



Coventina's Column

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In March 2008, the Scottish government announced that they planned to maintain paediatric oncology services at the four centres in which they are currently active (Glasgow, Edinburgh, Dundee and Aberdeen) rather than centralising them. Paediatric oncology is an extremely complex field, and doctors and nurses recognise that treatment is not confined to the physical, nor to the child alone in isolation from family. There are also long-term issues to consider: a recent article (*Pediatric Clinics of North America* 2008; 55: 251-273) stressed the importance of considering problems in children who recover from cancer. These include neurocognitive dysfunction, cardiovascular disease, infertility and gonadal dysfunction, and behavioural/psychiatric problems. Although the article focused on care in the US, Canada and the Netherlands, Coventina has noted over the decades that problems in survivors of childhood cancers are universal, so that the models discussed may also be helpful here.

A study from a fledgling Coventina's fondly remembered JHO/SHO nest Edinburgh's Western General Hospital, examines the use of the anti tumour necrosis factor antibody adalimumab in refractory Crohn's disease (*Alimentary Pharmacology and Therapeutics* 2008; 27: 308-315). The trial showed that adalimumab is effective in refractory Crohn's disease including in patients who had not reacted to another anti TNF ab, infliximab. However, as is the fear with anti TNF abs, a few patients developed severe infection or malignancy. Another study on patients with Crohn's disease (*The Lancet* 2008; 371: 660) investigated whether treating patients early with combined immunosuppression might reduce the need for corticosteroids or bowel resection at six months and one year. The study showed that early treatment with combined immunosuppression comprising infliximab, azathioprine and, only if necessary, corticosteroids, was more likely to lead to remission at six months and one year without need for corticosteroids or bowel resection than the use of corticosteroids as immediate first line therapy with azathioprine and infliximab given afterwards.

Anti tumour necrosis factor (TNF) antibodies also cropped up in a study into psoriasis (*British Journal of Dermatology* 2008; 158: 558-566). Investigators compared treatment with adalimumab with methotrexate or placebo. Significantly more patients attained a 75% improvement in the Psoriasis Area and Severity Index (PASI 75) with adalimumab (79.6%) than with methotrexate (35.5%) or placebo (18.9%) after 16 weeks, and more adalimumab patients achieved total

clearance of disease (16.7% adalimumab cf 7.3% methotrexate and 1.9% placebo). Side effects were similar in all treatment groups.

Coventina notes wryly that one of the rare idiosyncratic side effects in patients with Crohn's using adalimumab is, ironically, psoriasis in patients with no previous history of the skin disorder. Coventina has noticed that most intensive care units in Scotland and the rest of the UK use noradrenaline and adrenaline as first line drugs for parlously vasodilated patients with septic shock. However, in some intensive care units in North America, vasopressin is used along with catecholamines to help raise blood pressure in these patients (despite, Coventina frets, its anti-diuretic activity). However, a multicentre double-blind study from Canada in which patients with septic shock already on noradrenaline infusions were randomised to also receive either vasopressin or more noradrenaline (*New England Journal of Medicine* 2008; 358: 877-887) showed no significant difference in overall mortality rates at 28 and 90 days in the two groups of patients, although those patients with less severe septic shock did have reduced mortality at 28 days with vasopressin. The evidence does not support use of vasopressin in patients with septic shock.

Most doctors are aware of the cliché that prevention is better than cure. As far as physical conditions are concerned, prophylaxis can often have well defined goals. But prevention of relapse in psychiatric disease is more hard to quantify and qualify. Many studies have shown that relapse in severe psychiatric conditions is more likely when patients are subjected to stressful conditions, but in the cash-strapped NHS, prophylaxis of severe depressive illness is usually attempted only pharmacologically. A recent study suggests that psychosocial interventions may be effective in addition to pharmacological ones for the prevention of relapse in bipolar disorder. (*British Journal of Psychiatry* 2008; 192: 5-11). It seemed from the trial that cognitive-behavioural therapy in combination with usual treatment was useful in preventing relapse. Coventina recognises that it is difficult to standardise psychosocial intervention or to judge its effects, and in an era where politicians focus on expedient, headline-shrieking health issues, a grey area like this may not be seen as a priority. However, for some patients living with the black dog of bipolar disorder, this form of intervention may help make the difference between a fulfilling life and one full of despair.