not to terminate an affected pregnancy, are counted as a benefit, not a cost. In the cost–benefit assessment they consider every step from community information to the birth of the baby rather than solely considering the potential for prevention of births of affected children. In conditions in which there is no clear ethical or medical imperative for a prescriptive course of action, this approach seems to us to be appropriate. If the prognosis for children born with CF was appalling, then the case for informed choice as the primary aim would be less compelling. Ideally, an appropriate framework for decision-making would reflect this in an altered balance of benefits and costs. Similarly, if treatment for CF continues to improve such that life expectancy is little less than normal, this should also alter the balance of costs and benefits such that the option of termination of pregnancy, and hence possibly the entire screening programme, would be no longer tenable.

The issues raised by possible population screening for common diseases such as cancer, diabetes and asthma to identify genetic susceptibility factors are somewhat different. The concerns raised by Stone and Stewart perhaps apply more directly here. There are clearly conflicts raised when it is possible to specify increased risk of a disease at an individual level when there is no clear intervention to reduce that risk. Once again, it is important that a structured consideration of costs and benefits be employed to guide decision-making. We agree with Stone and Stewart that in the absence of this, political, professional and commercial interests are likely to have a major influence on decision-making.

Public policy in today’s society is unlikely to be decided simply on the basis of scientific evidence and professionally accepted ethical principles. The Government is likely to be influenced by media and market demand. We believe, nevertheless, that public health professionals should be actively advocating an evidence-based approach to policy making on screening and should support measures to enhance public understanding of these issues and promote lay involvement in policy making on screening. We currently have no societal structure that develops and transmits our society’s views on these issues. This is a major deficiency. The establishment of a Human Genetics Commission, similar to the Human Fertilisation and Embryology Authority, would be one positive step towards this goal.

References


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Anorectal disease: risk factors and delay in presentation in the United Arab Emirates

Sirs,

Operations for anorectal disease ranked second behind appendectomy as the most common surgical procedures carried out in 1994 at Al Ain Hospital. This underestimates the size of the problem, as not all patients with anorectal disease end up in theatre (and many prefer operative treatment overseas), whereas most patients with appendicitis face local emergency surgery. This unheralded problem of anorectal diseases facing medical practitioners and surgeons in Al Ain prompted a limited inquiry. A structured, interviewer-administered questionnaire was completed in 52 cases of anorectal disease (haemorrhoids, 34; anal fissure, 11; anal fistula, 7) and 129 controls (adult patients attending dermatology and ophthalmology clinics with no past history or symptoms suggestive of anorectal disease) at Al Ain and Tawam Hospitals. The make-up of cases and controls was similar by male gender (67 per cent, 69 per cent) and UAE nationality (29 per cent, 27 per cent).
The predicted risk factors of heavy lifting, prolonged sedentary activity, chronic cough, varicose veins, pregnancy, constipation, and family history of haemorrhoids were significantly more frequent among cases compared with controls \((p < 0.05, \chi^2\) or Fisher's exact tests), with the latter risk factor having the most significance \((p = 0.0005)\). Among cases, anal pain, prolapse and rectal bleeding were the most frequent presenting symptoms. Of medical concern was the delay in consultation, exceeding two months in 77 per cent of cases. Among this group, 45 per cent expressed delay of around one year or more, the maximum being 11 years. Illiteracy (no formal education) was the only significant factor associated with long delay \((p = 0.003)\).

There is a widespread clinical impression that rapid socioeconomic development and changes in lifestyle have led to the emergence of anorectal disease in the United Arab Emirates. Currently, malignancy ranks third behind cardiovascular disease and accidents as leading causes of mortality, with malignancies of the digestive system being the most frequent, ahead of carcinomas of the bronchus and breast. Clearly, there is scope for a health intervention input to increase awareness and reduce embarrassment among people with symptoms suggestive of anorectal disease, and so reduce delay in consultation.

Given the availability of colonoscopy at the present time, it is noteworthy that benign anorectal disease and colorectal neoplasia frequently coexist. There are also cost benefits in addressing the delay factor, as conversion of first-degree to second- or third-degree haemorrhoids, and of acute to chronic fissure, is associated with more specialized surgery and more frequent attendant postoperative complications.

References

