Correspondence

Correspondents are asked to be brief.

Ethics of Research and the Developing

Professor R. Ringelhann .......................... 643

Thrombosis and Carcinoma of the Prostate

E. A. P. Sutherland-Rawlings, M.R.C.S. ....... 643

Profile Analysis

A. L. Latter, F.R.C.P. ............................. 644

E.S.R. Surveys

W. W. Kay, M.B. ................................. 644

Thromboembolic Disease and the Pill

L. F. Nanni, M.D. ................................. 644

Uterus in Menopause

A. Mitra, F.R.C.S.Ed., and K. Das, M.D. .... 645

Vagotomy and Peptic Ulcer

C. V. Ruckley, F.R.C.S.Ed. ....................... 645

Continuous Ventilation and Oedema

H. S. K. Spence, F.R.C.P. ....................... 645

Pulmonary Tuberculosis Follow-up

C. J. Stewart, M.D. .............................. 645

Driving and Epilepsy

R. T. Paton, M.R.C.S. ........................... 646

Diabetes and the Driving Licence

P. J. O'Connell, M.D. ......................... 646

Paroxysmal Toxity

K. Fletcher, Ph.D., and A. A. B. Swan, F.R.C.P.S.; J. McEvoy, M.D. 646

Undiagnosed Abdominal Pain

M. Goldman, D.M.R.D. ......................... 647

Breast-milk Jaundice

T. Hargreaves, M.D. ............................. 647

Unified Filling System

V. Biske, B.Sc. ................................. 647

Acute Epiglottitis

H. P. Gauthum, F.R.C.S. ....................... 647

Cataracts

R. P. Farn, M.D. ................................. 648

Other Side of Table Mountain

Joyce E. Leeson, M.B. .......................... 648

Race and Commonwealth

B. Beach, M.B. ................................. 648

Psychotherapy of the Dying Patient

D. Yellowlee, M.B. .............................. 648

Handicapped Children

Olga E. Nietupski, M.D., D.I.P.L. ............... 649

The Specialty of Haematology

Mary D. Smith, F.R.C.P.GLASG., M.R.C.PATH. 649

Home or Hospital?

D. A. Johnstone, B.Ch. .......................... 649

Influenza Vaccination

J. B. D. Evans, M.R.C.S. ....................... 649

Staffing the Regional Hospitals

J. J. Shipman, F.R.C.S. ......................... 649

Private Beds

A. F. Rushforth, F.R.C.S. ....................... 649

Review Body Report Timing

J. A. Bigg, M.B. ................................. 649

Pain W. and W. E. Snell, F.R.C.P. .............. 649

Ethics of Research and the Developing Countries

Sir,—My colleagues sometimes receive letters from overseas research workers who want to embark on a project and seek help to perform analytical procedures on large numbers of blood samples taken from various groups of the local population. The would be authors offer co-authorship in the forthcoming paper (whatever the result should be) in reciprocation for collecting and sending on the samples. I am doubtful about the fairness and ethics of this practice and my doubts might be summarized as follows.

How can somebody be a true co-author if he has not taken part in the conception of the idea and the planning of the project? Collecting blood samples and posting them are not contributions to research at academic level, these are services which could be done by technicians and messengers.

Is it fair toward the individual donor, citizen, and taxpayer of a developing country to send his blood on request to another country with well-equipped laboratories and highly ambitious research workers? One must ask the question: 'Cui prodest?' Who benefits from it? Well, the answer is that because medical research is everybody's property, the whole world benefits from it. Perhaps this is theoretically so; practically the benefits are very unequently distributed and much less reaches the population from where the sample was taken.

Observation of patients and laboratory work executed under difficult circumstances locally has produced important new facts. One can see from the medical history of Ghana the first description of kwashiorkor in 1933 (the name of the disease was taken from one of the Ghanaian languages) and the discovery of Northern Ghana as the birth place of Hb C, first described in the United States. The influence of these and similar discoveries upon the medical and non-medical public of the country is profound.

I have never heard of the reverse exercise, namely of taking blood samples from overseas and sending them to a developing country to compare them with local material. Such a venture would be ridiculed and no community would be available to donate blood for such purposes. To train doctors, biochemists, microbiologists, and physicists for doing research is a very costly business and the developing countries pay a still higher price for it than their counterparts, despite the considerable help from foreign governments and international organizations in the form of scholarships. It is needless to say that in respect of volume and standard of medical research the gap between the two halves of the world is enormous, and joint effort is needed to narrow this gap. Generally speaking in the foreseeable future there seems little chance that basic research can be carried out in developing countries. However, there is a vast field open for applied research. In this context it is undoubtedly justifiable to insist that such projects which are based on investigations on local material should be carried out in the same country thus giving the local staff the opportunity to learn how to plan, organize, perform, and evaluate a project and for the local population to benefit from the results.

We are quite aware of the fact that all research procedures cannot be carried out locally because refined techniques need special facilities overseas. This makes it unavoidable that some samples have to be sent to those places. Nevertheless, this should be done after having done the bulk of the work with full co-operation of the local staff, locally. The developing countries invite research workers who are interested in tropical diseases, genetic problems, enzymatic abnormalities, etc., not to hesitate to use part of their grant to come to work there with the local staff in true partnership. I am sure they will have as much benefit from this venture as their counterparts, because they will know much more about the conditions where the material comes from.

In past centuries large numbers of the population of these countries were shipped off to work as slaves; during the colonial era raw materials were taken away to be processed in developing countries and agricultural products exported irrespective of the need of the local population. The growing conscience of the world, harsh political realities, and the awakened demand for freedom of the peoples of these countries abolished or scaled down considerably this one-way traffic. I think the time has come when the unidirectional flow of research material should also be eliminated.—I am, etc.,

BELA RINGELHANN.

Department of Chemical Pathology,

Ghana Medical School,

Kojo Bu Teaching Hospital,

Accra, Ghana.

Thrombosis and Carcinoma of the Prostate

Sir,—An increasing incidence of venous thrombosis having occurred in proven cases of prostatic carcinoma receiving large and continuous dosage of stilboestrol after their discharge from hospital has decided me to use an anticoagulant in conjunction with the hormone as a prophylactic agent against a possible thrombosis. Originally I thought this incidence might be attributed to old age or some obscure blood dyscrasia, and so I referred all such cases to Sir...
Ronald Bodley Scott for an expert hematologist. He reported to me confirmed the frequent incidence of thrombosis occurring in those cases of prostatic carcinoma undergoing hormonal therapy.

Later I became alerted by the thrombocytopenic tendency in the female towards the higher oestrogen content in the contraceptive pill. Now having lost a patient, aged 60 years, not due to his low-grade prostatic malignancy, but to extensive arterial thrombosis following months of intensive hormonal therapy, I have decided to continue future treatment under anticoagulant treatment subjected to adequate control.

Relatively speaking, prostatic carcinoma is a slow progressive disease affecting usually the aged. The mortality rate is slow compared with cardiovascular disease, to which most succumb in the end. So rather than precipitate the end why not incorporate a therapeutic measure to combat both?—I am, etc.,

E. SUTHERLAND-RAWLINGS.

London W.2.

REFERENCE

1 British Medical Journal, 1968, 2, 132.

Profile Analysis

SIR,—In spite of the fact that Professor T. P. Whitehead is an old friend for whose opinion I usually have the greatest respect, I feel it incumbent upon me to contradict a statement attributed to him in your leading article (22 August, p. 417).

"Thrombosis is not a disease, it is a service to medicine," is all very well from the point of view of Professor Whitehead, who is not medically qualified. It is, however, my considered opinion that the subject in the hands of the medically qualified practitioner is undoubtedly an important branch of medicine, in the same sense as any other branch of clinical pathology. To say it is not medicine would mean that there would no longer attract medical graduates, and this would be a catastrophe of the highest order.

You point out in your leading article that Professor Whitehead and his colleagues in Birmingham have suggested that profile analysis carried out on patients in general practice led to new diagnoses in 16 9% of patients. To quote from their article (7 March, p. 620) "iron deficiency anaemia from a serum iron and haemoglobin level alone is perhaps a little unwise, and I am surprised that in apparently only one of these cases was an obvious cause for the anaemia found, but in any case the diagnosis was not confirmed by the Committee on Safety of Drugs. As estimated by the authors this sample constituted less than 10% of the total number of cases that occurred during the time period described. A 10% sample would be more representative if it were either a random or representative of the whole. The sample given, most of the profile tests were hardly necessary.

I fully approve of the Birmingham work from a research point of view, and if the general practice which is reported is representative of general practice as a whole then one can only conclude that the large battery of biochemical investigations was not necessary. In fairness to the Birmingham workers they do point out that "The choice of tests should remain flexible in the light of further experience. . . ."

A final thought occurs to me. In what percentage of patients not showing abnormal chemical profiles would an altered diagnosis have been made if all of these had been referred to hospital?—I am, etc.,

A. L. LATNER.

Department of Clinical Biochemistry,
University of Newcastle upon Tyne.

E.S.R. Surveys

SIR,—Dr. H. Dale Beckett (15 August, p. 408) asks can E.S.R. surveys replace mass miniature radiography surveys when the latter are discontinued? The answer from experience is a qualified "yes."

In about 1940 E.S.R. surveys were used successfully at West Park Hospital, Epson, to identify patients likely to be suffering from tuberculosis. Shortly after being appointed to the Mental Hospitals Group Laboratory, I made E.S.R. surveys available to hospitals in the I.C.C. Mental Health service, Cane Hill Hospital being one of them. These surveys continued till mass miniature radiography became available to the hospitals.

E.S.R. surveys are relatively inexpensive, and with adequate skill, equipment, and organization can be carried out quickly. An average of 100 venepunctures an hour can be easily attained (our best was 120 in 54 minutes).

The disadvantage is the disadvantage of the E.S.R.—lack of specificity. About 20% of abnormal results—or even more—can be expected in patients with high rates need clinical physical examination and careful selection for full x-ray examination. Nevertheless, E.S.R. surveys can be made to work and be clinically valuable.—I am, etc.,

Greenfield, Bed ford.

W. W. KAY.

Thromboembolic Disease and the Pill

SIR,—In a recent paper by Dr. W. H. W. Inman and his colleagues (25 April, p. 203) an analysis is shown of 1,305 reports of thromboembolism occurring during the time period 1 January 1965 and 30 June 1969 in women using oral contraceptives. The conclusion made was "the data . . . . leave no doubt that there is a positive correlation between the risk of thromboembolism and the dose of oestrogen in oral contraceptives."

It is the purpose of this letter to point out reasons why this relationship cannot be proved by the data and methods used by the authors.

The study group was made up of cases of thromboembolism obtained from voluntary reports to the Committee on Safety of Drugs. As estimated by the authors this sample constituted less than 10% of the total number of cases that occurred during the time period. A 10% sample would be more representative if it were either a random or representative of the whole. This sample is obviously not random and questionably representative. Voluntary reports are known to be subjected to biases of all sorts. In fact, the sample appears to be biased in the direction of new drugs, since the Committee instruct the doctors to report all the reactions to new products and only the serious reactions which the doctor is asked to submit. The group makes no estimate of the equal risks for all the products. This departs from the acceptable procedure used in retrospective studies where, in addition to using patient control data, attempts are made to match them to the study group by characteristics such as predisposing conditions, age, parity, etc.

Additional uncertainties and biases arise from the use of market research estimate of sales as substitute for control data: patient change from product to product, time lag between sales and occurrence of a disease, etc.

The significance of the relation between thromboembolism and oestrogen dose levels was proved using a x² test with one degree of freedom. This test is in the text. It is really a test of the x² test in the text. It is fair to point out that if this dose level is eliminated no significant trend exists. For instance, when all the groups are combined, the ratio of observed/expected for the dose levels of 50µg, 75/80µg, and 100µg are equal to 1-07, 0-78, 0-98, respectively, which are not significantly different. These values were obtained after adjustments were made in order to have the total and expected frequencies equal to each other.

The authors also show that no significant differences exist between mestranol 100µg and ethinyl oestradiol 100µg. These are a different between mestranol 50µg and ethinyl estradiol 50µg (x²=2-5). It is interesting to note that following the same procedure it can be shown that mestranol 100µg does not differ from ethinyl oestradiol 100µg (x²=0-33) and that mestranol 75/80µg does not differ from ethinyl oestradiol 50µg (x²=0-89). These latter results appear to be related estimates available of the relative potencies of the two oestrogens.

The discrepancies shown above are a direct result of the lack of patient control data. To prove the possible existence of a relationship between thromboembolism and oestrogen dose levels the study must be based on a large, unbiased sample of thromboembolic cases and on carefully matched patient control data.—I am, etc.,

LUIS F. NANNI.

Rutgers University,
New Brunswick, New Jersey, U.S.A.

REFERENCES


