Phenformin and Stanozolol in Blood Fibrinolytic Activity

Sir,—It has been established that a combination of phenformin (Dibonit) and ethyleohostrol (Orabolan) increases the fibrinolytic activity in the blood. We have used this treatment for patients with cutaneous vasculitis and Behçet's syndrome in whom the fibrinolytic activity was reduced, and found that it not only increased this activity but produced clinically beneficial results.1

We have investigated if the same effects could be obtained by the administration of a combination of phenformin and stanozolol (Striba). Blood fibrinolytic activity was estimated by the euoglobulin lysis time method as described by von Kaulla slightly modified,2 and expressed in units by multiplying the reciprocal of the lysis times in minutes by 10,000.3 Twenty patients divided into two groups of ten each were investigated.

Table I.—Last Estimates on 10 Patients When Treated With Phenformin and Ethyleohostrol Compared With Estimates of Euoglobulin Lysis Time in units at 4 and 24 Week Period When Treated With Phenformin and Stanozolol.

<table>
<thead>
<tr>
<th>Phenformin + Ethyleohostrol</th>
<th>Phenformin + Stanozolol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean s. d.</td>
<td>At End of Week 4</td>
</tr>
<tr>
<td>56 4</td>
<td>93 0</td>
</tr>
<tr>
<td>Mean difference</td>
<td>0</td>
</tr>
<tr>
<td>P</td>
<td>Not significant</td>
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</tbody>
</table>

Table II.—Euoglobulin Lysis Times (in units) before and during treatment with Phenformin and Stanozolol: Comparison between “Before Treatment Estimations” and “Estimations at Different Time Period.”

<table>
<thead>
<tr>
<th>Before Treatment</th>
<th>At End of Week 4</th>
<th>At End of Week 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean s. d.</td>
<td>56 4</td>
<td>56 4</td>
</tr>
<tr>
<td>Mean difference</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>P</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

Group 1.—This group consisted of patients suffering from cutaneous vasculitis and Krugman's disease with decreased fibrinolytic activity who were treated with phenformin (50 mg. twice daily) and ethyleohostrol (2 mg. four times per day). They had been on this treatment for from 12 to 28 weeks with increasing improvement of their blood fibrinolytic activity. It was decided to switch them to phenformin (50 mg. twice daily) and stanozolol (5 mg. daily) and to estimate the blood fibrinolytic activity at four weekly intervals. At the time of writing they have been studied for 24 weeks.

Group 2.—This group included ten patients (seven with decreased and three with normal fibrinolytic activity) who had suffered a myocardial infarction three to four months previous to the study, and in whom the anticoagulant therapy was being tailed off. Before initiating the new treatment their blood fibrinolytic activity was estimated. Subsequently a combination of phenformin (50 mg. twice daily) and stanozolol (5 mg. daily) was administered and the blood fibrinolytic activity estimated at four-weekly intervals. The study of this group has so far been in progress for 28 weeks.

The increased fibrinolytic activity observed in the ten patients on phenformin-ethyleohostrol was maintained when this was replaced by phenformin-stanozolol (Table I). There was no significant difference between the effect of the two drug combinations on the blood fibrinolytic activity (P > 0.9).

The blood fibrinolytic activity was significantly higher after phenformin-stanozolol therapy in Group 2 (P < 0.001), and this increase which could be observed already at the end of four weeks' treatment was still present at the end of 28 weeks (Table II).

This pilot study indicates that the combination of phenformin-ethyleohostrol and phenformin-stanozolol is effective in increasing the blood fibrinolytic activity as that of phenformin-ethyleohostrol. We are, etc.,

I. SUDHAKARAN MENON, W. J. CUNLIFFE, D. WEIGHTMAN, H. A. DEWAR.
Royal Victoria Infirmary and University of Newcastle.

REFERENCES

Australia Antigen and Hepatitis

Sir,—I was, of course, interested in your leader on Australian antigen and hepatitis (31 January, p. 247), a subject with which the literature is being flooded, sometimes in papers from authors who have obviously not studied the subject of aetiology of viral hepatitis, particularly earlier work, in depth. I do not wish to detract from the extremely valuable work of Krugman and his colleagues,1 which, in contrast to earlier work in adult volunteers, showed that virus B could be transmitted by the oral route to children, but I would remind your readers that two epidemiologically and immunologically distinct forms of viral hepatitis were identified more than twenty years previously by workers in the U.S.A.2 3 and England.4 The sera from Krugman's two series of patients

with the agents MS1 and MS2 have, of course, provided a vital clue to the aetiology of virus hepatitis.—I am, etc.,

Virology Laboratory, F. O. MACCALLUM.
Department of Pathology, The Gibson Laboratories.
Radcliffe Infirmary, Oxford.


Bacteriuria in Infants

Sir,—I would like to draw attention to a misinterpretation of my findings (24 January, p. 207) which appeared in the leading article on bacteriuria in infants (p. 185). It was stated that only three infants had significant bacteriuria, and one of these infants was studied. In my paper I stated that three infants were noted to have transient bacteriuria. There were other infants with bacteriuria which did not clear spontaneously. The full results of this study will be published later.—I am, etc.,

Chirchhur Hospital, Christchurch, New Zealand.

G. D. ABBOTT.

Hospital Advisory Service

Sir,—Dr. P. Brinks (10 January, p. 108) corrects the Board of Control in support of his fears that the Advisory Service is intended as a first shackle in a series of fetters on the clinical freedom of consultants. The threat to clinical freedom in the heyday of the Board of Control lay in the fact that medical administrators of mental hospitals actually had legal and administrative control over the clinical actions of their colleagues. This was finally swept away by the Mental Health Act 1958 and the Mental Health Act of 1959. The introduction of the Hospital Advisory Service does nothing to alter the doctors' basic freedoms. It seems that, if the doctors' representatives are so intent on safeguarding those fears, it has hardly taken the most effective steps to realize them.

Shortly after the publication of the report on Ely Hospital,1 the Royal Medico-Psychological Association appointed a special committee of its council to consider the whole problem of inspection of hospitals. The R.M.P.A. has always considered that there is a case for a special consideration for those who suffer from both mental or physical infirmity, and are thereby placed in a long-lasting position of special dependence on those who care for them. The same concept applies in law, where a guardian ad litem may be appointed to safeguard those who cannot fully look after their own interests. Acceptance of this principle in no way implies acceptance of any curtailment of clinical medical freedom. It should also be noted that the special committee of the R.M.P.A. strongly recommended that any service created to safeguard the special interests of the physically and mentally infirm should be independent of the Department of Health and Social Security. It suggested that responsibility might be given either to the Privy Council or to the Lord Chancellor's