Mason et al. paper. More seriously and regrettably, this paper will now be referenced in the literature to deter clinicians from using any properly conducted CPT test to evaluate their patients.

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References


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Reply

We appreciate the opportunity to reply to the letter from Dr Pelmear. We agree entirely with his sentiment regarding the requirement for evidence-based medicine and the commendable editorial by Dr Nilsson. Dr Nilsson also quite rightly referred to ‘the danger in using diagnostic guidelines when based on past evidence they may continue to be applied even when newly emerging evidence suggests that they are obsolete’. We identify with this sentiment, and it has particular relevance to the issues raised in the letter by Dr Pelmear.

There are some puzzling and, we feel, factually inaccurate statements in Dr Pelmear’s letter. Although the Independent Medical Advisory Group (IMAG) agreed the Medical Assessment Process (MAP), only Dr McGeoch was involved in direct negotiations with the Department of Trade and Industry (DTI) and the Claimants Steering Group (CSG) (not ‘Committee’). Both of these parties wanted to continue with the use of the Taylor Pelmear Classification and neither was enthusiastic about the introduction of tests, although probably for different reasons. However, all of IMAG’s recommendations were eventually agreed. The CSG did not put any limit to the MAP. The non-medical input, referred to in the paper, occurred after the process was well under way. An example is the method for handling ‘late onset’ of symptoms.

IMAG, which was composed of fairly experienced workers in the hand-arm vibration field, did not see what was created as an ‘unsatisfactory screening process’. The average doctor examination time was 38 min and total time per claimant 1 h 48 min. It is our opinion, taking into account the number of claimants involved, that it is unfair to describe this as an ‘unsatisfactory screening process’. We are aware that Dr Pelmear’s examination could take much longer, but we are not comparing like with like. The total man-hours required could have been huge.

We were keen to be as frank as possible about the political and legal dimensions of the DTI Miners Assessment Process. It does not in any way diminish the validity of the data collected, or necessarily suggest that the database is flawed in terms of any subsequent analysis. In no other similar scheme anywhere else in the world has there been so much time invested in training, delivering and quality assuring the whole process as in this scheme. If anything, it could be argued this database is the most quality assured dataset ever created in the area of HAVS.

Dr Pelmear refers to a requirement for direct questions, which is exactly what the majority of the medical assessment process questionnaire entailed. In any sound history taking, it is appropriate to ask non-leading questions at the outset, so that the history can be given freely. This has always been our clinical practice. Direct questions can then be used, as appropriate, in a standardized fashion to ensure that all information is ultimately gathered. The examining doctors receive comprehensive guidelines written to take account of what was required in each part of the process and for each question that was asked.

We are surprised that there is any suggestion from Dr Pelmear that we did not ask a direct question regarding the date of onset and severity of Raynaud’s phenomenon. He himself, at the instigation of Dr McGeoch, became an auditor in the early part of the process, and must be fully aware of the questions which had to be completed. The system was standardized and set up exactly to obtain a true history of the facts and the written guidelines to facilitate this would stand up to any external scrutiny.

Dr Pelmear mentions ‘already established clinics’. For the pilot scheme, three specifically designed centres were created at the Health and Safety Laboratory (HSL) in Sheffield, one in Mansfield and one at Babcocks, Renfrew. However the original medical specification was based on that used at Babcocks engineering company since 1990. This specification was the work of Professor W. Taylor when he was, until his death, a consultant to the company. As far as Dr McGeoch is aware, Professor...
Taylor did not think this was an ‘unsatisfactory screening process’. In fact, he was delighted with it and was a joint author of a paper with the initial findings [1]. Professor Taylor was mentor, colleague and friend to both Dr Pelmear and Dr McGeoch.

Furthermore, the recommended standardized test procedures should take account of those procedures that have been peer reviewed and published in the context of the assessment of HAVS. The suggestion made in the Viewpoint article [2] ‘to reserve Stage 3SN for those with abnormal nerve conduction tests’ is a statement not in keeping with recently published peer reviewed papers. In the latter study, neurophysiological findings in 73 symptomatic vibration exposed workers showed that ‘severe subjective symptoms (3SN) were reflected in the vibrotactile thresholds and not in the neurophysiological findings’. Standardization of all tests used during the process was derived from the most recently available reviews of equipment used by the Institute of Sound and Vibration Research [3].

Dr Pelmear states there were initially problems with the data input and software. This is true, but hardly surprising. For this reason, we have looked at the data for different periods to detect any variations in the results.

Dr Pelmear makes some comments about the wisdom of the editors of *Occupational Medicine* in publishing our paper. We would only say that other peer-reviewed journals have also published papers containing similar findings and opinions after satisfying their own peer-review processes. Dr McGeoch found a lack of association between the CPT and vascular staging in workers at Babcocks [4]. This was published in *Occupational and Environment Medicine*. The author’s views are also to be found in the recently published paper in the British Journal of Surgery [5].

We feel it is reassuring that the peer-review process operated by *Occupational Medicine* is sound and robust enough to nullify any potential conflict of personal or vested interests in this increasingly controversial subject area. We are content to leave the decisions on publication to the editors of the respective journals.

References


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Reply

We thank the editor for the opportunity to respond to Dr Pelmear’s letter. Among other points, Dr Pelmear is concerned about the potential for our paper to mislead readers into assuming that any vascular test for HAVS based on a local cold provocation to the hands would hold little diagnostic value. We take the opportunity to reiterate that our conclusions relate to the particular format of the ‘standardized’ cold provocation test (CPT) in the paper. The format of the test was promulgated and reported as a ‘standardized test’ [1,2] and also used within the DTI compensation assessment of UK miners. Therefore, this version of the CPT is widely known within the UK and is potentially available for further diagnostic use at a number of test centres. We feel confident that the readership of *Occupational Medicine* can apply judgement to evidence relating to specific tests on a disease modality rather than all suggested tests for the modality.

Dr Pelmear also suggests that ‘by implication [we] cast doubt on properly conducted CPT procedures being conducted in laboratories by others across the world’. That was not our intention, but we would also point out that the literature on CPT tests shows a wide range of test formats and strategies, the nature of the cold provocation, and the test outcome metric used. The reported sensitivities of many CPT tests appear poor and may only have value in research epidemiological studies rather than in diagnosis of the individual [2–4]. There still appears to be no universal agreement on a specific CPT test that has been shown from independent centres to meet the

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