

Myotoxicity is a well known side-effect of statins, with a reported incidence of 1–7%.³ No cases of rhabdomyolysis due to monotherapy with ezetimibe have been described. However, myopathy triggered by ezetimibe in patients taking statins has been documented in two patients.⁴ Although MD is a known cause of rhabdomyolysis, the present case strongly suggests that myotoxicity may be elicited by ezetimibe, and poses the question of whether ezetimibe may trigger muscular damage by mechanisms that are presently unknown.

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Discordant public and professional perceptions on transparency in healthcare

Sir,
Transparency is becoming a major issue in healthcare.^{1,2} Recent work shows substantial differences between views of physicians and those of the public

on medical errors:³ while the public views open reporting as a very effective way of reducing errors, physicians prefer confidentiality. We conducted a survey to evaluate the potential contribution of a disclosure policy to hospital image. Our findings shed additional light on the discordance of opinions between physicians and the public.

We conducted a phone survey (in Hebrew, Russian and Arabic) of a representative sample of the Israeli public ($n=570$) using random-dial software. Respondents were asked to predict the effects of a transparency policy upon public image of hospitals and doctors, and also to what extent physicians report mistakes.

In addition, we conducted 115 face-to-face interviews of physicians with questions similar to those of the public survey, in three major teaching hospitals (two from Israel, one from the US). They included 53 residents, 54 attending physicians (from internal medicine, surgery and gynecology), six department heads and two hospital directors.

The majority of the public indicated that an open disclosure policy would enhance the image of hospitals (Figure 1). By contrast, a majority of physicians predicted that disclosing mistakes would damage the image of the hospital ($p<0.001$ vs. the public). American and Israeli physicians had similar distribution of opinions.

Since Israel has a markedly heterogeneous population, we examined whether ethnic or social groups might have different answers. In all sub-groups, including Russians, Arabs, and people with low or high levels of education, the majority consistently responded that transparency would benefit hospital image.

Both the public and physicians thought that disclosure to patients of individual mistakes by

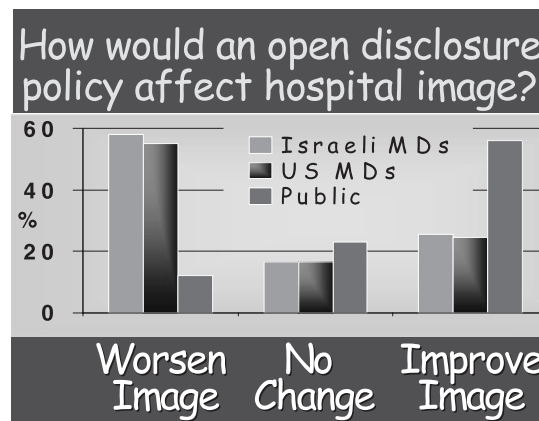


Figure 1. Effect of a disclosure policy upon hospital image, as perceived by the public and by physicians.

doctors would enhance the doctor's image. The public thought that in fact, few or none of the doctors disclose errors, whereas both Israeli and American physicians felt disclosure was common ($p < 0.001$). The public and the physicians agreed that publication of performance data would improve hospital image.

Our survey suggests that while physicians from both sides of the Atlantic Ocean share scepticism about the value of transparency, people from very diverse backgrounds share convictions regarding its importance. As discordance between public and doctors seems to cross cultures, bridging over mistrust appears to be a global challenge. It seems that both the public and physicians know physicians make mistakes, but physicians may not yet fully appreciate the extent of this public understanding.

Transparency in itself appears to become, in public eyes, an indicator of quality. 'Tell the truth and tell it fast'⁴ should become standard in healthcare, as recently adopted in Australia,⁵ but this cultural shift may be a tough professional challenge.

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Post-traumatic hyponatraemia due to acute hypopituitarism

Sir,

Hyponatraemia following traumatic brain injury (TBI) is a common complication, occurring in 13% of cases.¹ The commonest cause of hyponatraemia is the syndrome of inappropriate antidiuretic hormone secretion (SIADH), which is responsible for over 90% of cases,¹ whereas cerebral salt wasting, medications and injudicious use of intravenous fluids may also cause hyponatraemia following TBI. As glucocorticoid deficiency can present with hyponatraemia similar to that found in SIADH, it is essential to exclude adrenal insufficiency before making a diagnosis of SIADH.² This may be of particular importance in the case of TBI, as recent data have indicated a high frequency of undiagnosed hypopituitarism among long-term survivors.³ In addition, 16% of acute head injury patients show biochemical evidence of adrenocorticotrophin (ACTH) deficiency.⁴ Acute hypopituitarism with ACTH deficiency may therefore be a potentially important, cause of hyponatraemia in patients with acute TBI, which is misdiagnosed as SIADH.

To illustrate this potential pitfall in diagnosing post-traumatic hyponatraemia, we report our recent experience of three cases where acute TBI was complicated by hyponatraemia of between 125–130 mmol/l (normal 135–145 mmol/l) with all the biochemical features of SIADH (clinical euvolaemia, inappropriately concentrated urine and a natriuresis).² All three patients had significant head trauma. Patient A had a penetrating skull injury after falling from a ladder (Figure 1), patient B had diffuse axonal injury after a road traffic accident and patient C had intracerebral haematoma following a fall. At presentation, patients A and B were also hypotensive (blood pressures of 80/30 and 70/40 mmHg, respectively) and hypoglycaemic (plasma glucoses of 0.9 and 2.5 mmol/l, respectively) and required vasopressor support and continuous intravenous dextrose infusion. Patient C had normal blood pressure and plasma glucose. The diagnosis of post-traumatic hypopituitarism with ACTH deficiency was suspected in cases A and B because of the combination of