LETTERS

MJA policy on sponsored supplements

Jon N Jureidini

To the Editor: I am concerned that the Journal supplement "Early intervention in youth mental health", published on 1 October 2007, may contravene the *MJA* policy on sponsored supplements. Item 9 of that policy (http://www.mja.com.au/public/information/instruc.html#Supplements) states:

> The supplement's articles should not favour drugs/interventions/views/products of the supporting body to the detriment of other drugs/interventions/views/products.

While many of the articles in this supplement are clearly scientific papers, a minority read more as advertorials and promote the interests of two of the supplement's sponsors.[1-3]

The ORYGEN–*headspace* approach to adolescent mental health differs from the approach of other expert organisations, including the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Infant, Child, Adolescent and Family Mental Health Association.[4] Both these organisations support ORYGEN and *headspace* in seeking to enhance mental health services and transition to adult services for adolescents, but not in the proposed "specialist youth-specific (12–25 years) mental health services providing comprehensive assessment, treatment and social and vocational recovery services"[2] (Dr Phill Brock, Chair, Faculty of Child and Adolescent Psychiatry, RANZCP, personal communication). This arrangement does not fit with the way in which other service providers (education, juvenile justice, medicine) are organised, or with the legislative framework that protects the rights, welfare and safety of children (0–17 years of age).

Children are not young adults, and child and adolescent mental health service models differ significantly from the traditional focus of adult mental illness. Most teenagers require a family-centred, developmentally appropriate, contextually sensitive, multimodal and systemic model that is less well developed in adult mental health services, including ORYGEN.

In spite of claims to the contrary in the supplement, these different approaches are in competition for resources. ORYGEN and *headspace* have a product to sell (to government and to the medical and lay community). The publication of this supplement has provided them with a platform without presenting an alternate view.

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1 McGorry PD. The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Med J Aust* 2007; 187 (7 Suppl): S53-S56.
2 McGorry PD, Purcell R, Hickie IB, Jorm AF. Investing in youth mental health is a best buy [editorial]. *Med J Aust* 2007; 187 (7 Suppl): S5-S7.
3 McGorry PD, Tanti C, Stokes R, et al. *headspace*: Australia's National Youth Mental Health Foundation — where young minds come first. *Med J Aust* 2007; 187 (7 Suppl): S68-S70.
4 Australian Infant, Child, Adolescent and Family Mental Health Association. Position paper. Improving the mental health of infants, children and adolescents in Australia. http://www.aicafmha.net.au/resources/files/Position_Paper_AICAFMHA_071106.pdf (accessed Nov 2007). ❑

Patrick D McGorry, Anthony F Jorm, Rosemary Purcell and Ian B Hickie

In reply: Dr Jureidini's response to the "Early intervention in youth mental health" supplement is puzzling and idiosyncratic. He asserts some kind of impropriety on our behalf or that of the *MJA* — an assertion we strongly reject.

All articles were peer reviewed by experts in the field, including the editorial,[1] which is obviously and explicitly the authors' point of view and therefore open to debate, which we welcome. Other articles Jureidini characterises as "advertorial" are genuine descriptions of new models of care.[2,3] Far from selling a product, we are advancing legitimate clinical and scientific arguments, and describing active reforms in mental health. Our "interests" are the pursuit of better mental health care and outcomes for young Australians, pure and simple.

No evidence is provided for the assertion that the models described are in competition for resources. *headspace* has been fully funded with a completely new allocation of federal resources, with no funding redirected from other programs to support it. Furthermore, the youth mental health reform model was selected by the Australian Government through a nationally competitive tender process, in which anyone with a different approach was free to put it forward; indeed, several other submissions were considered and rejected.

Similarly, no resources have been diverted to create the ORYGEN model; it is simply a successful restructure of existing resources that is demonstrably better accepted and more effective. Evidence shows that young people and their families find services structured in this way much more user-friendly, and levels of access, engagement and retention are substantially increased over traditional models.

One of us (PM) is a member of the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and neither we nor *headspace* are aware of any official position of the RANZCP that is inconsistent with or unsupportive of the *headspace* development. Most of the 30 new *headspace* services across the nation are being established in partnership with local child and adolescent psychiatrists and public mental health services. While many psychiatrists are supportive of and working within the *headspace* and ORYGEN models, a small subset have expressed a fear that strengthening the focus on adolescents and young adults will somehow disadvantage children. Where is the evidence to support this fear?

We are wholly supportive of further investment and improvement in mental health services for children. Unnecessary division on this issue will hamper all progress and is against the interests of patients and families. We strongly agree that there is clearly unmet need in the 0–12-years age group, as well as a further need for preventive interventions beyond the clinical service system, which may in time reduce the surge of incident cases of adult-type disorders.

We call on Dr Jureidini to put his efforts into increasing resources and developing innovative service models to improve the mental health of both children and young people, rather than engaging in sterile arguments over professional territory and distribution of existing resources that will benefit no-one.

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1 McGorry PD, Purcell R, Hickie IB, Jorm AF. Investing in youth mental health is a best buy [editorial]. *Med J Aust* 2007; 187 (7 Suppl): S5-S7.
2 McGorry PD. The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Med J Aust* 2007; 187 (7 Suppl): S53-S56.
3 McGorry PD, Tanti C, Stokes R, et al. *headspace*: Australia's National Youth Mental Health Foundation — where young minds come first. *Med J Aust* 2007; 187 (7 Suppl): S68-S70. ❑

Martin B Van Der Weyden

In reply: I welcome Dr Jureidini's criticisms regarding the publication of the *MJA* supplement "Early intervention in youth mental health".[1]

Dr Jureidini has two major concerns. First, a number of articles in the supplement are deemed to unilaterally advocate concepts arising from the ORYGEN–*headspace* program, with the suggestion that this exclusivity contravenes the *MJA* policy for publishing sponsored supplements. Second, he claims that the general framework of the ORYGEN–*headspace* program does not have the endorsement of professional bodies such as the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Eminent mental health experts reviewed the articles in the supplement and, interestingly, not one of these authorities raised the RANZCP's misgivings. This could mean that propagation of the Faculty's concerns in the psychiatry fraternity may be selective, or that the rationale for its position has not convinced psychiatrists at large.

Dr Jureidini's other concern — that the supplement favoured the ORYGEN–*headspace* approach at the expense of other interventions, views or products — reflects the very essence of supplements. The fundamental purpose of publishing research or commentaries is to enter information into the publishing–evidence–integration cycle, wherein the dissemination of evidence or ideas is intended to promote change by influencing other researchers, health care professionals, the public and, ultimately, policymakers.

Indeed, the ORYGEN–*headspace* program must have influenced policymakers, as the federal government recently announced grants totalling $19 million to support the national roll-out of the *headspace* program, especially in rural communities.[2]

Even if the publication of the *MJA* supplement played little or no part in this political endorsement, I am content that it has, at least, fostered debate and may well play a part in improving mental health services for young Australians.

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1 Early intervention in youth mental health [supplement]. *Med J Aust* 2007; 187 (7 Suppl): S1-S70.
2 Creswell A. $19m package makes hearty difference to headspace. *The Australian* 2008; 12-13 Jan: 18. ❑

Respiratory syncytial virus infections in children in Alice Springs Hospital

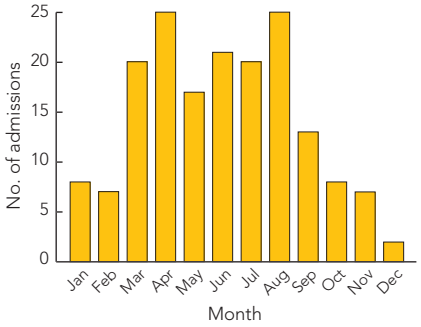
Apakasimaka Dede, David Isaacs, Paul J Torzillo, John Wakerman, Rob Roseby, Rose Fahy, George Clothier and Andrew White

To the Editor: Little is known about the epidemiology of respiratory syncytial virus (RSV) in arid, desert regions generally, and in central Australia in particular. We performed a 5-year retrospective study from 2000 to 2004, inclusive, of children aged less than 2 years who were admitted to Alice Springs Hospital and identified as having RSV infection. RSV was detected using direct immunofluorescence (Light Diagnostics SimulFluor; Millipore, Billerica, Mass, USA) on nasopharyngeal secretions. The test has a reported sensitivity of 92%.[1] We extracted demographic data from case notes and obtained population data from the Northern Territory Department of Health[2] and the Australian Bureau of Statistics.[3]

From case notes over the 5 years, we identified 173 eligible children with RSV infection. The annual incidence rate was 21.4 per 1000 children under 2 years old. The rate in Aboriginal children was 30.9 per 1000, and the rate in non-Aboriginal children 11.6 per 1000 ($P < 0.0001$). The monthly distribution of cases is shown in the Box. Cases occurred throughout the year, and in every month, but there was a peak in admissions from March to August, which covers the Australian winter.

Because Alice Springs Hospital is the only large hospital in the region, and almost all children needing hospital admission for RSV infection will be admitted there, our incidence rates of hospitalisation for RSV infection closely approximate population rates. However, we may have under-estimated the incidence because we only included children in hospital with proven infection, so we may have missed children who were not tested, or whose immunofluorescence test results were falsely negative. There may have been selection bias regarding admissions. Nevertheless, we found that Aboriginal children were more likely than non-Aboriginal children to be hospitalised with RSV infection, a finding in keeping with the known high incidence of pneumonia and bronchiectasis in Aboriginal children.[4,5] While the incidence of RSV infection peaked in winter in central Australia, infections occurred throughout the year, and the winter predominance was less marked than is the case in temperate Australia.[6] These data provide valuable information about RSV infection in an arid, desert region and can inform decisions about active or passive immunisation against RSV infection in central Australia.

Monthly distribution of admissions to Alice Springs Hospital of children aged less than 2 years with respiratory syncytial virus, 2000–2004*



*Inclusive. ◆

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Cushing's syndrome can precipitate diabetes but mask non-Hodgkin's lymphoma

Lai Y Wong, John Moore, Debbie Hill, Phil Brenner, Warick Delprado, Jennifer Turner, Joanne Taylor, Lesley Campbell and Jerry R Greenfield

To the Editor: We report the serendipitous finding of non-Hodgkin's lymphoma in a patient with adrenal Cushing's syndrome.

A 62-year-old previously well man (body mass index, 22 kg/m^2) was referred to our institution with newly diagnosed type 2 diabetes, hypertension and dyslipidaemia. Clinical findings included oral thrush, bilateral severe pitting lower limb oedema, lower limb proximal myopathy, kyphosis, and increased abdominal girth (waist circumference, 92 cm), raising suspicion of Cushing's syndrome (Box 1).

Biochemical assessment revealed normal electrolytes, an unsuppressed early morning cortisol (following 1 mg dexamethasone), urinary free cortisol 6475 nmol/day (reference range, 0–250 nmol/day), and undetectable adrenocorticotropic hormone levels. Twenty-four-hour urinary catecholamine was normal. His testosterone level was 3.2 nmol/L, and dehydroepiandrosterone sulfate level was normal.

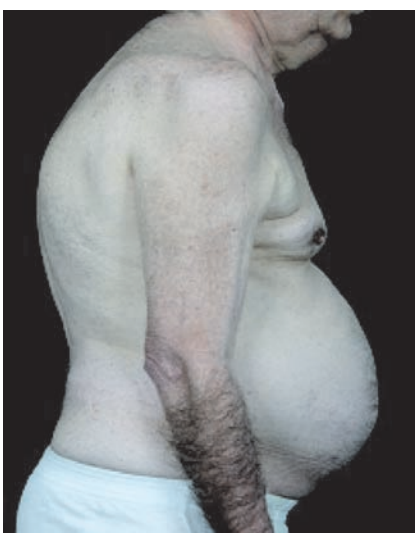
Abdominal computed tomography showed a right adrenal mass that measured 3.1 × 2.8 × 3.4 cm (density, 36 Hounsfield units). Thoracic spine x-rays revealed wedge compression fractures at T-10 and T-11. Bone densitometry showed T-scores of –3.3 at L2–4 and –2.3 at the right femoral neck. Total body fat (18.5 kg; 33%) was higher than the recommended range for age and sex (13%–25%).

The patient had a laparoscopic right adrenalectomy. Surgical excision was complete. Post-operatively, blood glucose and blood pressure returned to normal. Histopathology revealed an adrenal cortical tumour with atypical features, including a preponderance of eosinophilic cells, small numbers of clear cells, prominent nuclear pleomorphism, large nucleoli and occasional mitoses (Box 2A). However, the proliferation fraction (Ki67) was low and there was no necrosis. There was no large vessel invasion, although a single area of small vessel invasion was present (Box 2B).

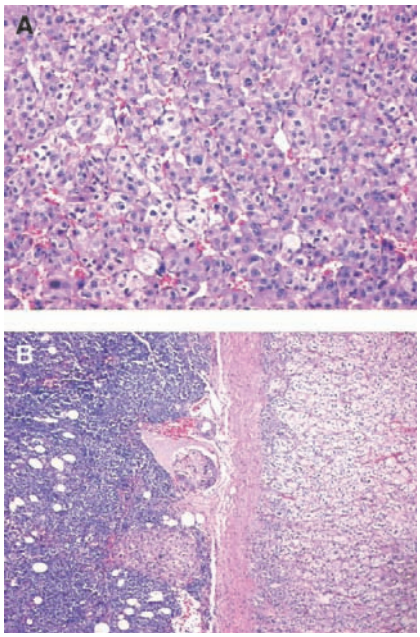
Unexpectedly, the adipose tissue adjacent to the adrenal gland was infiltrated by a diffuse large B-cell non-Hodgkin's lymphoma (Box 2B). This was confirmed by positive CD20 immunohistochemistry. Bone marrow biopsy was normal. [^{18}F]Fluorodeoxyglucose positron emission tomography (FDG-PET) scan showed increased uptake in the right adrenal bed only. The patient was treated with six courses of CHOP chemotherapy (cyclophosphamide, doxorubicin, vincristine and prednisolone) in combination with rituximab. A repeat FDG-PET scan 1 month after chemotherapy was clear.

We speculate that lymphoma progression was suppressed by the coexistent steroid-producing adrenal tumour. The decision to treat the non-Hodgkin's lymphoma was, in part, based on reports of progression of haematological disease following treatment of Cushing's syndrome.[1,2] Although histopathological examination of the tumour revealed some features suggestive of adrenocortical carcinoma, the distinction between adenoma and carcinoma can be difficult. In patients with recurrent or metastatic adrenocortical carcinoma, partial response has been reported using a combination of cylophosphamide, vincristine, cisplatin and teniposide.[3] Two of these agents were used to treat our patient's lymphoma.

1 Patient appearance at presentation, with obvious kyphosis and abdominal swelling



2 Immunohistochemistry



A: Right adrenal tumour composed of enlarged pleomorphic cells with prominent nucleoli.

B: Adrenal cortex (on right) with tumour showing focal vascular invasion (centre), plus adjacent non-Hodgkin's lymphoma (on left). ◆

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Australia needs an expanded immunisation register

Allen C Cheng, Carmel M Hobbs and Priscilla M Robinson

To the Editor: We agree wholeheartedly with Skull and Nolan's call for a lifetime immunisation register to enhance monitoring of coverage, provide a clinical support service and provide data for program evaluation.[1] An expanded register could also provide information on the vaccine coverage for childhood diseases that may increasingly affect adults (such as varicella and measles), for immigrants who may receive childhood vaccines after childhood, and for occupational groups (eg, influenza vaccine for health care workers).

However, we note some policy implications that need to be addressed before such an expanded register could be implemented. In August 2007, at a La Trobe University seminar on human papillomavirus vaccination, the 180 participants (mainly students and staff of La Trobe University) were asked to fill out a survey that included a question about the acceptability of a lifetime vaccination register. Of the 154 who responded, 8.5% were not in favour of such a register and another 8.5% declined to answer that question (unpublished data). This suggests that there may be significant barriers to the implementation of a lifetime register.

Principal among the concerns cited were the implications for privacy, which were also noted by consumer groups.[2] As with the existing Australian Childhood Immunisation Register, people will need to be aware of what data are being collected (including policies for data retention), their choice to opt out, and a clearly defined purpose in gathering the data (in particular, that the data will not be used in a punitive manner). People will also need to be assured that there are unambiguous policies governing access to the register and penalties associated with breaches of confidentiality.

These concerns have led to the suggestion that a private health record should be developed instead,[2] but such a record would be unlikely to be adopted widely and could not be used for monitoring or program evaluation.

Development of an expanded register could also present potentially significant logistical problems. We would suggest a staged approach, beginning with expanding the current childhood register to include adolescents of school age and elderly people. Incentives to improve vaccine coverage in these groups could be modelled on the current General Practice Immunisation Incentives Scheme, which provides service incentive payments, outcomes-based payments and immunisation infrastructure funding. Many Indigenous Australians are currently covered through Aboriginal-controlled community health organisations. With the consent of those organisations, data could be absorbed into a national register. Later stages of implementation might see the inclusion of special groups (such as post-splenectomy patients and immigrants) and people receiving occupation-related and travel-related vaccines. The register could eventually be expanded to encompass the full Australian population.

The current redevelopment scoping study for the Australian Childhood Immunisation Register[3] is due for completion in 2008. We support enhancing the current central register, but clearly defined policies to protect privacy are required to address public concerns.

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1 Skull SA, Nolan TM. Australia needs an expanded immunisation register for further improvements in vaccine delivery and program evaluation [editorial]. *Med J Aust* 2007; 187: 504-505.
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Susan A Skull and Terrence M Nolan

In reply: We welcome additional dialogue on the important issue of developing a whole-of-life immunisation register in Australia. As with introduction of any register, logistics and concerns about privacy must be carefully considered, and a stepwise approach may well be appropriate.

However, it is important to note that a non-acceptance rate of 8.5% derived from a small and potentially non-representative survey of seminar attendees does not necessarily represent a significant barrier to implementation of such a register.

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Humanising medical practice: the role of empathy

Marion Lustig

To the Editor: I congratulate Haslam on his excellent overview of the role of empathy in medicine.[1] He rightly reminds us that empathy is not vague or ill defined; rather, its presence improves clinical outcomes, and it can be both learned and lost. I would go further and argue that empathy is not an optional extra but a clinical competence essential for sound medical practice, no matter what our specialty. All clinical practice requires a doctor–patient relationship, the core skill of which is empathy.

I wish to draw readers' attention to a time-honoured but, in Australia, somewhat neglected educational activity where empathy is the major focus — that of Balint groups. In London in the 1950s, Hungarian-born psychiatrist Michael Balint and his wife Enid developed a unique method for studying the doctor–patient relationship.[2]

A Balint group is an experiential, small-group educational activity in which practising clinicians meet regularly to discuss their own doctor–patient interactions. The focus is on the emotional content of the doctor–patient relationship; the group's primary task is to describe and empathise with both the doctor's and the patient's experience. Participants' learning, therefore, is based on real-life situations they have encountered in their practices.

A rationale for this kind of training is that all doctors tend to have habitual responses to certain clinical situations. Although these responses can be strengths which doctors bring to the care of some patients, they can also limit their capacity to help other patients. In certain situations, limits to doctors' capacities for empathy may be unhelpful or even harmful to patients.

A growing body of research suggests Balint-group training increases:

- practitioner sensitivity to hidden patient cues;[3]
- the proportion of the consultation spent listening to the patient;[4]
- practitioners' experience of wellbeing during the consultation;[3,5]

- practitioners' sense of control in their work situation;[5] and
- practitioners' work satisfaction.[6]

At the same time it decreases:

- practitioner burnout;[3,5] and
- unnecessary prescriptions,[3] referrals[5] and tests.[5,6]

In many countries today, Balint-group training is used in undergraduate and postgraduate education, most often in general practice training, but also in psychiatry, paediatrics, obstetrics and gynaecology, and internal medicine. At an international level, the vibrancy and energy of Balint-group work is reflected in the 26-year-old International Balint Federation (http://www.balintinternational.com). The Balint Society of Australia (http://www.balintaustralia.org), formed in 2005, joined the Federation in 2007.

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Drowning and three-wheel strollers

Charles Bridges-Webb

TO THE EDITOR: I note the concern expressed by Byard and Matthews about the safety of three-wheel strollers.[1]

Surely a safer method of control would be for the brake to be on at all times other than when the stroller is in use? This could be done by having a lever that had to be held in position by the user in order to move the stroller.

Should not this be required in the safety standard?

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1 Byard RW, Matthews N. Drowning and three-wheel strollers [letter]. *Med J Aust* 2007; 187: 597-598. ❑

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