Prevention of Coronary Disease

SIR,—I would like to comment on your attitude to the prevention of coronary heart disease at a population level as expressed by you in your leading article "The Prevention of Coronary Heart Disease" (21 September, p. 689).

You are discouraging about a preventive programme at a population level and you base a rather nihilistic outlook on the lack of certainty that such a programme might succeed and on the difficulties of its application. But we will never assess the value of the preventive approach in the field of coronary heart disease until we try it, and I submit that the accumulated experience of epidemiologists and clinicians would strongly suggest the logic and efficacy of prevention at a population level. In this regard I would agree with the view of J. B. Hickie¹ quoted by you.

I do not question the reservations you make about the unproved significance of risk factors, about the efficacy of secondary prevention, and about patient co-operation, but it is regrettable that you should take such a discouraging attitude in this important public health field. If the time is not yet ripe to institute preventive measures on a national level, when will the time be ripe? Surely it is not too early to start a public educational campaign based on the considerable knowledge of risk factors which has already accrued. To my mind coronary heart disease is a highly predictable disease, and, because many of the risk factors are man-made and capable of modification, it is preventable at a population as well as a personal level.—I am, etc.,

Dublin 4, Eire.

RISTEÁRD MULCAHY.

REFERENCE

- ¹ Hickie, J. B., *Med. J. Aust.*, 1968, 1, 159.

Asthma from Aspirin

SIR,—Your observations on this subject (4 January, p. 6) may turn out to be the thin end of a very big wedge. From the writer's personal experience it appears that allergic rhinitis and sinusitis are extremely common reactions of aspirin consumers in the early stages of a cold. This aggravates and complicates a perfectly harmless and transient rhinorrhoea.

But why stop here? One can infer that the tracheitis and bronchitis often noted in aspirin-treated flu and coryza are primarily allergic reactions to the therapy. This statement can easily be confirmed by treating such cases by placebo only and noting the uneventful resolution without a cough. The acute gastritis with occult bleeds and the acute gastric erosions with haematemesis could be allergic signals in another target area.

Aspirin has been used for 50 years in ever-mounting quantities among vastly spreading populations under many disguises. Allergy to the drug will escalate. For this reason upper respiratory tract infections by virus will become increasingly complicated by drug allergy, will involve longer disability, and will require the deployment of expensive antibiotics to control a drug-induced disease.—I am, etc.,

Romford, Essex.

P. D. MULKERN.

Hong Kong Flu

SIR,—I am surprised no one has written to you before concerning the hysterical outburst by the press and the B.B.C. with regard to this subject. Every day there is a headline. We must expect a severe epidemic or not; we should be vaccinated or cannot be because there is no vaccine available; thousands of cases in America and hundreds of deaths; or, it's not very serious, no worse than previous epidemics; 250,000 doses of vaccine released next week.

Cannot the press and the B.B.C. be controlled or at least persuaded to behave more responsibly in a matter which affects every family doctor, and, by the unnecessary anxiety they have created, increases their work tremendously? Not to mention the disastrous effect it will have on production when the epidemic starts.

Am I right in assuming that the immediate effect of vaccination is to lower resistance for a couple of weeks and that by now it is too late to advise immunization, even if the vaccine becomes available? I managed with great difficulty to obtain 30 doses about six weeks ago and 10 doses last week.—I am, etc.,

F. DESMOND MACCARTHY.

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Fibrinolysis in Renal Disease

SIR,—A decreased fibrinolysis in blood¹⁻⁵ and tissues⁶ has been reported in patients with chronic renal disease. On the other hand, increased fibrinolysis has occasionally been observed in patients with carcinoma of the kidney.⁷ The findings^{8,9} that kidneys of subjects without renal disease make a significant contribution of plasminogen activator to the circulation by supplying quantities greater than those removed in the liver prompted us to investigate the activator content in the blood of patients with chronic renal failure to find out whether the diseased kidneys behaved similarly.

Twelve patients aged between 13 and 40 with chronic renal failure, all of whom were on regular outpatient haemodialysis, were investigated. Blood samples were collected from the arteriovenous shunt immediately before haemodialysis was begun and heparin administered. The euglobin-lysis time (E.L.T.), which was chosen for its value as a measure of plasminogen activator content, was estimated in duplicate by von Kaulla's method¹⁰ slightly modified.¹¹ The fibrinolytic activity was derived from these lysis

Euglobulin-lysis Time (in Units) in Arterial Blood on Four Different Days in Subjects With Terminal Renal Failure on Outpatient Haemodialysis

Subjects	Day				Mean
	1	2	3	4	
1	18.5	23.8	25.6	11.9	19.9
2	32.7	33.3	45.4	15.1	31.6
3	22.7	20.8	27.0	20.8	22.8
4	32.7	25.6	35.7	23.8	29.4
5	16.6	27.7	25.3	21.7	22.8
6	13.5	14.4	14.7	15.1	14.4
7	21.7	26.6	30.7	18.5	24.3
8	25.0	25.6	35.7	31.2	29.3
9	16.6	27.0	16.6	22.7	20.7
10	15.1	15.6	13.8	17.8	15.5
11	41.6	45.4	29.8	35.7	38.1
12	31.7	33.3	24.3	25.6	28.6
Total					297.4
Mean					24.78

times and expressed in units by multiplying their reciprocals by 10,000. Four separate estimations on four different days were made in all the patients. The E.L.T. was found to range between 11.9 and 45.4 units (see Table). When this was compared to the E.L.T. in arterial blood of age-matched subjects without renal disease,^{8,9,12,13} no significant difference between the two groups was observed. In spite of this, it cannot be concluded that the diseased kidneys have no deleterious effect on the production of plasminogen activators. The clear picture will not emerge until blood from the veins is studied.

The level of activator content in venous and arterial blood is different,^{8,9,11-13} and in a recent study H. A. Dewar and I. S. Menon¹⁴ have demonstrated that from venous blood the major part of this content is removed during the passage through the lungs. Consequently they suggested that this organ may play a part in the regulation of the plasminogen activator content in the circulation. If this hypothesis is proved to be correct, then even if there is a decrease in the activator content of the venous blood in patients with chronic renal failure this would not be demonstrated in our study of arterial blood from the shunt.

Our thanks are due to Professor D. N. S. Kerr and Dr. H. A. Dewar for their encouragement, and Mr. Alan Martin for technical assistance.

—We are, etc.,

I. SUDHAKARAN MENON.

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Prevention of Migraine

SIR,—Frequent attacks of migraine are notoriously difficult to treat. As the advertisement says, you can count on one finger the drugs that may prevent them. But methysergide maleate has a large number of adverse reactions and many physicians are loath to use it. For the past 15 months I have been trying amitriptyline hydrochloride (Tryptizol) in small doses, with most encouraging results. So far 12 patients with two or more attacks of typical migraine headache a week have been treated. All except one are highly satisfied with the results. The dosage used was three or four 10-mg. tablets a day. On stopping the drug the attacks tended to return to their former frequency. No untoward side-effects were observed.