HealthWatch

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Prince Charles calls for integration

... but what precisely does he mean, and do we really need it? Thurstan Brewin, past Chairman of Health Watch searched through the gobbledygook for some substance, but was sorely disappointed with the result.

> **There are few things more satisfying", writes the Prince of Wales, "than to see an idea that one truly believes in take hold."**

So what is this idea? It is the "Integration of complementary and orthodox medical practices." And where does he say this? In a glossy eight-page booklet entitled A New Vision For Health Care that accompanies a 70-page document, both published by his brain child, "The Foundation for Integrated Medicine."[1]

It is billed as a discussion document, so let's discuss it. And let's be a little more blunt than is usual these days when, for fear of giving offence, so many are afraid to say publicly (sometimes even privately) what they really think.

Everything is sincere and well meant, but there is more hope than substance. "With mutual respect and understanding, preventative health care would become the norm". Would it? Empty rhetoric of this kind solves no problems. Everyone agrees that prevention is better than cure, but it's no good just theorising about it, there has to be some evidence that prevention is being achieved. Treatment must "centre on the individual", but since all good doctors and nurses already aim to do this, and always have done, why propose it as if it is a new idea? And if Prince Charles wants doctors to be allowed to refer patients for unconventional remedies-or to give such remedies themselves-he is pushing at an open door. They are already free to do either of these things. Moreover, since mainstream medicine is entirely pragmatic and not tied to any special belief or system, there is no problem about actually incorporating into it any really effective remedy, which then becomes mainstream.

Most of the report, it must be said, is longwinded and repetitive. Prince Charles is a wise and witty supporter of the Plain English campaign. Assuming that he approved the text, this admirable side of his character seems to have deserted him. A final three pages entitled "Analysis of factors identified as promoting integrated health care" lists no fewer than 49 separate points, almost every single one being no more than a bland statement of the obvious-often couched in limp or ugly jargon. One of the 49 declared goals, for example is, "the alleviation of relapsing dysfunction". In other words, both style and content are very similar to the 1994 Labour Party policy document on Complementary Medicine that was roundly criticised in HealthWatch Newsletter no 14 at the time and that soon sank without trace, being evidently not at all to the taste of Tony Blair, who wanted New Labour to represent practical common sense and realism.

Taking a cue from the BMA's second report on Complementary Medicine (which ran away from some valid criticisms voiced in its first report a few years earlier) there are repeated calls for more training for each separate complementary "discipline" and "profession". Apparently almost any new theory or remedy that anyone likes to dream up, however fanciful, is to be dignified with such terms.

There are also repeated calls for more research, but whereas the anonymous writers of some parts of this document clearly have a good grasp of what they mean by this (including at one point a very fair explanation of the need to compare results in a reliable way by means of randomised controlled trials, or RCT) others seems to be floundering a little. "It is by no means the case that RCT will always be the appropriate choice-it depends on the kind of question being asked-and *on who wants to know the answer and why"* (our emphasis). What is this supposed to mean? It sounds muddled and more than a little paranoid. But the Foundation is funding research and, as a start, £160,000 has been spent on trials "that meet the highest scientific standards", though we are not told if this includes a reliable comparison of outcome after different interventions.

The first case history in the eight-page booklet must surely be particularly embarrassing to most, if not all, of the medically qualified members of the various committees recruited for the main project. It typifies the worst kind of pseudo-science-the use of the language of science to describe bogus concepts for which there is no good evidence.

> A one year old baby girl continues to be unwell following an infection. A complementary healer (presumably) diagnoses her as suffering from "congestion of her immune system". Cranial osteopathy (the healer's hands placed on the child's head) then enables her "to recover fully by helping the drainage within the body to flow naturally, in this way enhancing her immune system."

"Never mind *how* it worked, it worked" is a popular reaction to criticism of this sort of gobbledygook. But since ultimate recovery is frequently seen, even without any treatment of any kind, the evidence for benefit is as feeble as the evidence for causation.

Complementary medicine can often supply relaxation, diversion, relief and extra attention (often, as frequently happens in mainstream medicine, too, while the condition is improving spontaneously) but probably a lot more than this-though reliable outcome comparisons are always welcome. And let's not forget that mainstream medicine, with all its triumphs, faults and failures, has always taught that reassuring, comforting and encouraging is an essential part of the job-and that a huge amount of time is spent on this.

So what would be the outcome of integration? Perhaps mainly an increase in the status of unregistered practitioners. Is this really such a good idea? Is it really what society wants?

Prince Charles has many fine qualities and his views on this particular subject are clearly heartfelt and sincere. But many of us in HealthWatch are equally caring and equally sincere-and have probably seen or experienced even more physical and psychological tragedy and suffering than he has. To us, his idea of the "Way forward for the next five years" is more likely to be a way backwards. Ultimately it is those that he most wants to help who would suffer most from a climate of conviction and superstition rather than evidence and reason-and from the lack of progress associated all through history with these mostly soft, anti-rational, mystical, ancient or hopelessly speculative theories and remedies. Unless human nature changes, there will always be a place for them in every society-and enthusiasm for them will rise and fall, as it has always done. But even just in the UK there are at the moment a very large number of them, each with its own beliefs and theories, each with a similar number of patients who believe they have benefited. To boost their present standing by fully integrating them into mainstream medicine would confuse the public, damage priorities and be a retrograde step.

Thurstan Brewin

Reference: Integrated Health Care. A way forward for the next five years." Available from "The Foundation for Integrated Medicine", Suite 201, 16 Baldwin Place, London ECIN 7l",l. Price £10.

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ISFE grant

We are very pleased to announce that HealthWatch has received a grant of 12,750 Swiss francs (approximately £5,000) for the years 1999 and 2000 from a Swiss-based charity which seeks to support Nutrition Research and Nutrition Education.

The Foundation Board of ISFE (Internationale Stiftung fur Ernahrungsforschung und Ernahrungsaufklarung) considered that our Newsletter made a significant contribution to nutrition education in the UK, although they did not always agree with what was published there.

This grant covers the projected deficit in HealthWatch's finances over the next two years, and gives us time to try to increase membership of HealthWatch so that the members' subscriptions cover the cost of producing the Newsletter by 2001.

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Use of therapeutic touch "unjustified"

Therapeutic touch, taught in more than 100 colleges and universities in 75 countries, is based on the idea that people have an 'energy field' that is detectable and modifiable by therapeutic touch practitioners. But in a recent study a group from the California-based organisation, The National Council Against Health Fraud (NCAHF) found that experienced practitioners were unable to detect the "field" under test conditions.

In the NCAHF study, practitioners rested their hands on a flat surface to see if they could perceive the "energy field" of a schoolgirl who hovered her hand over one of the practitioner's hands. The child's hands were screened so the practitioner could not see them. The experiment was designed so that, if perception of energy fields through therapeutic touch was possible, the experimental subjects should have been able to detect the experimenter's hand in 100% of trials. Chance alone, however, would produce an average score of 50%.

Experienced therapeutic touch practitioners stated the correct location in between 40 and 50% of the tries-fewer even than by chance alone.

JAMA 1998; 279: 1005-1010.

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Editorial: Is this a licence to distort the truth?

A HealthWatch member, who is well known as an expert in his field, recently gave an interview to a team making a TV programme. He was alarmed to receive from the TV company, shortly afterwards, a request for him to sign a bizarre "release form" which, to all appearances, seemed to give his express permission to use - and distort - his views as they wished.

Does this explain, he wondered, why such silly views are sometimes attributed to people who had always seemed quite sensible?

Here is an extract from the form, described in the accompanying letter as a "beaurocratic formality".

> "In consideration for the mutual promises herein contained and for good and valuable consideration, the receipt of which is hereby acknowledged, I hereby irrevocably grant to [the television company] and its employees, agents, licensees, successors, assigns, and those acting with [the television company's] permission or upon its authority (collectively, the "licensed parties", the absolute exclusive and unrestricted right and permission to record, copy, reproduce, adapt, edit, summarize, copyright, publish, exhibit, distribute, perform and otherwise exploit by any and all uses and media, now known or hereafter devise, throughout the universe and forever (collectively, "use") my appearance, name, likeness and voice in any manner, format or context whatsoever (collectively, the "materials"). This grant of rights is made without limitation upon time, circumstances, location, market or medium of use, and includes without limitation all uses of the materials in and related to the television programme (not yet named), and in all types of advertising and promotion of that program or any other factual or fictional film or program and of the services of the licensed parties or any of them."

Could it be they plan to use our member's likeness on promotional tea-towels? The form went on...

> "I hereby waive any right to inspect or approve the materials or the use to which such materials may be applied."

The signatory of the form would also have agreed to release the TV company from any liabilities resulting from legal claims relating to use of the "materials".

Scary stuff, eh?

What worried our member; and what concerns HealthWatch, is that by signing such a form he would sign away any right to ensuring the accuracy of the resulting programme. Even without meaning to distort the truth, members of the media can-like the rest of us-misunderstand and misinterpret material (especially if they are working with scientific and technical issues that their experience may not qualify them to fully understand). And, once an inaccurate item has been broadcast, there is virtually no means of effective redress. It has already been seen and believed by millions.

Our member commented, "I would like to think that the reason they asked me to take part in their programme was that they thought I was a responsible academic who meant what he said, and I treasure that opinion among colleagues whom I respect. I cannot imagine what 'good and valuable consideration' I would exchange for it."

And, no, he didn't sign.

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EMEA: erratum

AN ARTICLE in issue 29 of the *HealthWatch newsletter* (April 1998), contains an error

The article, entitled "The EMEA celebrates its third birthday", by Michael Allen, gives the E.M.E.A. budget as 2821 million ECU. This incorrect figure was the result of a scanning error The author has pointed out that the correct figure is 28 and a half million.

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Clinical trials: They would say that, wouldn't they?

It's unfair to be cynical about the results of trials produced by industry to support their products' claims, argues Health Watch Committee Member Michael Allen. Many reports held on file at pharmaceutical companies are subjected to review processes which are at least as searching as those applied by peer review.

The current passion for evidence-based medicine is much to be applauded, but throws up the occasional inconsistency.

For example, the November 1997 number of the *MeReC Bulletin* [1] concludes from a review of the value of topical nonsteroidal anti-inflammatory drugs (NSAIDs) that the quality of evidence is poor, there is a marked placebo response and that the therapeutic role of topical NSAIDs is unclear. In contrast, a review from the Pain Unit of the Oxford Radcliffe Hospital published a few weeks later [2] concludes, "Topical NSAIDs are effective in relieving pain in acute and chronic conditions."

The reviews each list 24 references, but reading the methods section of the second article soon identifies that the difference is not just the way the same data are interpreted, but that very different data sets were reviewed. The *MeReC* article does not state how articles were selected, but it can be assumed the writers followed academic practice and only cited articles published in peer-reviewed journals with Medline as their main searching index. This way, they include only nine small randomised comparisons with placebo in their review.

The Pain Unit authors, on the other hand, based their conclusions on a systematic review of 86 trials involving more than 10,000 patients, some against placebo, some against other active modalities. They accessed this additional information firstly by the use of many indexing systems, but also by writing to interested parties, including pharmaceutical companies, and getting from them reports of additional clinical trials. They included in their analysis all studies that met their severe and objective quality criteria regardless of where or if they were published.

Perhaps many doctors, on seeing a reference to "data on file at the company", ho-hum the Mandy Rice Davis response* regarding reliabihty of the data. But I would make the arguments that:

Pharmaceutical companies have great difficulty having their good research papers accepted by the most reputable peer-reviewed journals, so they tend not to be identified by routine literature searches;

Many reports on file at pharmaceutical companies are subjected to review processes which are at least as searching as those applied by peer review and should be accepted and evaluated critically by those seeking reliable evidence.

The first is easily understandable. In general, pharmaceutical companies tend to perform straightforward efficacy and safety studies to obtain information that will get them to market with their product. Good journals want to publish interesting articles and certainly would not regard a first-class clinical trial against placebo of the umpteenth ibuprofen gel as such. The alternative for the company to publish in the sort of peer-reviewed journal that charges by the page and manages to complete peer review in the time it takes the cheque to clear, is an unattractive bending of the rules. Publication bias is usually considered to work against the publication of negative or ambiguous results. So it does, but the bias against work seen as boring is just as real.

Information which Regulatory Authorities will accept in order to draw conclusions on a medicine need to meet strict criteria. In addition to the usual "state of the art" requirements for trial design, statistical reliability etc. that would form part of a systematic peer review before a paper can be accepted for publication, there are conditions imposed by guidelines which now apply world-wide. The Americans usually refer to data upon which the authorities can base a reliable decision as pivotal data and this shorthand descriptor will be used in this article.

Pivotal data must meet scientific criteria, but also must have been generated by systems conforming with the ICH guideline on Good Clinical Practice (GCP). what does this mean?

The organisation responsible for setting international regulatory standards is the International Conference on Harmonisation of Technical Requirements for the Registration of Pharmaceuticals for Human Use (usually abbreviated to ICH). This is made up of the Regulatory Authorities of the three large blocks (the EU, Japan and the US) with representatives of the regulated industry. Guidelines issued to date include those giving guidance on the format and content of the clinical report and statistical criteria to be applied; the GCP guideline has bearing upon the accuracy and honesty of the studies (an important concern also to someone undertaking peer review of a submitted article).

Readers who have come across GCP trial systems will have noted that, for the physician, they formalise patient protection measures adopted by the World Medical Association in the Helsinki Declaration. For the sponsor; usually a pharmaceutical company, many of the responsibilities are targeted at avoidance and detection of inaccuracy and fraud. During the run of the trial the company will perform regular monitoring visits at which the case record forms will be checked back to the patients' records. It will also arrange an audit, to confirm the competence of the trial centre's systems. A further audit is made by the Regulatory Authority in the US and this will eventually be the case also in Europe and Japan.

"Guidelines" and "guidance" suggest the option not to follow the recommendations exists, but this guidance is voluntary only for a company that wishes to go out of business; data derived from studies not performed

according to ICH GCP guidelines will not be accepted as pivotal, so will not get medicines registered, nor new indications agreed.

Checked and verified clinical data are then put through an independent assessment process. Each country has its own approval system and there are pan-EU systems (described in Newsletter 29). The UK system involves an evaluation within the Medicines Control Agency which forms the basis of a decision by the expert Committee on Safety of Medicines and is generally regarded as one of the best in the world. Such a review could never be regarded as inferior to a journal's peer-review process.

Thus "data on file" at the pharmaceutical company includes these carefully verified and fully assessed data, as well as post-marketing studies, some of which may not be fully validated and reviewed. It is hard to see therefore why publications in peer-reviewed journals should be *automatically* considered to be more valid than pivotal studies at the company; the same judgement criteria should be applied to both.

The more important point to make is that when people use the expression *evidence-based medicine,* they should explain clearly how good the evidence they use is. As mentioned above, the methods section of the article from the Oxford group detailed their search strategy; they also provide full details of the way they assess the quality of the evidence provided by each individual paper. This provides the essential information that reviewers and other experts require to accept or dispute their conclusions. The *MeReC Bulletin* has certainly carefully researched the comparative costs of the products, but the evidence for efficacy they collected is much less than is available, so a distorted view may have been obtained.

I referred to evidence-based medicine as a passion in the introduction, because it seems to me the science sometimes seems secondary to conviction. Also, evidence-based medicine seems often to be used to justify the use of the cheapest treatment. As a taxpayer, I am not against economy but, in the 1066-style accountancy practices that prevail throughout the country and certainly in the NHS, savings out of one budget are not balanced by potential savings from another Just to know the price of a treatment and its immediate effect should not be the only interest.

No HealthWatch Newsletter article would be complete without a report of an uncontrolled study in one patient, to give critics something to laugh at. I am suffering the consistent and severe paid that follows varicella zoster (shingles) and I *know* ibuprofen gel works because I get relief within 5 minutes of application and the pain comes back again about 5 hours later Relief of this quality cannot be obtained with a systemic dose of 2.4 g ibuprofen daily. I have argued here that the weakness of the evidence for topical NSAIDs commented upon by the *MeReC Bulletin* relates to publication bias predicated upon the boring nature of the studies concerned. Of course, I am aware that another problem is that the pain models used, often associated with rapidly self-limiting conditions, are not as reliable as those associated with a more consistent pain. But much of the market for topical NSAIDs lies with the self-limiting conditions and the market determines where the trial efforts of pharmaceutical companies are concentrated.

Michael E Allen

*If any Newsletter reader is too young to remember the Keeler affair; it was Mandy Rice-Davis, on being told that the men she claimed she had associated with denied this, succinctly stigmatised those who tell little self-interested terminological inexactitudes when she replied, "They would say that, wouldn't they?".

References

1. *MeReC Bulletin* 1997 8: 8.
2. Moore RA et al. *British Medical Journal* 1998; 316 (7128): 333-8.

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Minimally invasive therapies for benign prostate disease

Supposedly simple and effective treatments for prostatic enlargement are being advertised in newspapers by private clinics. But how simple are they, and are they effective? Could people be paying good money when they might be better having no treatment at all? Two experts from the Bristol Urological Institute give their opinions on currently available treatments.

Men from their mid-forties onwards are prone to benign prostatic enlargement, in which there is an increase in the substance of the prostate. At the microscopic level this is called 'benign prostatic hyperplasia' (BPH) and, if marked enough, the prostate, which is located at the outlet of the bladder, obstructs the flow of urine when passing water.

The resulting "benign prostatic obstruction" causes a range of symptoms that include increased frequency of urination, urgency in the need to urinate, hesitancy to start the stream, and a decreased flow, to name but a few. It is these symptoms that bring the patient to his doctor.

In the last 10 years there has been a revolution in the treatment of benign prostatic obstruction. Studies of the

natural history of the disorder, that is, how it develops over time, suggest that symptomsdo not necessarily get worse to the point of inevitable need for intervention. This allows a "watchful waiting" policy for those who are minimally symptomatic or unbothered by their symptoms. Drugs now offer an alternative to surgery for some men, with numerous randomised control trials showing that drugs can reduce symptoms and improve flow. However, not all men are suitable for non-surgical therapy. First, a significant proportion do not respond. Second, the drugs have side-effects that some men find intolerable and finally some complications of obstruction, such as a complete or partial inability to pass urine ("urinary retention"), are an indication for surgical intervention from the outset.

The principal surgical treatment has until recently been transurethral resection of the prostate (TURP), an operation performed under general or spinal anaesthesia and requiring on average three to five days in hospital. This operation is well established and is one of the most common procedures performed in the NHS today. It is considered the 'gold standard' treatment against which all other therapies should be compared. However, there has been a recent upsurge in "minimally invasive" therapies, driven largely by the desire of medical equipment manufacturers to produce an alternative to TURP. The principle of treatment is the same as in TURP, ie, to remove excess prostatic substance to relieve the obstruction, but in a way that limits or removes the need to stay in hospital and reduces the complications of TURP.

The number of different types of minimally invasive treatments has increased over the last decade. The energy sources include microwaves, radiofrequency waves, and high-intensity focused ultrasound; lasers are used to vaporise or coagulate; and there are electrosurgical techniques. Each type of treatment has its own particular advantages and disadvantages. A convenient classification is by the therapeutic temperature generated. Transurethral microwave therapy can be either low energy (45-600C) or high energy (60-800C). Transurethral needle ablation delivers low-level radiofrequency energy (80-2000C) via needles inserted into the urethra. Transrectal high-intensity focused ultrasound (1000C) thermocoagulates by generating high temperatures within the beam focus. Transurethral electrovaporization (200-4000C), which has become increasing popular in recent years, combines two electrosurgical effects (tissue vaporization and dessication), thus removing prostate substance but with little bleeding. Finally; several laser devices are showing promising results, including interstitial laser coagulation, visual laser ablation, and holmium laser resection. These different devices use different laser energies.

A comparison and final judgment of these minimally invasive treatments is challenging. All sorts of variables must be measured and judged against one another, variables such as effectiveness, side-effects, whether the response lasts, cost, anatomical considerations, and the need or not for anaesthesia. There is a large amount of data that now allows some conclusions about comparison with TURP. Although the subjective response after TURP and minimally invasive procedures is much the same, objective improvements in flow and bladder function are always greater after TURP. The need for a second intervention is considerably more likely after minimally invasive therapies than after TURP and use of these newer treatments is limited by anatomical considerations such as an excessively large prostate. Minimally invasive procedures shift the complications from the period of the operation, which is when complications occur with TURP to the period after the operation. Prolonged urinary retention, discomfort on passing urine, and excessive passing of urine at night are particularly common, often for several weeks.

The revolution in prostate therapies in the last ten years has produced some innovative and promising techniques, but none as yet has been shown to be better than the well-established standard surgical treatment of transurethral resection of the prostate (TURP). However, when facmg the possibility of prostate surgery, the important question you should be asking is not which type of therapy should I have, but which technique is my surgeon comfortable with and how many procedures has he or she per-formed. Success rates from all operations are very much operator-dependent. If having trouble with your prostate, the best place to start is your general practitioner, and referral to a urologist, rather than the phone number of a clinic advertised in a newspaper.

Alun W Thomas (Research Registrar), Paul Abrams (Consultant Urologist),Bristol Urological Institute

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Another cure for cancer?

Neville Goodman reports on the media's handling of two of the most recent 'cancer cure" stories and wonders whether our fear of the dread disease is distracting us from helping those already suffering.

The two big cancer stories in April and May got the newspapers' usual Jekyll and Hyde treatment of medical matters. News editors have entirely different motives from feature editors: the *Independent's* front page "Drugs 'Kill Cancer Tumours" on the day the mouse urine story broke became "Miracle? what miracle?" a few days later.

We've been here before, and there'll be further visits. Cancer is the dread disease, and the slightest hint that IT may be beaten is cue for over-enthusiasm. The first story was of a single gene that governed whether mice grew tumours when exposed to a carcinogen found in tobacco smoke. Extrapolation was immediate: turn the gene on (or was it off?) and no one would ever get cancer again, or at least would not develop secondary cancer Never mind that this was mice, that it was only cancers triggered by a single carcinogen, and that the enzyme

controlled by the gene might have functions necessary to an otherwise healthy life. There was even the suggestion that smokers might pop a pill so they could smoke to their hearts' content without getting lung cancer Ten times as many smokers die because of the cardiovascular effects of smoking, but no pharmaceutical company would bechurlish enough to point that out.

The second, mouse urine, story was much bigger. Two substances in the urine caused tumours in mice to regress. Three newspapers made the story their lead: the *Independent* (above); the *Express* ("Cancer: Is This Finally a Cure?"); and the *Daily Mail* ("New Drug Kills Cancer"). Other newspapers, including the *Guardian* ("Scientists say mouse urine can cure cancer"), were more circumspect. The story was big enough to drive the share price of the drug company involved up from $12 to $83 on the day of the announcement, although it later settled somewhat. On one of the cancer Websites on the Internet (alt.support.cancer) desperate patients were asking where this drug could be obtained and whether they could be involved in trials. Sensible postings about the reality of the discovery included the angry remark that the whole story was more likely to benefit the drug company, and even more those who had bought early and sold quickly,, than anyone suffering from cancer

Among the quoted soundbites was one from James Watson, co-discoverer of the structure of DNA and now involved in the Human Genome Project, apparently claiming that this was the biggest biological discovery since Darwin. Watson is one of a small group of scientists who are so well known(Stephen Hawking is another) that they can get away with speculation that would be dismissed from anyone less revered. But this blatant piece of blarney seems to have been a misquote or mis-juxtaposition of ideas by the media. In a letter to the *New York Times* later the same week, Watson wrote of cancer research "littered with promised treatments that raised hopes, only for them to be dashed...".

In no other area of medicine is there such a roller-coaster of hopes and failed promises. In no other area of medicine must doctors and others involved in looking after patients (a better word than victims) spend so much time countering false hope. Only a week after mouse urine, the *Express* added in the latest results from using tamoxifen in breast cancer and ended an editorial, "Perhaps we can dare to hope that the war against this terrible disease is entering its final triumphant phase." A woman from a support group, while encouraged by tamoxifen, stressed that it was important that more money must be found for research, so that a cure would be found more quickly.

There is something we must concentrate on, and it is not pouring more and more money into cancer research. Instead of looking to some mythical future, we need to look after the patients who have got cancer at the moment. Their svmptoms and sufferings are real, and we shy away because we are afraid of cancer We pretend we are helping by putting money in the tins for cancer research. Perhaps the hospice and Macmillan nurse movement would be a better place for our support. Whatever the future of medicine, we will still die. The humanity of a society should be judged not by how much it spends on medical research, but on how its people die. News editors are not likely to ride with that one.

Neville Goodman Consultant Anaesthetist, Southmeads Hospital, Bristol

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Letter: Medical fraud on the Internet

Dr Robert Baker, a Research Fellow in Infectious Diseases at the Department of Medicine, University College London, writes:

Dear Sirs,

I am currently working (aside from my main research interest, which is the immunoendocrinology of TB) on a publication based on medical fraud perpetrated via the Internet.

I have found plenty of cranky Websites, some of which are clearly downright dangerous. My piece would be immeasurably improved, however, by some *bona fide* case reports. I can find plenty of Americans and Australians who have been defrauded or worse by unscrupulous practitioners. Given the nature of the press in the UK, I know that most editors would prefer something more local.

I would very much like to hear from anyone who has purchased "health" products via the net and regretted it, either from cost to their well-being or their bank balance.

You may be interested in adding this URL to your list of related websites, it's a sort of Australian "Quackwatch":

Yours faithfully

ROBERT BAKER

Contact Dr Baker at: UCLMS / ICMSM Centre for Infectious Diseases, The Windeyer Building,46 Cleveland St, London W1P 6DB

Pager: 01426 172766, Tel: +44 171 636 8333 ext 3199,Fax: +44 171 6368175

e-mail robert.baker@ucl.ac.uk

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Letter: The last word on vitamin B6

Linda Lazarides, Director of the Society for the Promotion of Nutritional Therapy refers to articles in Health Watch newsletter issue 28 and the ensuing correspondence in issue 29:

Dear Sirs,

I do feel I should point out that David Bender's reply still shows an incomplete grasp of the law. The Government has not proposed to restrict the sales of unlicensed vitamin B6 supplements above a certain level to pharmacies. Its proposal is to *ban* the sale of all unlicensed vitamin B6 supplements above 10 mg. In referring to the sale of products in pharmacies and on prescription, it is referring to the very few products which have medical licences, all these licenses without exception-I am informed-being for the treatment of nerve damage caused by the drug isoniazid.

There is no legal provision which would or could allow the Government to ban any unlicensed supplements from health food shops and make them pharmacy-only. No bill or amendment to cur-rent food law has even been suggested to this effect, let alone passed.

Linda Lazarides

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