

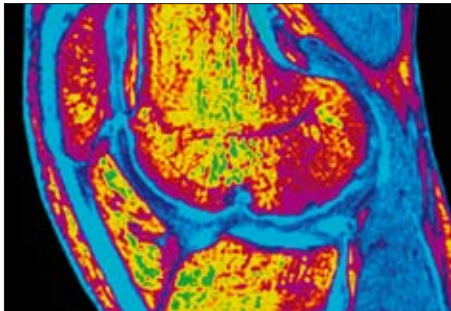
LETTERS

Letters are selected from rapid responses posted on bmj.com.

▶ To submit a rapid response go to any article on bmj.com and click “respond to this article”

OSTEOARTHRITIS OF THE KNEE

“Osteoarthritis” on imaging may be normal wear and tear



SIMON FRASER, ROYAL VICTORIA INFIRMARY/SPL

Bennell and colleagues’ clinical review on the management of knee osteoarthritis describes a sensible and measured approach based on the evidence.¹ The recent access of general practitioners and triage staff to magnetic resonance images has resulted in a flood of patients referred to hospital for arthroscopy for tears of the posterior horn of the medial meniscus. History and examination of these patients do not support this diagnosis. It is a normal finding on magnetic resonance imaging in patients of 50 and over² and is part of the ageing process.

To diagnose these patients as having osteoarthritis is, however, problematic. Pain experienced around the knee is frequently not from within the knee. Patients with radiological findings that fit the criteria for a diagnosis of osteoarthritis may not have pain. This therefore means that knee pain and radiological changes may be coincidental. The high rate of knee pain reported after knee replacement³ may reflect the wrong diagnosis, not a poorly performed operation.

I prefer to tell patients that their knee has undergone normal wear and tear similar to a car engine that has done 70 000 miles. It needs care and attention, not replacement. Replacement is needed when the subchondral bone is exposed and conservative and medical management has failed.

Bennell and colleagues note that lifestyle changes are more important than operation in the initial management of osteoarthritis of the knee. The term osteoarthritis means ending up in a wheelchair to the patient concerned, and referral to a surgeon when used in a radiology report.

Simon T Donnell orthopaedic surgeon and honorary professor, Norfolk and Norwich University Hospital, Norwich NR4 7UY, UK simon.donnell@nnuh.nhs.uk

Competing interests: STD is president elect, British Association Surgery of the Knee; co-editor, *The Knee* journal; and consultant for Tornier (implant manufacturer).

- 1 Bennell KL, Hunter DJ, Hinman RS. Management of osteoarthritis of the knee. *BMJ* 2012;345:e4934. (30 July)
- 2 Kemp MA, Lang K, Dahill M, Williams JL. Investigating meniscal symptoms in patients with knee osteoarthritis—Is MRI an unnecessary investigation? *The Knee* 2011;18:252-3.
- 3 Wylde V, Dieppe P, Hewlett S, Learmonth ID. Total knee replacement: Is it really an effective procedure for all? *The Knee* 2007;14:417-23.

Cite this as: *BMJ* 2012;345:e5594

SELF MANAGEMENT OF DIABETES

Structured, reinforced patient education can work

Snoek argues that self management education is of limited effect because it did not persistently improve metabolic control in some recently published clinical trials in patients with type 1 and type 2 diabetes.¹ The problem is not that education itself is ineffective but in the design and delivery of such trials. For instance, a six hour crash course in patients with newly diagnosed type 2 diabetes would, without reinforcement, be unlikely to turn them into competent lifelong self carers.

We found persistent and reproducible clinical, psychological, and cognitive improvements in patients with diabetes who were seen for one hour every three months in a structured group education programme fully embedded within clinical practice. It took, however, two to four years to achieve significant results in type 2 and type 1 diabetes.^{2,3}

What clinicians and educators, especially clinical educators, tend to overlook is that they are dealing with people at a difficult time of their lives. The onset of diabetes, or any chronic disease, profoundly affects people’s perceptions, emotions, and relationships with themselves and their loved ones.⁴

Our almost 20 year long experience with patient education has taught us that it requires time, training, competence, patience, passion, and humility. It means accepting the complexity of disease and of those affected by it. Harmonising the work of operators, with all their preconceptions and misconceptions, is possibly the most difficult part. As Livingstone observed, “An education is incomplete unless it leaves people with a philosophy of life, and never was this more needed than in our age of uncertainty.”⁵

Marina Trento head, laboratory of clinical pedagogy Massimo Porta professor of medicine, University of Turin, 10126 Turin, Italy massimo.porta@unito.it

Competing interests: None declared.

- 1 Snoek FJ. Strategies to optimise clinical outcomes for patients with diabetes. Good professional consultation skills and self management education work, but effects don’t endure. *BMJ* 2012;344:e2673. (26 April)
- 2 Trento M, Gamba S, Gentile L, Grassi G, Miselli V, Morone G, et al; for the ROMEO investigators. Rethink Organization To Improve Education And Outcomes (ROMEIO). A multicentre randomised trial of lifestyle intervention by group care to manage type 2 diabetes. *Diabetes Care* 2010;33:745-7.
- 3 Trento M, Borgo E, Kucich C, Passera P, Trinetta A, Charrier L, et al. Quality of life, coping ability, and metabolic control in patients with type 1 diabetes managed by group care and a carbohydrate counting program. *Diabetes Care* 2009;32:e134.
- 4 Biro D. An anatomy of illness. *J Med Hum* 2012;33:41-54.
- 5 Livingstone R. What is education? *BMJ* 1953;ii:454-6. www.bmj.com/content/2/4834/454.

Cite this as: *BMJ* 2012;345:e5100

PAINFUL SICKLE CELL EPISODES

NICE guidance ignored incentive spirometry

It is disappointing that the National Institute for Health and Clinical Excellence guidance on managing an acute painful sickle cell episode in hospital did not advocate incentive spirometry as an effective, simple, and cheap (about £14 (€18; \$22)) non-pharmacological intervention,^{1,2} given that up to 54% of inpatients currently receive it as standard care.³ It involves awake patients taking 10 maximal inspirations every two hours.

Randomised data in patients presenting with chest or back pain show an absolute risk reduction of 36.8% (95% confidence interval 12.5% to 61.2%) for pulmonary complications (associated with the development of acute chest syndrome) and reduced hospital admission.⁴ Inclusion within this high profile guideline would have improved suboptimal or inconsistent use,³ and because the number needed to treat is just 2.7 (1.6 to 8.0) would have immediately benefited patients and budgets.

Amit Patel specialist registrar in haematology and intensive care medicine, Imperial College London; Imperial College Healthcare NHS Trust, MRC Clinical Sciences Centre, Hammersmith Hospital, London W12 0NN, UK amit.patel@imperial.ac.uk

Competing interests: None declared.

- 1 Gillis VL, Senthinathan A, Dzingina M, Chamberlain K, Banks E, Baker MR, et al; on behalf of the Guideline Development Group. Management of an acute painful sickle cell episode in hospital: summary of NICE guidance. *BMJ* 2012;344:e4063. (27 June.)
- 2 National Institute for Health and Clinical Excellence. Sickle cell acute painful episode: management of an acute painful episode in hospital. CG143. 2012. <http://guidance.nice.org.uk/CG143>.
- 3 Miller ST, Kim HY, Weiner D, Wager CG, Gallagher D, Styles L, et al; Investigators of the Sickle Cell Disease Clinical Research Network (SCDCRN). Inpatient management of sickle cell pain: a “snapshot” of current practice. *Am J Hematol* 2012;87:333-6.

- 4 Bellet PS, Kalinyak KA, Shukla R, Gelfand MJ, Rucknagel DL. Incentive spirometry to prevent acute pulmonary complications in sickle cell diseases. *N Engl J Med* 1995;333:699-703.

Cite this as: *BMJ* 2012;345:e5370

CONTRACEPTIVE SERVICES

Shortcomings of natural family planning methods

Stress, alcohol use, sexually transmitted diseases, partial breastfeeding, mental and intellectual challenges, chronic diseases, and uncooperative partners all thwart fertility awareness based methods (FABMs). Libido can be so strong that a 30% chance of encountering an HIV positive partner will not dampen it.

I remember John Billings around 1978 promoting his method in Lesotho, where I first witnessed the tyranny of excessive fertility. Many Basotho worked in South Africa, returning home for a few days every 3-6 months on mine buses. Billings was quite optimistic about their rescheduling intercourse at their homecoming in the hope that six months later the mucus might be less slippery.

FABMs are used respectively by 2.7%, 3.7%, 7.0%, 3.9%, 2.8%, and 28.4% of women in Ireland, Italy, the Philippines, Latin America, Uganda, and Poland.¹ Historically, their powerful church sabotaged all other options, so why so few users? In Poland and Latin America this sabotage resulted in enormous abortion rates, now improving with less church influence.

There are no examples of noticeable reductions in birth rates with FABMs, while they abound with modern methods—for example, in Brazil, Iran, Thailand, Ireland, Canada, North Africa, China, and South Africa.

A study in Edinburgh reported that the odds ratio of another termination of pregnancy occurring within two years after having intrauterine devices (IUDs) or implants fitted at the index termination was 0.05 and 0.06 respectively compared with the pill.² Pills, condoms, FABMs, and even implants require continuing commitment. Few will choose FABMs; even fewer will practise them. With implants and IUDs the contraceptive effort has largely been accomplished on leaving a clinic.

Contraception should be evaluated on an intention to use basis—that is, compare women provided with IUDs with those given pills, condoms, or instructions for FABMs.³ If only Evans could do such a study and prove his claims for FABMs.⁴ The Vatican would sponsor it. Douwe A Verkuyl obstetrician, Refaja Hospital, Stadskanaal, Netherlands verkuyl@freeler.nl
Competing interests: DAK believes that ideally every baby should be wanted and planned. He is afraid that his children and grandchildren will live in a world where everyone is at war with everyone else over resources because we have not satisfied the current enormous unmet demand for contraception.

- 1 UN. World contraceptive use, 2009. Contraceptive prevalence by method. www.un.org/esa/population/publications/WCU2009/Data/UNPD_WCU_2009_Contraceptive_prevalence_method.xls.
- 2 Cameron ST, Glasier A, Chen ZE, Johnstone A, Dunlop C, Heller R. Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy. *Br J Obst Gynaecol* 2012;119:1074-80.
- 3 Verkuyl DA. Intention-to-treat studies crucial for contraception research. *Contraception* 2009;80:234-6.
- 4 Evans C. Natural family planning is effective and culturally acceptable. *BMJ* 2012;345:e4908. (23 July)

Cite this as: *BMJ* 2012;345:e5566

INCREASE IN PERTUSSIS

May be due to increased recognition and diagnosis

I have meticulously studied all cases of whooping cough in my practice since 1977 and I have published many papers on the subject, mainly in the *BMJ*.

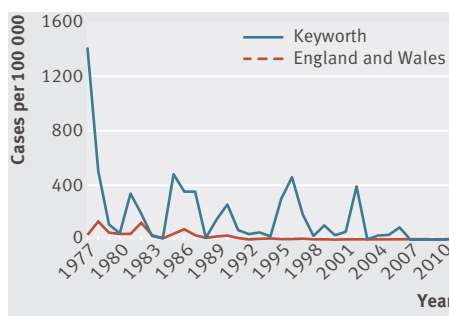
The increase in reported cases coincides with similar increases in the US and Australia.¹ A large proportion of this increase is probably the result of better recognition and diagnosis. My data provide good evidence that it never went away. What went away was the ability of doctors to recognise it, and in the absence of a practicable diagnostic test, official figures fell.

Email feedback from people who have had whooping cough indicates that, in the past five years, doctors in the UK, US, and Australia have become more willing to consider the diagnosis in adults. This coincides with the wider availability of a practicable blood test.

I have noted a high incidence, including in teenagers and adults, for 20 years. For example, in 2002 my practice (11 000 patients) diagnosed 44 cases, 5% of all cases notified in England and Wales that year; 14 were confirmed by culture. A further eight were tested serologically and all were positive. Nineteen were aged 12 years or more.

The figure compares cases in my practice (Keyworth) with England and Wales. It shows a steady fall in notifications in England and Wales after 1982, which contrasts with the continued high rate in Keyworth.

Incidence may really be increasing, and I fully support any new immunisation strategies that will



Numbers of cases of pertussis in Keyworth and England and Wales per 100 000 population (rounded to the nearest whole number), 1977-2011

reduce the risks to infants, but I think the Health Protection Agency should be cautious when using its own possibly flawed data to support well intentioned policy changes.

Douglas Jenkinson retired general practitioner, Keyworth Medical Practice, Nottingham NG12 5JU, UK dougjenkinson@btinternet.com

Competing interests: DJ has a website that provides whooping cough information. He offers a fee paying advice service. The fees from this do not cover the expense of maintaining the site.

- 1 Kmiotowicz Z. Pertussis cases rise 10-fold among older children and adults in England and Wales. *BMJ* 2012;345:e5008. (23 July)

Cite this as: *BMJ* 2012;345:e5463

REFLECTIONS ON TESTOSTERONE

Rise and rise of unnecessary testosterone prescription

Male hypogonadism is characterised by sexual dysfunction, loss of muscle bulk, central obesity, fatigue, mood and sleep disturbances, osteoporosis, and anaemia. Although these features are associated with low serum testosterone, not all men with low serum testosterone are definitively hypogonadal, and there is a large symptom overlap with obesity and non-endocrine illness. Importantly, testosterone replacement may not be appropriate for men with mild, functional, or transient hypotestosteronaemia.

As Delamothe points out,¹ drug companies have run aggressive marketing campaigns that equate hypogonadism with low serum testosterone, despite the lack of long term safety data and inconsistent improvement in symptoms. We collated data on the use of testosterone preparations from the Department of Health's prescription cost analysis for community pharmacies 2000-10, for England, Scotland, and Wales. We also examined community requests for serum testosterone assays in men to the biochemistry department at the Newcastle upon Tyne Hospitals Trust over the same period.

Prescriptions for testosterone increased by nearly 90%—from 157 602 to 298 134 items annually—in that period. Prescriptions for transdermal testosterone increased fivefold after testosterone gels were introduced in 2003. Costs increased by 267%, from £3.2m (€4.1m; \$5m) to £11.7 million yearly over the same period, with more than half being spent on transdermal testosterone. Local requests from primary care for serum testosterone measurement also increased, from 347 requests in 2000 to 823 requests in 2010. However, the number of men with unequivocal hypogonadism (testosterone <6.0 nmol/L) remained roughly constant at 5.2% in 2000 and 6.3% in 2010. We believe that many men in the UK are receiving unnecessary testosterone replacement. Similar trends have been seen in Australia and Switzerland.^{2 3}

Regulation of industry advertising to primary care is inadequate. National guidance on the indications for testosterone replacement is urgently needed.

Earn H Gan clinical research fellow in endocrinology, Institute of Genetic Medicine, Newcastle upon Tyne NE1 3BZ, UK earn.gan@ncl.ac.uk

Stewart Pattman specialty registrar, chemical pathology (metabolic medicine), Department of Clinical Biochemistry, Royal Victoria Infirmary, Newcastle upon Tyne, UK

Simon Pearce professor of endocrinology, Institute of Genetic Medicine, Newcastle upon Tyne NE1 3BZ, UK

Richard Quinton consultant and senior lecturer in endocrinology, Endocrine Unit, Royal Victoria Infirmary, Newcastle upon Tyne, UK

Competing interests: None declared.

- 1 Delamothe T. Monkey business: reflections on testosterone. *BMJ* 2012;345:e4967. (23 July.)
- 2 Handelsman DJ. Pharmacoepidemiology of testosterone prescribing in Australia, 1992-2010. *Med J Aust* 2012;196:642-5.
- 3 Nigro N, Christ-Crain M. Testosterone treatment in the aging male: myth or reality? *Swiss Med Wkly* 2012;142:w13539.

Cite this as: *BMJ* 2012;345:e5469

MELANOMAS IN PRIMARY CARE

Editorial was muddled

Newton-Bishop and Lorigan's thinking on whether we can improve the identification of melanomas in primary care is muddled and their conclusions are lazy.¹ They object to current referral rates for suspected melanoma, despite 91% compliance with referral guidelines, but offer no guidance on what referral rates should be. They give no international comparators to indicate whether UK practice is at variance with global norms. Instead, they offer a ridiculous comparison with the rate of positive diagnoses in suspected leukaemia, which is diagnosed with an objective blood test for which no dermatological equivalent exists.

They seem to believe that too many possible skin cancers are referred and quote the UK statistics disparagingly, despite providing no objective evidence of underperformance. Extraordinarily, they use the term "correct" for referrals that lead to a diagnosis of skin cancer. Are they really suggesting that it is "incorrect" to refer a possible cancer unless it is retrospectively confirmed as cancerous? The most charitable interpretation is that their grasp of logic has failed. A less charitable one is that they are promoting the dangerous idea that GPs are somehow failing if they refer possible skin cancers that turn out to be benign.

Having denounced GPs for supposedly over-referring suspected cancers, they conclude that the higher average stage of melanoma at presentation in the UK (compared with Europe) is "probably" due to GPs' lack of dermatological training. By this stage, the reader can hardly be surprised that the authors offer no evidence for

another slur on primary care. The possibility of patients presenting late to GPs is not considered, and neither do the authors stop to wonder how GPs could refer too late while complying closely with expert referral guidelines.

Joanna Bayley general practitioner, Gloucester Health Access Centre, Gloucester GL1 1PX, UK joannabayley@yahoo.com

Competing interests: None declared.

- 1 Newton-Bishop J, Lorigan P. Identifying melanomas in primary care: can we do better? *BMJ* 2012;345:e4244. (4 July.)

Cite this as: *BMJ* 2012;345:e5416

Wanted: better scoring systems that work in primary care

Newton-Bishop and Lorigan completely miss the point.¹ It is a shame that two secondary care professionals were asked to reflect on how primary care can improve the identification of melanomas.

GPs' management of melanoma has been completely disempowered by the two week wait referral system. Although suspicious lesions are seen quickly by a dermatologist, other lesions can wait months. We quickly learnt after missing a diagnosis of melanoma to refer any suspicious lesion—hence the low proportion of patients correctly referred.

Secondary care uses secondary care features to determine scoring systems such as MoleMate or Mackie. In my experience, a worried patient will always have an itchy mole if asked and will often present with bleeding because a benign lesion has been knocked.

To improve the identification of melanomas in primary care GPs need better scoring systems that work in a primary care population. They need to be empowered to use techniques such as re-review of patients, photography, and perhaps dermoscopy. They do not need throwaway non-evidence based remarks that they need more training from dermatologists who have never worked in primary care.

James A Cave general practitioner, Downland Practice, Newbury RG20 8UY, UK james.cave@nhs.net

Competing interests: JAC is a GP.

- 1 Newton-Bishop J, Lorigan P. Identifying melanomas in primary care: can we do better? *BMJ* 2012;345:e4244. (4 July.)

Cite this as: *BMJ* 2012;345:e5408

Authors' reply

Our editorial was about a new technology being tested to improve diagnostic accuracy in primary care.¹ On the basis of the study's findings we intended to support targeted education of primary healthcare teams and specialisation within teams to maximise

diagnostic accuracy and referral in primary care, not to criticise primary healthcare physicians. We understand the difficulties of diagnosis in both primary and secondary care.

Variation in survival between countries is high: Eurocare 4 reports that five year survival for patients diagnosed in 1995-9 ranged from 63% (Poland) to 92% (Northern Ireland), with Wales at 74% and England at 85% (www.eurocare.it). National Cancer Intelligence Network data show a range for those diagnosed in 2001-5 from 79% in one region of the UK to 92% in another. The patient experience survey for 2010 suggests that most patients with melanoma are referred in a timely fashion.² However, these large variations even within the UK suggest room for improvement, some perhaps in diagnosis in primary care. Variation probably reflects stage at excision—as a result of late presentation or failure to detect and treat quickly—in a comparatively small proportion of patients.

Increased physician training and specialisation ought to improve outcomes, particularly in a condition that relies on visual recognition. Walter and colleagues' study showed a significant improvement in "appropriate" referral without an increase in the false negative rate in trained GPs.¹ Cave comments that GPs need better scoring systems and greater empowerment. Education is key, but most UK medical students receive little dermatology training, and outpatient dermatology rarely forms part of GPs' training, yet consultation about moles is common. The

UK Melanoma Taskforce thinks GPs need improved education about skin cancer (www.skcin.org). Cancer Research UK and the British Association of Dermatology launched an online tool (www.doctorsnet.co.uk) this summer, funded by the Department of Health, to aid in

decision making for referral under the two week wait rule.

Julia Newton-Bishop professor of dermatology, Leeds Institute of Molecular Medicine, Leeds LS9 7TF, UK
Paul Lorigan senior lecturer in medical oncology, University of Manchester/Christie NHS Hospital, Manchester M20 4BX, UK
paul.lorigan@manchester.ac.uk

Competing interests: None declared.

The full reply is at www.bmj.com/content/345/bmj.e4244/rr/597416.

- 1 Walter F, Morris H, Humphrys E. Effect of adding a diagnostic aid to best practice to manage suspicious pigmented lesions in primary care: randomised controlled trial. *BMJ* 2012;345:e4110. (4 July.)
- 2 Lyratzopoulos G, Neal R, Barbiere J, Rubin GP, Abel GA. Variation in number of general practitioner consultations before hospital referral for cancer: findings from the 2010 national cancer patient experience survey in England. *Lancet Oncol* 2012;13:353-65.

Cite this as: *BMJ* 2012;345:e5417



JAMES STEVENSON/SPFL

MULTIMORBIDITY AND INVERSE CARE

System needed to account for multimorbidity in each practice

As a GP who for 20 years has served a population that is within the 5% most deprived in the country, Mercer and colleagues' analysis of multimorbidity and the inverse care law matches my experience exactly.¹ I systematically ration my time and persistently feel that I am (out of necessity) short changing my patients of professional input.

The current obsession of clinical commissioning groups with cost (meetings are dominated by reducing secondary care costs or by matters such as NHS Health Checks, which are tangential to our population's needs) deprives practices in poorer areas of resources because budget setting ignores the differences in multimorbidity between practices, which are exaggerated by the choice agenda. In my commissioning group cluster, the practices that lose out on prescribing incentive schemes are those with higher multimorbidity. After years of prescribing reviews, we are now at a point where to be "good" and stay in budget may require deliberate undertreatment compared with other practices.

Ironically, the practices under the most pressure are probably those that the NHS could learn efficient prescribing from, but because their "poor" performance obscures this, they are the most likely to be deemed in need of "help."

We urgently need a system of resource allocation for primary and secondary care budgets that accounts for multimorbidity at the practice level. This should be based on practice derived data because secondary care derived data discriminate against practices that are good at keeping these patients out of secondary care. GP records should be good enough because most practices have been claiming payment on the quality and outcomes framework for years on the basis that their records are electronically summarised. The tools for doing this, such as the Johns Hopkins Adjusted Clinical Groups Case-Mix System, already exist.



David J Shepherd general practitioner trainer, Saffron Group Practice, Leicester LE2 6UL, UK daveshep@nhs.net

Competing interests: None declared.

DJS is also senior clinical research fellow in the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care—Leicestershire, Northamptonshire and Rutland (LNR-CLAHRC).

1 Mercer SW, Guthrie B, Furler J, Watt GCM, Hart JT. Multimorbidity and the inverse care law in primary care. *BMJ* 2012;344:e4152. (19 June.)

Cite this as: *BMJ* 2012;345:e5464

LYME BORRELIOSIS

BIA position paper on Lyme borreliosis is evidence based

Pearson and Huyshe-Shires refer to the "unaccredited" nature of the British Infection Association (BIA) position paper on Lyme borreliosis, saying that doctors "could more usefully be directed to the Lyme Disease Action website, which is accredited to the Department of Health's Information Standard."^{1 2}

The BIA has never sought such accreditation and has no plans to do so. It considers this to be unnecessary for the quality assurance of its position paper, which was based on the best available guidelines from Europe and the US, all published in peer reviewed journals.

The BIA comprises a substantial proportion of UK medical microbiologists and infectious diseases physicians. The position paper was written with the full involvement of members through two consultations, the first with the council and the second with the full membership. There was never any dissent on the general content or principal messages of the paper. We believe the paper truly reflects the opinions and knowledge of the relevant body of medical professionals in the UK and is consistent with extant guidelines produced to the highest standard consistent with the National Institute for Health and Clinical Excellence accreditation administered by NHS Evidence.

The BIA continues to commend this paper as a resource for patients and doctors who want to understand current knowledge on Lyme borreliosis and who wish to avoid the non-evidence based and sometimes emotive writings that continue to confound the literature. The BIA is committed to supporting research on Lyme borreliosis and is engaged with the James Lind Alliance, Lyme Disease Action, and others to agree priorities for research into true uncertainties surrounding the diagnosis and management of the disease.

P Cowling guidelines secretary

J Stockley president

jane.stockley@worcsacute.nhs.uk

P Moss president elect

A Miller BIA representative on James Lind Alliance review of Lyme disease
British Infection Association, Princes Risborough HP27 0JN, UK

Competing interests: None declared.

- 1 Pearson S, Huyshe-Shires S. Doctors need accredited information on Lyme borreliosis. *BMJ* 2012;345:e4727. (16 July.)
- 2 British Infection Association. The epidemiology, prevention, investigation and treatment of Lyme borreliosis in United Kingdom patients: a position statement by the British Infection Association. *J Infect* 2011;62:329-38.

Cite this as: *BMJ* 2012;345:e5364

MILITARY METAPHORS FOR DISEASE

Metaphor may fill the space created by uncertainty

I read Wiggins's article with interest, 24 hours or so into my third cycle of chemotherapy for metastatic colon cancer.¹ Our use of metaphor does seem to follow societal preoccupations—for example, the persistence of seafaring metaphor in common parlance and those of war and combat when used in biomedical practice and so beautifully illustrated by Susan Sontag in her two seminal essays.^{2 3}

Those of us with cancer at my cancer centre talk openly about our shared experience. Together we create our narratives, and this fortnightly or three weekly conferencing gets us through as we collectively receive (or, rather, are infiltrated by) our drugs intravenously.

With these people I hear little metaphor, but I do hear talk of feelings, friends, families, and the wider impact of the illness. When family members visit, or medical staff attend, the conversation often changes, and I begin to hear metaphors.

Perhaps metaphor fills the space created by uncertainty. So where there is uncertainty, and ignorance, both within the physician and the patient, we use metaphor to bridge those gaps in conversation when we don't know what to say—an awkward and ill considered attempt to make both sides feel better. I hear this too from friends in their written and spoken communications (mostly written) and in family groups and, of course, also from healthcare professionals. But it doesn't seem to be a part of the here and now conversations between those of us in the centre.

I suggest that more active listening and less talking to fill the uncomfortable silences could improve the quality of communication with my doctor, nurses, and family—to allow our mutual ignorance and uncertainty to be shared. This way we may feel more human and less embattled. Jim N Hardy general practitioner, Bethnal Green Health Centre, London E2 6LL, UK jim.n.hardy@dsl.pipex.com

Competing interests: None declared.

- 1 Wiggins NM. Stop using military metaphors for disease. *BMJ* 2012;345:e4706. (12 July.)
- 2 Sontag S. Illness as metaphor. Donoghue, 1978.
- 3 Sontag S. AIDS and its metaphors. Farrar, Straus, and Giroux, 1988.

Cite this as: *BMJ* 2012;345:e5468