CORRESPONDENCE

Oral anticoagulants

Sir—I enjoyed reading Professor A Breckenridge’s authoritative article (21 February, p 419) on the above subject in which he underlines the need for a pharmacological basis in drug therapy. He stresses that a therapeutic trial should be properly designed and notes that in the case of oral anticoagulants used in arterial disease the “better” the trial—that is, the nearer it fulfilled the seven criteria considered necessary—the worse oral anticoagulants fared. It is also interesting that none of the 59 studies of these drugs in arterial disease was considered perfectly designed. All scientists and statisticians and most clinicians will have no quarrel with this, but the implication that therefore oral anticoagulants are useless in arterial disease is, I think, fallacious.

Firstly, the necessity that successful therapy must have a rational basis is in question. Carbamazepine for trigeminal neuralgia, amantadine for Parkinsonism, and electric convulsion therapy for severe depression are a few examples accepted (even if occasionally misused) by most experienced clinicians as useful forms of treatment based on serendipity rather than scientific deduction.

Secondly, the premise that the failure of a drug to show significant advantages in a perfectly designed clinical trial indicates its uselessness is also unacceptable to many experienced and open-minded doctors. Often the drug will have shown some statistically insignificant advantages in the nearly perfect trials but significant advantages in the less perfect, and the question must be asked what is the reason for this difference. I think that the imperfections of some trials (and I include my own in these) stems from an author’s intuitive selection of patients to enter the trial. This is, of course, anathema to the statistician but is the cornerstone in deciding treatment in the individual patient, as indications and contraindications can be worked out not, as the statistician would say, blindly but on the basis of experience and a careful weighing-up of many factors. My own particular interest has been in occlusive cerebrovascular disease, and although I am more selective than formerly I still think oral anticoagulants are useful in some patients, mostly those with transient cerebral ischaemic attacks or with progressing hindbrain ischaemic infarction.

Thirdly, the scientific premise that if a drug is unable to alter the function of the main causative agent of a disease it is therefore ineffective in that disease is also sometimes questionable. Professor Breckenridge rightly points out that platelets play a fundamental role in the genesis of arterial thrombosis and are unaffected in vitro by oral anticoagulants. However, the secondary clot which is the “red rug” is often seen in the carotid artery at operation attached to the platelet aggregation or “white head” of the thrombus and consists of clotted blood in fibrin. Many of us believe that this clot is associated with some manifestations of occlusive cerebrovascular disease, and we know that its appearance can be modified, as in venous thrombosis, by oral anticoagulants. Further evidence of this lies in the disappearance of the carotid murmur in some patients with transient cerebral ischaemic attacks when they are treated with oral anticoagulants.

It is for these reasons that I think it a mistake to suggest that oral anticoagulants are entirely useless in arterial disease, although I have modified my own original enthusiasm considerably, especially as I found that my original success with these drugs in cerebral infarction was not apparently due to any modification of the arterial thrombosis but to the influence on the occurrence of pulmonary embolism associated with venous thrombosis in the legs. This is certainly a point for the scientist, but fortunately the clinician can sometimes be right for the wrong reasons.

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Oral anticoagulants

A B Carter, FRCP

Assessment of preoperative cases

P R Fletcher, BM

Rapid serological diagnosis of outbreaks of hepatitis

N R Grist, FRCPath

Dispersal of biliary calculi by irrigation

G T Watts, FRCS

Preventing animal diseases

J Allcock, MRCVS; Constance A C Ross, FRCPATH, and others

Compensation for congenital defects

Lynda Chalker, MP

Rib pain

J H Cyriax, MD; J F Dark, FRCS; R Lefever, MRCGP; C S B Galasko, FRCS, and J L Boak, FRCS

SI units

D R John, FRCS, and A H James, FRCP; P R Pannall, MB

Chemotherapy for breast cancer

H M Carter, FRCS

Radiology and endoscopy in acute upper gastrointestinal bleeding

W G Scott-Harden, FRCS

Immunisation against whooping cough

G T Stewart, FFPM

Primary gout affecting the sternoclavicular joint

H L F Currey, FRCP

Serum creatine phosphokinase and malignant hyperpyrexia

F R Ellis, FRCS, and others

Phenformin and lactic acidosis

J C W Edwards, MB

Beta-blockers in the treatment of chronic simple glaucoma

C I Phillips

Thrombotic complications in acute polyneuritis

B Jane Leese, MRCP

Guillain-Barré syndrome in acute hepatitis

P L Ng, and others

Toxic effects on nerve conduction velocity

R Lauwersy, MD, and others

Ocular toxicity due to rifampicin

D J Girling, MRCP

United Kingdom in Figures, 1975 edition

M J Ball, MFCM

Laparoscopy explosion hazards with nitrous oxide

G B Drummond, FFARCS, and D B Scott, FFARCS

Endoscopic papillotomy

B H Hand, FRCS

Phenyltoin and serum cholesterol

S Livingston, MD

Uterine hypertonus after induction of labour with prostaglandin E2 tablets

T W Ogg, FRCP, and others

Dyslexia

Florence Pinkerton, MB

Medical manpower

G V D Cox, FRCPEd

Consultants’ ballot

A J Ross, FRCS

Family planning in hospitals

G S Lester, FRCS; R T Booth, FRCS; C T F Ealand, FRCS, and others

Discretionary increments for community physicians

P J Heath, MB

Incentive and reward

P J Hellwell, FFARCS

Points from letters

Medical manpower (F S A Doran); Ball-bearing-bomb injuries (R I Wilson); Febrile fits and diazepam (B Thalayasingam); Frequency of respiratory illness (L J Capel and M Crippin); First aid in acute myocardial infarction (G F Baines); Vaginal candidiasis (S M Jenner); Practolol and colosotomy excision (J R D Brown); Recurrent abdominal pain in children (A Duff); Attempted suicide in labour (G M Woddis); Treatment of rib fractures (H D W Powell); Hospital night staffing (T F Davies); Baby feeding (T H Hughes-Davies)