

## Points

### Effect of knowledge of one result on interpretation of another

Dr WILLIAM L ALDIS (Sylva Medical Centre, Sylva, North Carolina 28779, USA) writes: Dr Thomas Gjørup and others (4 January, p 27) show that clinicians are "influenced" in the interpretation of one test result by the availability of another. I am surprised at their surprise at this result. The inclusion of "prior probability" is one fundamental way that the mature clinician differs from the neophyte in his use of clinical information. For example, if a patient calls to tell me that he has just vomited some red material, maybe pickled beets, I will interpret this differently, and act differently, if I know that he has just left the hospital with the diagnosis of oesophageal varices. While we do not need to dignify this process with the term "Bayesian analysis" (physicians quite innocent of formal contact with decision theory use it every day), it is nevertheless nice to know that for any diagnostic test or piece of clinical information a mathematical relation between prior probability of illness and "predictive value positive" exists and can be described by a formula known as Bayes's theorem. It is true that "in controlled clinical trials preconception is regarded as inappropriate," but equally true that in clinical practice preconception is essential.

### A false phoenix

Drs HAMISH BOYD (Dean) and JOHN HUGHES-GAMES (President, Faculty of Homoeopathy, London WC1N 3HR) write: As homoeopathic doctors we share the concern expressed in your recent leading article (21-28 December, p 1744) at the alarming growth of dubious "fringe" medical practice. In the case of homoeopathy the present worrying situation has arisen out of a severe shortage of doctors trained in homoeopathy compared with the public demand for this form of treatment, combined with a dearth of research in homoeopathy. These two factors have conspired to create an atmosphere in which ill trained, unqualified practitioners can thrive and make wild claims.

In response to the problem the Faculty of Homoeopathy has formed a committee on higher training in homoeopathic medicine, which has recently agreed, and will shortly be publishing, guidelines for the training of specialists in homoeopathy. These guidelines call for specialists to possess an appropriate higher qualification (in addition to the membership of the faculty) and to complete at least four years' training subsequently, of which part should be spent in a suitable orthodox medical hospital training post and part in an approved homoeopathic unit. We believe that these guidelines provide a realistic framework for training specialists in homoeopathy to a high standard. We look to the Joint Committee on Higher Medical Training, the Council for Postgraduate Medical Education, and other interested bodies to lend their support to these proposals.

Dr PETER FISHER (Department of Rheumatology, St Bartholomew's Hospital, London EC1A 7BE) writes: Professor Paul Turner (25 January, p 269) accurately summarises the problems facing would be researchers in homoeopathy. Although considerable we do not think they are insurmountable. We are currently conducting a series of clinical trials of homoeopathy in rheumatology. The first has been completed (Fisher P, *et al.* 40th congress of International Homoeopathic League, Lyons, 1985). A choice of three homoeopathic remedies was permitted; one was prescribed according to the usual criteria for patients with fibrositis in a double blind placebo controlled study. There was some overall improvement in pain and sleep in the active group compared with the placebo group. Further analysis showed that this improvement was statistically significant when there were clear symptomatic indications, regardless of which remedy was prescribed, but there was no more effect than placebo when such prescribing criteria were lacking. This conclusion cannot yet be

regarded as definitive, but, if correct, it would reconcile an apparent contradiction between the results of two previous double blind trials of homoeopathy in rheumatology. One showed a single homoeopathic remedy to have no effect greater than placebo in osteoarthritis,<sup>1</sup> while the other showed that freely selected homoeopathic remedies were significantly more effective than placebo in rheumatoid arthritis.<sup>2</sup> This inconsistency might be resolved on the basis that homoeopathic remedies have a very narrow range of action, so that if only one remedy is prescribable the number of patients responding to it is small and statistically insignificant. If, on the other hand, any of the large number of homoeopathic remedies is permitted the probability of patients in the active group receiving remedies to which they are responsive is much greater.

- 1 Shipley M, Berry H, Broster G, Jenkins M, Clover A, Williams I. Controlled trial of treatment of homoeopathic treatment of osteoarthritis. *Lancet* 1983;i:97-8.
- 2 Gibson RG, Gibson SLM, MacNeill DA, Watson-Buchanan W. Homoeopathic therapy in rheumatoid arthritis: evaluation by double-blind clinical trial. *Br J Clin Pharmacol* 1980;9:453-9.

Dr ALAN STEWART (London W1N 3FF) writes: The most fundamental principle of homoeopathy that "like cures like" is not, as Dr Paul Turner states, "at such variance with contemporary clinical science" (25 January, p 269). Examples exist in the world of pharmacology and nutrition. Aspirin to excess may produce hyperpyrexia,<sup>1</sup> yet all doctors have probably recommended aspirin in the treatment of fever. Furthermore, correction of a vitamin B<sub>6</sub> deficiency can correct an associated neuropathy,<sup>2</sup> yet an excess of vitamin B<sub>6</sub> can itself produce a neuropathy.<sup>3</sup> The homoeopathic principle of "like cures like" is simply a principle of therapeutics, and—like any principle—it has areas of applicability, which have yet to be fully defined. Hopefully, the design of clinical studies will be sensitive enough to assess the principles as well as the practice of homoeopathy and the nature of individual response. A double blind crossover placebo controlled trial of specific homoeopathic remedies in patients who seem to respond to such treatment may be worth considering. Such a design has been used to assess food intolerance in hyperactive children.<sup>4</sup>

- 1 Laurence DR, Bennett PN. *Clinical pharmacology*. 5th ed. London: Churchill Livingstone, 1980:427.
- 2 Sauberlich HE, Canham JE. Vitamin B<sub>6</sub>. In: Goodhart RS, Shiels ME, eds. *Modern nutrition in health and disease*. 6th ed. Philadelphia: Lea and Febiger, 1980:216-28.
- 3 Schaumberg H. Sensory neuropathy from pyridoxine abuse. *N Engl J Med* 1983;309:445-8.
- 4 Egger J, Carter CM, Graham PJ, Dumley D, Soothill JF. Controlled trial of oligoantigenic treatment in the hyperkinetic syndrome. *Lancet* 1985;i:540-5.

### Massive bladder haemorrhage

Dr J DE KRAKER (Emma Kinderziekenhuis, Amsterdam) writes: Bladder haemorrhage as a complication of treatment for cancer in patients given cyclophosphamide has decreased dramatically since mesna (sodium-2-mercaptoethanesulfonate) was introduced many years ago. In fact, it is now exceptional and not in the range of 40% as stated by Mr N Bullock and Mr R H Whitaker (30 November, p 1522) in their references from 1966 and 1967.<sup>1</sup> Prevention in these cases is the best treatment.

- 1 Habs MR, Schmahl D. Prevention of urinary bladder tumors in cyclophosphamide-treated rats by additional medication with the uroprotectors sodium 2-mercaptoethane sulfonate (mesna) and disodium 2,2'-dithio-bis-ethane sulfonate (dimesna). *Cancer* 1983;51:606-9.

### Informing the hospital of patients' drug regimens

Dr G A C HOSIE and Dr J HOSIE (Glasgow G13 2SW) write: We were dismayed to read the paper by Mr C Claoué and Mr A R Ethington (11 January, p 101) recording the inaccuracies of some general practice drug records. We use the well tried system of a surgery master repeat prescription card for all patients

receiving regular medication. This is updated whenever a relevant drug is requested. It is crucial that every drug prescribed is noted in the correct place together with the date and the quantity given. To achieve this we always have the patient's case record and master repeat card to hand, whether the consultation takes place in the surgery, at the patient's home, or over the telephone, and we are therefore aware of all the drugs that have been prescribed for that patient. What the doctor wants the patient to take, however, is not necessarily what the patient is taking. Poor communication in describing the purpose of the treatment, patients' difficulties with drug nomenclature, side effects that have stopped the patient taking the drug, prescription of drugs on home visits or emergency calls that have not been recorded in the notes, and drugs "borrowed" from friends or relatives can all contribute to inaccuracies in general practitioners' forms and should be taken into account.

### Doctor's unawareness of the drugs their patients are taking

Dr PETER C ARNOLD and others (Independent Associates Pty Ltd, New South Wales, 2029 Australia) write: Dr D Price and others and Drs C Claoué and A R Elkington (11 January, p 99 and 101) have drawn attention to the problems of GPs knowing what drugs their patients are taking and of hospital doctors obtaining this information. Some years ago we prepared a simple drug chart that we give to elderly patients and those taking several drugs. We ask them to bring the chart to each consultation and to keep it with the drugs or in some other place where it can readily be consulted. The chart (190 × 142 cm) is large, allowing for large printing of names, and is on heavy "no carbon required" paper so that we have a copy for our records.

### Awards for research into crippling diseases

Colonel ANDREW BREARLEY-SMITH (National Fund for Research into Crippling Diseases) writes: Mr John Walford (25 January, p 274) was, of course, absolutely correct. The grant we made to Professor John Scales and his colleagues at the Institute of Orthopaedics was, as we explained in our press release, "the biggest single research award ever made" by us. We are sorry that the gremlins which bedevil all editors should have made us seem to be trying to start a charity league table or obtain an entry in the *Guinness Book of Records*. As chairman of the Association of Medical Research Charities, I would like to draw attention to the growing contribution to medical research from the charitable sector (some £90m in 1984-5), the subject of a special booklet to be launched on 25 February 1986.

### Does hospital noise disturb patients?

Dr IAN M DALE (Occupational Health Service Central Unit, Glasgow G1 1JA) writes: In the article by R L Soutar and Dr J A Wilson (1 February, p 305) the authors stated that "because of the logarithmic scale noise levels of 67 dB(A) are roughly equivalent to a noise 10 times the recommended level of 35 dB(A)." In fact, for each increase of 3 dB the noise level roughly doubles; thus a noise level of 67 dB is almost 1600 times louder than one of 35 dB.

### Correction

#### Incidence and duration of neck pain among patients injured in car accidents

The following acknowledgments were omitted from this short report by Dr G T Deans and others (11 January, p 94): "The proportion of people in the community with neck pain was discovered only with the help of Drs Alun Evans and Malcolm Kerr of the Belfast Monica Project. Dr Chris Patterson and others in the medical computing and statistics department of the Queen's University provided help in analysis, and we are also indebted to our typist, Mrs Marie Loughran."