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LETTERS

IRRITABLE BOWEL SYNDROME

The problem of insoluble fibre in irritable bowel syndrome

I was surprised to read in the popular press that, according to the *BMJ*,[1] fibre is good for irritable bowel syndrome.

In 1994 we suggested that, at least in secondary care, cereal fibre was more likely to do harm than good in patients with irritable bowel syndrome.[2] Now, as a gastroenterologist probably seeing more cases of severe irritable bowel than most of my colleagues, I find that the total exclusion of all cereal fibre, such as bran and brown bread, from the diet is one of the most rewarding treatment strategies I can offer.

Ford and colleagues acknowledge that bran (insoluble fibre) as opposed to ispaghula (soluble fibre) is not effective in irritable bowel syndrome but claim that it does not exacerbate symptoms,[1] presumably because of the lack of side effects reported in the trials they reviewed. However, trials of fibre have traditionally looked for improvement or no improvement and do not allow for the possibility of deterioration because fibre is considered a natural, harmless product. Indeed, any worsening of symptoms is likely to be attributed more to a spontaneous exacerbation of the disorder than to a side effect of the bran.

The potentially harmful effects of bran are likely to be exaggerated in secondary and tertiary care because, by definition, patients who are not made worse are less likely to be among those referred. And in primary care, bran is less deleterious, although it can still cause an exacerbation in some patients.[3]

With evidence based medicine and the rapid dissemination of research results to the media, we must still listen to what our patients are telling us, especially when the question is subtly different to the question that has been addressed by the evidence. And we must be extremely careful about the accuracy of what we write, especially in the abstract of a paper, as this is commonly the only part scanned by busy readers. Ford and colleagues' concluding statement in their abstract ignores the substantial differences between soluble and insoluble fibre, thus encouraging some patients to continue with a treatment, insoluble fibre, which at best is doing them no good but at worst may be doing them harm.

Peter J Whorwell professor of medicine and gastroenterology, Wythenshawe Hospital, Manchester M23 9LT **peter.whorwell@uhsm.nhs.uk**

Competing interests: None declared.

1 Ford AC, Talley NJ, Spiegel BMR, Foxx-Orenstein AE, Schiller L, Quigley EMM, et al. Efficacy of fibre, antispasmodics, and peppermint oil in irritable bowel syndrome: systematic review and meta-analysis. *BMJ* 2008;337:a2313. (13 November.)
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Why pills more than skills?

The effectiveness of fibre, antispasmodic drugs, and peppermint oil in irritable bowel syndrome should further increase interest in other low cost, low toxicity interventions.[1 2]

The heavy emphasis on pharmacotherapy found in so many British and US guidelines on irritable bowel syndrome results in continuing monthly expenditures for patients in the United States, as well as generally encouraging ongoing patient passivity and dependence on the medical system.

Hypnotherapy seems to relieve symptoms as well as or better than pharmacotherapy, with no side effects. However, unlike pharmacotherapy, it also improves quality of life and psychological state, including the sense of self empowerment and self control, which correlate with higher motivation for ongoing self care.[3] Furthermore, continual professional treatments are not needed: the beneficial effects from the initial treatments seem to be sustained over time, with patients reporting continued relief from symptoms for at least five years.[4]

A meta-analysis of 17 randomised trials of hypnotherapy and cognitive behavioural therapies compared with control treatments (including waiting list, symptom monitoring, and usual medical treatment) had an estimated number needed to treat of 2.[5] This compares favourably with Ford and colleagues' 11.5 for soluble fibre, 5 for antispasmodics, and 2.5 for peppermint oil.[1]

Hypnotherapy and cognitive behavioural therapies are currently reserved for treatment in secondary and tertiary care. Why not advance research on their role in primary care? Why save the best for the worst?

Gregory A Plotnikoff medical director, Penny George Institute for Health and Healing, Abbott Northwestern Hospital, Minneapolis, MN 55407, USA **gregory.plotnikoff@allina.com**
Mark B Weisberg clinical health psychologist, Minnesota Head and Neck Pain Clinic, St Paul, MN 55114, USA

Competing interests: None declared.

1 Ford AC, Talley NJ, Spiegel BMR, Foxx-Orenstein AE, Schiller L, Quigley EMM, et al. Efficacy of fibre, antispasmodics, and peppermint oil in irritable bowel syndrome: systematic review and meta-analysis. *BMJ* 2008;337:a2313. (13 November.)
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Don't forget amitriptyline

As Jones argues,[1] a holistic and integrated approach is necessary for irritable bowel syndrome. Therefore Ford and colleagues[2] should have mentioned somewhere the potential benefits of amitriptyline. At low doses (10-25 mg at night) some patients, particularly those with diarrhoea predominant irritable bowel syndrome, derive symptomatic benefit. A recent meta-analysis by the same authors has shown a positive effect with a number needed to treat of 4.[3]

Amitriptyline remains an old but important addition to the clinicians' armamentarium and is in keeping with a holistic approach for patients with irritable bowel syndrome.[4]

John S Leeds specialist registrar in gastroenterology, Gastroenterology and Liver Unit, Royal Hallamshire Hospital, Sheffield S10 2JF **john.leeds@sth.nhs.uk**
Clare M Leeds GP registrar, Belgrave Medical Centre, Sheffield **john.leeds@sth.nhs.uk**
David S Sanders consultant gastroenterologist, Gastroenterology and Liver Unit, Royal Hallamshire Hospital, Sheffield S10 2JF

Competing interests: None declared.

1 Jones R. Treatment of irritable bowel syndrome in primary care. *BMJ* 2008;337:a2213. (13 November.)
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Cite this as: *BMJ* 2009;338:a3150

HYPERSENSITIVITY TO HPV VACCINE

More data from Australia on sensitivity to HPV vaccine

We concur with Kang and colleagues' report on the school based quadrivalent human papillomavirus (HPV) vaccine programme in Victoria and South Australia that documented that IgE mediated hypersensitivity to the vaccine is rare.[1] However, their case of a positive skin test result with generalised urticaria after the first dose and anaphylaxis after the second is noteworthy. It raises the question of subsequent doses when presumptive hypersensitivity occurs and whether hypersensitivity may be more common with HPV vaccines.

Ascertainment of immediate hypersensitivity should be optimal in a school based programme. In New South Wales, the largest Australian state, we estimated the incidence of anaphylaxis in the school programme to be 2.6 per 100 000 doses (95% confidence interval 1.1 to 5.2),[2] which is compatible with that calculable from Victoria and South Australia of 0.53 per 100 000 (0.06 to 1.9).[1] Similarly, 42 notifications of suspected hypersensitivity from the 2007 school programme in New South Wales is a rate of 15.6 per 100 000 doses (11.2 to 21.1) compared with 35 notifications in Victoria and South Australia, or 9.2 per 100 000 doses (6.4 to 12.8),[1] substantially higher than typical rates from passive surveillance.[3]

Immunisation providers need to be aware of the possibility of hypersensitivity reactions after vaccination; a clinical management algorithm has recently been published.[3] The experience of other countries embarking on large scale school based HPV vaccination—using the divalent vaccine in the UK and the quadrivalent vaccine in Canada—will inform the accuracy of the Australian estimates, which suggest that hypersensitivity may be more common with quadrivalent HPV vaccine than other vaccines.[1-3]

Peter B McIntyre director, National Centre for Immunisation Research and Surveillance of Vaccine-Preventable Diseases, Royal Alexandra Hospital for Children, Westmead, Sydney, NSW 2145, Australia
peterm@chw.edu.au
Julia M L Brotherton medical epidemiologist, Victorian Cervical Cytology Register, PO Box 310, East Melbourne, VIC 8002, Australia
Margaret A Burgess honorary professor, University of Sydney and Royal Alexandra Hospital for Children, Westmead, Sydney
Andrew S Kemp professor of paediatric allergy, University of Sydney and Royal Alexandra Hospital for Children, Westmead, Sydney

Competing interests: None declared.

1 Kang LW, Crawford N, Tang ML, Buttery J, Royle J, Gold M, et al. Hypersensitivity reactions to human papillomavirus vaccine in Australian schoolgirls: retrospective cohort study. *BMJ* 2008;337:a2642. (2 December.)
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HOW SHOULD HEALTH BE DEFINED?

Health is quality of process

The works arising from the Pioneer Health Centre in Peckham strongly illuminate how health should be defined.[1 2] Health is visible in the process of life, not in status at any time. It is the quality of the movement from this moment to the next that counts, and it is independent of present circumstance. Most people of fairly lowly but self reliant means are healthier than those who are very wealthy and cannot boil an egg, or fear to walk the streets without a bodyguard.

Peckham defined health as the faculty for mutual synthesis with one's environment. I would suggest a simpler version—health is the ability to participate in creation (or constructive activity).

By this definition, most of us are healthy most of the time. Doctors study how empty the glass may be: health practice would wish to know how full. Having made a modest career of health practice these past 30 years, I know that it is quite different from medicine, but can rapidly reduce demand for medicine—by up to a half, in my experience. It reduced my personal prescribing to under half the national average (prescribing analysis and cost (PACT) figures).

Whether we are yet ready to expand our vision this much remains to be seen. I doubt if the initiative will come from within medicine. Examples of good health practice crop up everywhere in education projects and social enterprises, nevertheless. Economic and climatic constraints will force healthy living on us eventually, or we shall perish.


GETTY IMAGES

Peter Mansfield retired medical practitioner, Newark NG24 1ET peter.mansfield47@ntlworld.com

Competing interests: None declared.

1 Jadad AR, O'Grady L. How should health be defined? *BMJ* 2008;337:a2900. (10 December.)
2 Pioneer Health Foundation. The Peckham experiment. www.thephf.org

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Why the definition of health matters

The definition of health is important.[1] There is a biomedical component to health, but it exists in a setting that includes biological, personal, relational, social, and political factors.[2 3]

For too long, we as doctors have been timid about defining health, and mostly operated at the level of "absence of disease." For too long, we as a society have allowed politicians to get away with shunting health off to a "medical domain," thus avoiding focus on the large scale social and political forces that create health and illness.[4] We need to rediscover the force of Virchow's statement: "Medicine is a social science and politics is nothing but medicine on a grand scale."

In my essay I propose: "Health is best seen as an ongoing outcome from the continuing processes of living life well. Living life well would be defined in terms of wealth, relationships, coherence, fitness, and adaptability. Disease avoidance would be a minor part of this view of health."[2]

Such a definition is a political statement, informed by my knowledge of medicine and its social context. I believe that achievement of health should be a goal of public policy and that we should want to achieve healthy individuals in a healthy society. I see health as being a moral and practical good in itself, as well as a means towards other ends. If health is to mean anything it has to include ideas of human flourishing and abundance.

As a doctor I need an aim, and a context, for my practice of medicine that goes beyond treatment of illness, important though that is.

Peter G Davies GP principal, Keighley Road Surgery, Halifax HX2 9LL npgdavies@blueyonder.co.uk

Competing interests: None declared.

1 Jadad AR, O'Grady L. How should health be defined? *BMJ* 2008;337:a2900. (10 December.)
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REGULATION'S THREAT TO RESEARCH

Regulation of research

In the open season for hunting research ethics committees[1] the letters show how researchers may be their own worst enemies. For example, Parker waited for nearly a year for a response from the Medicines and Healthcare Products Regulatory Agency, which need not have been approached.[2] He then applied sequentially to the ethics committee and research and development department when he should have done so concurrently at the start. Samuel's study might have been regarded as audit or service development, not requiring ethical approval.[3]

The process of ethical review cries out for simplification and abbreviation. For example, a distinction could be made between interventional research and the plethora of projects arising from undergraduate and postgraduate studies in pursuit of degrees.

The unacknowledged source of frustration is government. The Human Tissue Act 2004, for example, is arguably an over-reaction on the part of government and the chief medical officer (with the complicity of the royal colleges) to the publicity after the Bristol and Alder Hey inquiries. Importantly, this was not reproduced in the European Union or United States.

There is scope for further restructuring research ethics committees, partly by amalgamation. The committee I chair operates three panels which meet on consecutive weeks, so that delays are minimal. It can be helpful if the chair is medically qualified, or, if not, that the deputy is, and is also easily available. Less attention should be paid to "so what" studies and more to interventional research. This is where a medical qualification may be helpful, on the basis that "old poachers make the best gamekeepers."

David E B Powell chairman, South East Wales Research Ethics Committee, Peniel, Carmarthen SA32 7HF
david.powell58@btopenworld.com

Competing interests: DEBP is chairman of a research ethics committee.

1 Godlee F. It's time to change how Europe regulates research. *BMJ* 2008;337:a2986. (11 December.)
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Over-regulation, Russian style

Bureaucratic and ethical control that damages research is not limited to the United Kingdom.[1]

When ethical control of applications for clinical trials was introduced in Russia many years ago, the federal law on drugs stated that only drug developers can initiate trials. To my knowledge, Russia is the only country where state or academic or non-industrial organisations are barred from initiating clinical research. This tool is systematically used to block any independent drug research.

The requirement to insure participants of clinical research against possible harm has also recently been hijacked by industry. Although some clinical studies are connected with minuscule risks from experimental procedures (such as the risk from interview or donating a urine sample), ethics committees demand the full scale insurance, which makes a study impossible without generous external support.

This situation results in poor quality clinical research in Russia, limited to case series and convenience sample cohort studies. Such regulation may be only an outcome of a corrupted legal system. After the Russian president Medvedev declared war on corruption, the new amendments to the law on drugs were prepared by the ministry of health, again limiting the right of initiation of trials to industry.

Vasiliy V Vlassov professor, Moscow Medical Academy, Trubetskaya 8, Moscow, 101000 Russia
vlassov@cochrane.ru

Competing interests: None declared.

1 Stewart PM, Stears A, Tomlinson JW, Brown MJ. Regulation—the real threat to clinical research. *BMJ* 2008;337:a1732. (16 October.)

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LEFT-RIGHT DISCRIMINATION

It's all about coordination and laterality

McManus's editorial on discrimination against left handed people and Leiske's article on left-right discrimination in surgical trainees raise important questions that extend beyond the use of surgical instruments.[1 2] Spatial awareness requires binocular vision but most surgeons have a dominant eye too. The operating microscope is set to the dominant eye, and the operating field may not be in the centre if the teaching arm or camera is set on the opposite side. Modern microscopes get around this by taking the teaching image from above the beam splitter.

If monocular endoscopes are used, crossed laterality may not be a problem. However, UK otorhinolaryngological clinics are set up for right eye dominant and right handed people. People who are left eye dominant but right handed have a problem, as do those who are left eye dominant and left handed.

Teaching surgery to right handed trainees who want to stand on the same side of the operating table as the right handed surgeon may be best when using an endoscope but in other situations a left hander standing on the opposite side may allow better access for the trainee or assistant.

People also have a dominant ear, and this may be a problem for some patients, particularly children with unilateral glue ear, in whom a problem on one side may cause disproportionate difficulties. Usage is not always a sign of laterality: Jimi Hendrix, for example, wrote with his right hand but played the guitar left handedly.

The debate must extend beyond the confines of handedness to get to grips with hand-eye coordination and laterality. Let us leave the term dexterity out of it.

Adrian Drake-Lee consultant ear, nose, and throat surgeon, Queen Elizabeth Hospital, Birmingham B15 2TH
adrakelee@aol.com

Competing interests: AD-L is a left handed surgeon with a dominant right eye, ear, and foot who has a left handed sister, brother in law, daughter, and granddaughter. All the other members of the family are right handed.

1 McManus C. Left-right discrimination in medicine. *BMJ* 2008;337:a2906. (16 December.)
2 Leiske B. The left-handed surgical trainee. *BMJ* 2008;337:a2883. (16 December.)

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MORTALITY ON MOUNT EVEREST

Important points in analysing deaths on Mount Everest

Firth and colleagues' analysis of all the deaths on Mount Everest during 1921-2006 did not address some important points.[1]

Did more climbers die on their first attempt than on subsequent attempts? What drugs were they taking? Some climbers might be taking dexamethasone.[2] The summit bid starts at midnight, which may be a confounding factor for death while climbing. Similarly, crowded climbing and delaying the summit bid should also be considered.

How was ataxia assessed? Climbers are using crampons, are roped, and have oxygen cylinders and masks in addition to gloves and clothing. Ataxia cannot be diagnosed unless Romberg's test or the sharpened Romberg test is done.

Most importantly, the authors did not consider high altitude deterioration[3] as an important factor in causing death at such extreme altitudes with the longer time of exposure. Instead, they speculate that headache, nausea, and vomiting are not heralds of high altitude cerebral oedema at extreme altitudes.

Matiram Pun junior doctor, Tribhuvan University Teaching Hospital, Institute of Medicine, Kathmandu, Nepal
matiram@gmail.com

Competing interests: MP participated in medical research in the Everest region and at the base camp in 2007; worked as a volunteer physician in Manang and Thorang Phedi medical

aid post of the Himalayan Rescue Association of Nepal in 2008; and is secretary of the Mountain Medicine Society of Nepal.

1 Firth PG, Zheng H, Windsor JS, Sutherland AI, Imray CH, Moore GWK, et al. Mortality on Mount Everest, 1921-2006: descriptive study. *BMJ* 2008;337:a2654. (11 December.)
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DO ANTIBIOTICS AND ALCOHOL MIX?

Alcohol and sexual behaviour

Lwanga and colleagues explored beliefs about the effects of alcohol on antibiotic treatment among patients attending a genitourinary medicine service.[1]

We conducted a small prospective study of 274 patients attending our genitourinary medicine service who required a week's course of antibiotic treatment. We found that high alcohol consumption, especially binge drinking, during treatment was associated with non-compliance with behavioural advice about sexual abstinence ($P<0.001$), essential to ensure effective cure for many sexually transmitted diseases. Non-significant trends were also found in relation to alcohol use and compliance with treatment.[2]

Dispelling any myths about the effect of alcohol on the efficacy of treatment is reasonable, but patients should be counselled that high alcohol consumption and binge drinking during treatment may lead to risk taking behaviour necessitating retreatment.

Sangeetha S Sundaram specialty doctor, genitourinary medicine, Royal South Hants Hospital, Southampton SO14 0YG
sangeetha@doctors.org.uk
S Samraj specialist registrar, genitourinary medicine/HIV
Raj Patel consultant, genitourinary medicine/HIV

Competing interests: None declared.

1 Lwanga J, Mears A, Bingham JS, Bradbeer CS. Do antibiotics and alcohol mix? The beliefs of genitourinary clinic attendees. *BMJ* 2008;337:a2885. (16 December.)
2 Samraj S, Learner H, Patel R. Compliance among patients with high alcohol consumption in genitourinary medicine. *Int J STD AIDS* 2008;19:286.

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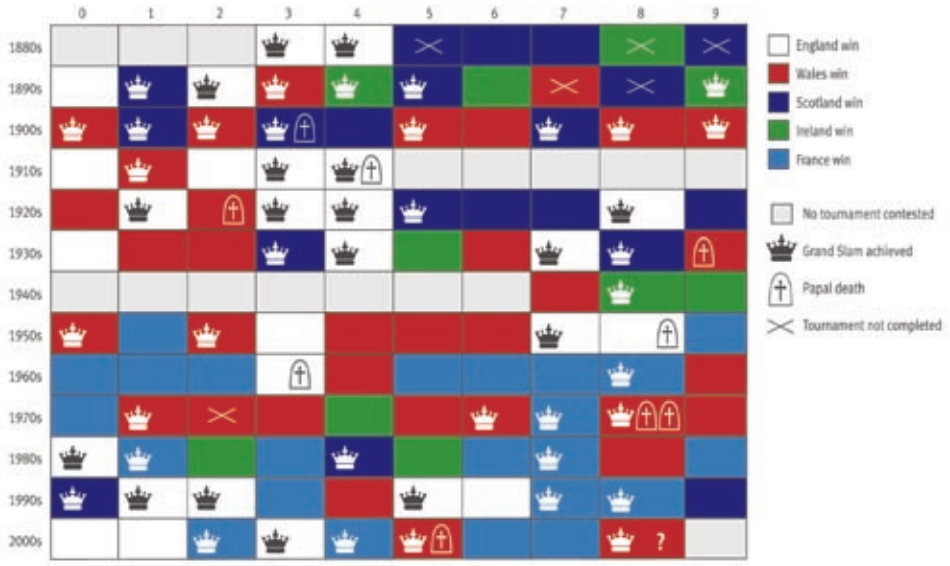
WELSH RUGBY AND THE POPE

Effect on Welsh rugby of the Pope who would not die

In 1981 Pope John Paul II was shot in the stomach and critically wounded by Mehmet Ali Agca. He went on to make a full recovery after surgery. This was also the year that Wales did spectacularly badly, coming second to last in the Five Nations (as it then was) championship, though admittedly only on points difference. During the rest of this Pope's long pontificate, Wales suffered. It was a lean period in which Wales won only two Five Nations championships in 1988 and 1994. Nothing untoward happened to the Pontiff in 1988, but it might be noteworthy that he fell and fractured his femur in 1994.



Clearly the link between Welsh rugby success and Papal health requires further study.[1]

Paul W Keeley consultant palliative physician, Glasgow Royal Infirmary, Glasgow G4 0SF
Paul.Keeley@ggc.scot.nhs.uk

Competing interests: PWK is a Roman Catholic and an Englishman.

1 Payne GC, Payne RE, Farewell DM. Rugby (the religion of Wales) and its influence on the Catholic church: should Pope Benedict XVI be worried? *BMJ* 2008;337:a2768. (17 December.)

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Don't worry, Your Holiness!

We are slightly concerned about the effects of the paper by Payne and colleagues on the Pope's mental health.[1] Hence we suggest:

- Calling for a crusade against Welsh rugby
- Engaging a good psychotherapist in the Vatican medical team to support our Pope
- Buying all the copies of Payne and colleagues' article to save Pope Benedict XVI from reading it
- Asking the Pope to pray a little bit harder for the England, Scotland, and Ireland rugby teams and a little less for Wales.

However, we feel much more worried about the Welsh rugby team than the Pope's health, which is in good hands. Indeed, in Italy "every time a Pope dies" means "something so rare that it never happens." So our interpretation of Payne and colleagues' paper is that the Welsh rugby team should improve its performances and try to win more frequently.

Walter Gianni geriatrician, Geriatric Unit, INRCA, IRCCS, Rome, Italy **walgianni@hotmail.it**
Paola Gazzaniga oncologist, "Sapienza," University of Rome, Rome
Stefano Zuccaro geriatrician and member, Vatican medical team, Ospedale Israelitico Rome, Rome
Giuseppe Luzi immunologist, "Sapienza," University of Rome, Rome

Competing interests: The authors are all doctors working in Rome, SZ in the Vatican medical team, and are devout Catholics.

1 Payne GC, Payne RE, Farewell DM. Rugby (the religion of Wales) and its influence on the Catholic church: should Pope Benedict XVI be worried? *BMJ* 2008;337:a2768. (17 December.)

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RISKS FROM HEAVY METAL MUSIC

"Mosh pit" breast?

Patton and McIntosh failed to mention the more modern development of headbanging behaviour associated with heavy metal music.[1]

At a recent Black Sabbath concert (Heaven and Hell line up reunion with Dio as lead singer) it was thought necessary to engage a number of more modern thrash metal bands to attract a younger audience. During the set by Lamb of God I was amazed to see what seemed to be a fight breaking out in front of the stage. People were pushing, punching, kicking each other with abandon. I made some enquiries among younger members of the audience, and apparently this is referred to as "moshing." This must surely represent a greater risk of injury than the more traditional headbanging, and I was glad to see it all stopped once Sabbath took the stage.

I have seen a case of extensive bruising to the breasts associated with underlying fat necrosis caused by trauma inflicted during a moshing session—a case of mosh pit breast perhaps?

Philip J Drew professor and consultant breast surgeon, Royal Cornwall Hospitals NHS Trust, Truro TR1 3LJ
philip.drew@hyms.ac.uk

Competing interests: None declared.

1 Patton D, McIntosh A. Head and neck injury risks in heavy metal: head bangers stuck between rock and a hard bass. *BMJ* 2008;337:a2825. (17 December.)

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