancer and the importance of good communications between them.

Copies of the full report can be obtained from: Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancashire OL10 2PZ.

Further information on the SMAC report on lung cancer can be obtained from: Dr Duncan Macpherson, Room 405 Eileen House, 80-94 Newington Causeway, London SE1 6EF.

CMO letters in 1994

Copies of letters issued by the Chief Medical Officer can be obtained from the Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancashire OL10 2PZ. (The prefix PL/CMO(94) should be added when ordering.) Topics covered between June and October 1994 are listed below.

9. Standing Medical Advisory Committee: Report on the management of lung cancer: current clinical practices (1994).

10. National measles and rubella immunisation campaign.

11. Influenza vaccine.

12. Measles and rubella immunisation campaign.

CMO's Update

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