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Two views on health screening

At a recent meeting sponsored by the Department of Health and organised by HealthWatch prizewinner Annabel Ferriman on behalf of the Medical Journalists' Association, journalists were updated on the screening situation by speakers from two different viewpoints, and heard comments from Dr Muir Gray, the Director of the National Screening Programme, and Mrs Tessa Jowell, Minister of State, Health Department. John Garrow was there.

Prevention is better than cure, and in the case of cancer early detection offers better hope of curative treatment than later detection. These truths, so obvious that they hardly need stating, underlie the present policy of encouraging women to accept mammography to detect breast cancer before the lump is big enough to feel, and cervical smear testing to detect the early pre-cancerous changes in cervical cells before the cancer develops and invades surrounding tissue.

Other programmes for health screening are currently being considered, and in some cases pilot projects are being set up to see if they work in practice.

The first view came from Julia Patnick, the National Co-ordinator of these programmes, who addressed the question: Have we got it right? She concluded that the answer, in general, was "Yes" but admitted that things were not perfect. So far as the media were concerned the big stories were the failures in the programme of cervical screening at Canterbury, and of breast screening at Exeter. The exposure of these failings was evidence that audit was performing well, not that the system was ineffective.

The report of the breast screening programme for 1998 was made available at the meeting. The programme is based on the original Swedish Two Counties Trial, which was able to compare two populations, of which one had access to breast screening and the other did not. The mortality from breast cancer in the screened population decreased more rapidly than in the control population. The cost of the UK programme is £35m/year. In 1998 1,340,000 women were screened, 71,000 women were recalled for assessment because they had a suspicious film, and 7,370 cancers were detected.

In the case of cervical screening the scientific basis is less strong, since there has been no equivalent of the Swedish study for breast screening, but now the programme is so established that it would not be possible to set up a trial to measure incidence of cervical cancer in a screened, compared with an unscreened, population. The supporting evidence relies on trends in incidence and mortality before and after screening was introduced. This is set with pitfalls of interpretation. For example, if a cancer is detected early the survival after diagnosis will be longer than if it is detected later, even if the date of death is unaffected. Also, when a screening programme is introduced the apparent incidence suddenly increases, and then the incidence decreases because the cancers, which would have been detected later without the screening programme, have already been detected. Thirdly, in the case of cervical cancer the problem is further complicated by the changing sexual habits of the population, which might have caused cervical cancer to increase. If in a screened population it does not increase this may (or may not) show efficacy of the screening programme.

Dr Angela Raffle, who is responsible for the cervical screening programme in Avon Health Authority, presented an alternative view. She pointed out that cervical cancer ought to be an ideal type for detection by screening, since it develops slowly, spreads locally, and can be treated effectively by surgery or radiotherapy. However she had serious reservations. For example, it is not the case that abnormal cells will be found only in the smears of women destined otherwise to die of cervical cancer. She and her colleagues had reported¹ that between 1988 and 1993 they had tested 225,974 women, of whom no fewer than 15,551 had abnormal smears. Since the

annual death rate from cervical cancer in the region is 30 to 40 a year, this must mean a very large number who would never have developed cancer. And that even with perfect detection and prevention this programme could not prevent more than about 200 deaths from cervical cancer in five years. Experience since 1995 had not caused her to change her concerns about the cost-benefits of cervical screening. The initial money cost was high, and there was a heavy cost in anxiety to the 15,000 women who had abnormal smears, most of whom would never have developed the cancer.

After publication of the Lancet [1] paper the Department of Health was invited to comment: Baroness Cumberledge had said she did not know why in Avon 15,000 women had been caused to worry unnecessarily about a cancer they did not have, so she would set up an enquiry. The media interpreted this as evidence of incompetence in the Avon screeners, and protested loudly. In fact, the false positive rate was similar to that of other regions (except that they had not publicised the fact).

False negatives bring even greater vilification, and it is indeed tragic if a woman undergoes screening and later dies of cancer the screening did not detect. Yet all the speakers agreed that detection and prevention could never be perfect: there would always be women with abnormal smears who would not die of the cancer, and there would always be women who die of the cancer despite an apparently normal smear. Unfortunately politicians find it easy to blame the screeners for failures which are inherent in the test they are required to apply, and they do not take seriously their responsibility to state publicly the limitations of any screening programme, however conscientiously applied.

The speakers also agreed that it was becoming increasingly difficult to recruit workers to screening programmes, and it is easy to understand the reason. A cytologist may be happy to spend the working day looking at slides from high-risk patients, in whom there is a good chance of making a diagnosis that will benefit the patient. It is a different matter to examine 250,000 slides in which the chance that the patient will benefit is about 1:1000, and when any failure in the screening will result in public censure.

The reaction to all this from the medical journalists in the audience covered a wide spectrum. At one extreme there was an individual who complained that the screening programme was not sufficiently comprehensive, and that it should be made better by better technology and applied to a wider range of diseases. At the other extreme there were those who thought the motivation for screening was to advance political popularity rather than public health. No doubt the truth lies somewhere on this continuum. My own reaction was gratitude that I am not required to work in a health screening programme.

John Garrow

Reference: Lancet 1995; 345: 1469-73.

See also the [HealthWatch position paper on screening](#)

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NEWS: Evidence-based challenge to complementary medicine

Doctors are failing their patients by not being able to advise on the merits of different complementary medicines, writes Professor Edzard Ernst of Exeter University's Department of Complementary Medicine in the journal Annals of the Rheumatic Diseases.

Around half the UK population is thought to use complementary medicine at some time in their lives, a figure that is even higher among patients with rheumatological disorders.

Many of the published studies on complementary medicine to date have not been conducted rigorously enough and the results are contradictory, contends Ernst. While practitioners and scientists have argued that complementary medicine does not lend itself to double-blind randomised controlled trials, randomised trials can be run on complementary medicine techniques, he says, and these are still the best measure of safety and effectiveness that there is—essential information for patients before they embark on treatments.

"The bottom line of all this seems clear," asserts Ernst. "Evidence based complementary medicine must no longer remain a contradiction in terms. We need to be able to advise our patients responsibly about the risks and benefits of these treatments. Failing to take this challenge would be nothing less than disregarding the best interests of our patients." *Annals of the Rheumatic Diseases* 1999; 58: 69-70.

"Serious adverse effects" from CAM "Natural" does not mean "risk-free", concludes a paper recently published in the *International Journal of Risk & Safety in Medicine*.

Exeter's Department of Complementary Medicine, working with the Princess Elizabeth Orthopaedic Hospital and BBC News West, analysed questionnaires returned by 686 GP's and 121 members of the public and uncovered experiences of serious adverse effects ranging from paraplegia following neck manipulation, to the deaths of two children after homoeopaths advised changing or stopping essential medication.

No fewer than 11% of the GP's who returned questionnaires reported serious or potentially serious adverse effects. Of those which arose directly from the therapy, spinal manipulation was most often the cause—examples included severe whiplash injury with paralysis, and repeated manipulation of a thoracic tumour. Herbal treatments, various diets and acupuncture accounted for most of the remainder of direct effects reported. There were also reports of indirect effects, these usually involved interference with effective orthodox care for conditions such as asthma, diabetes and cancer.

The public should be made aware that complementary and alternative therapies are not necessarily risk free, say the authors, and GP's need to be aware of risks when referring patients to CAM practitioners.

Reference: Abbot NC, Hill M, Barnes J et al. International Journal of Risk & Safety in Medicine 1998; 11: 99–106.

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Negative results for homeopathy “proving” trial

A trial by researchers at Southampton University recently failed to produce evidence in support of one of the key tenets of homeopathy.

Homeopathic medicine is based on the principle that like cures like; in other words, a substance that, highly diluted, produces characteristic symptoms in healthy individuals (a “proving”) can be used to cure the same symptoms in people who are ill. In conventional medicine the notion understandably generates deep scepticism, not least because the prescribed substances may be so dilute that they could not contain even one single molecule of the original substance.

In the November issue of the Journal of the Royal Society of Medicine, three researchers from Southampton—Kathryn Goodyear, a medical student; George Lewith, a physician and Director of the Centre for the Study of Complementary Medicine and Lorraine Low, a statistician—report a pilot study on this matter.

In healthy volunteers they sought to determine whether the effects of a twice-daily C30 dose of Belladonna, an infinitesimal amount believed by homeopaths to cause symptoms including dry mouth, headache and diarrhoea, were distinguishable from those of placebo. Every day the volunteers, who did not know which preparation they were receiving, completed a questionnaire on the presence or absence of certain symptoms, some of which were “true” (listed in homeopathic texts as Belladonna effects) and others “false”.

The results of this trial were negative. That is, there was no statistically significant evidence of a proving reaction for Belladonna C30. However, the researchers recommend bigger trials are needed to topple “proving symptoms” as a key tenet of homeopathy.

Journal of the Royal Society of Medicine, November 1998

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You name it...I can't promise to make it happen

A magazine advertisement which promised “You name it I will make it happen...” was the subject of a complaint upheld by the Advertising Standards Authority recently. The ad claimed that the spiritualist Queenie Lane, described in the headline as “High Priestess”, could be called upon to undertake such tasks as, “removal of a curse, revenge, confidence, weight loss, weight gain, appearance, a job status.” The Advertising Standards Authority considered that the specific claim, “I WILL make your dreams come true Guaranteed...” could not be substantiated by the information submitted to them. The advertiser was asked to remove the claim and amend the advertisement wording accordingly.

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OBITUARY: Arnold E Bender, 1918 to 1999

Professor Arnold Bender, a founding member of the committee of HealthWatch, died peacefully at home on February 21st after a short illness.

He graduated in Biochemistry from the University of Liverpool, then spent the war years at British Drug Houses Ltd in London. After the war he took his PhD at the University of Sheffield, on the effects of ionising radiation on the endocrine glands, and worked with Professor Sir Hans Krebs in the Dept of Biochemistry at Sheffield, when they pioneered the teaching of nutrition to medical students.

He left academic life in 1947, initially to lead a research team at Crookes Laboratories Ltd where he and the late Derek Miller developed what is now the almost universally accepted method of assessing protein quality and nutritional value. In 1953 he moved to become Head of Research at Bovril Ltd, and then in 1961 to become Head of Research and Development at Farley's Infant Foods. In this post he claimed to be possibly the only nutritionist

to have formulated and brought to market a commercially successful and nutritionally sound infant weaning food.

In 1964 he returned to academic life, initially as a senior lecturer in the Department of Nutrition at Queen Elizabeth College; he was appointed to a personal chair in 1971, and to the established Chair of Nutrition and Dietetics and Head of Department in 1978. He retired from academic life in 1983, but remained active in scientific and professional affairs, and scholarship and writing until a few weeks before his death.

He was the author of some 150 research publications and major academic reviews, and 14 books, many of which have become major reference works and standard textbooks at school and university level. In addition he wrote prolifically for the non-specialist audience, both articles in magazines and journals, and also such books as *Health or Hoax: The Truth About Health Foods and Diets* (Elvendon Press, 1985).

Over the years he made a significant contribution to the professions of Nutrition and Food Science, not only in his teaching and writing, but also as an editor of professional journals, and a tireless and dedicated committee member of, inter alia, the Nutrition Society, The Institute of Food Science and Technology, and The Royal Society of Health and Hygiene, as well as HealthWatch.

Arnold Bender will be sorely missed not only by his friends and family, but by the wider world of nutrition and food science, as well as by all who valued his careful scientific approach to all questions and problems. He truly believed in, and practised, the HealthWatch motto of "enhancing informed choice through reliable information".

David A Bender

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LEGAL MATTERS: Secret out-of-court settlements in drug injury cases

Dr Andrew Herxheimer explains the dangers that lurk behind secrecy clauses, and proposals to curb such clauses, in this important article, originally published in The Lancet on 13 February (Lancet 1999; 353: 517–18.) For legal actions settled out of court it is common for the settlement to include a secrecy clause. A settlement out of court has advantages for both parties: it saves time and money, and it attracts less publicity than a trial. The courts also save time and costs. However when a personal injury case is settled out of court, other people who have suffered a similar injury may remain unaware of it, so they may lose the opportunity to obtain redress. This is an injustice and a public mischief.

Suppose that a person injured by a drug sues the manufacturer. The company wants to avoid adverse publicity, and is willing to pay for that. Where a reasonable settlement is offered, but with a secrecy clause, the client's interest is to secure damages there and then. If the offer is rejected the client might get nothing; the client might also not survive long enough for the case to come to court.

Doctors come into the picture as experts providing reports for the plaintiffs and the defendants. Their primary responsibility is to the court. Their reports in such cases should, as a matter of public policy and of medical ethics, not be subject to blanket secrecy clauses agreed between lawyers. The General Medical Council (GMC) has recently issued a helpful statement, emphasising that doctors when they act as expert witnesses, as at other times, must make the care of patients their first concern [1]. "These are not duties that can be signed away in any contract or agreement. If doctors involved in legal cases learn information which indicates that, unless further action is taken, patients will continue to be at risk, they are obliged to act on it." The phrase about patients continuing to be at risk implies possible future injury to other patients, and probably does not cover the right of people who have already suffered damage, to information that might help them obtain compensation. This right might appear to be more a legal than a medical issue. In reality, it is an issue about the priority given to commercial interests as against the public interest taken by the courts and parliament.

Suppression of information that can help to protect people from harm or which would make people aware of a possible entitlement to compensation is obviously against the public interest, too. Disclosing data on newly recognised risks, and doing so promptly can be regarded as a duty. The difficulty, for regulators as well as for expert witnesses, is to judge when a previously unsuspected harmful effect becomes a "recognised risk". Usually such decisions are made by a drug regulatory agency in discussion with the manufacturers concerned, but the data and the expert assessments on which the decision is based are rarely made public, even later [2]. The secrecy means that the public is inadequately protected; it also helps drug regulators to avoid litigation by preventing people discovering their possible entitlement to compensation. A secrecy clause in litigation has similar effects. It may be narrow or wide, covering the fact of settlement, the amount, the identity of the parties, and the nature of the case. It may even require the plaintiff's lawyers to agree to refuse instructions in any future cases of the same kind against the same defendant. Such a condition is used in the USA, and something like it was imposed in the Opren (benoxaprofen) settlement in the UK. That settlement also barred the plaintiffs' experts from acting in any future cases. The solicitors—and the Law Society—appealed to the High Court on this point. But the Court upheld the clause, arguing that the solicitors' duty was to their existing clients. The Court's judgment, now the law, is based on a rather circular argument. If unfair conditions had not been imposed on existing clients, their interest would not have been threatened. In the Opren cases not covered by the settlement another group of solicitors had to start from scratch. Commercial interests were given priority over consumer and public interests.

Secrecy clauses can also cover documents that are disclosed to the plaintiff during litigation. They cannot be used in another case. In multiparty product-liability cases this has been partly overcome by grouping together in one action plaintiffs who can all benefit from the documents disclosed. This does not however help 'late' plaintiffs who miss the group. The rule also applies to an expert's report dealing with the merits of a case and liability. Typically such a 'generic' report is based on extensive research by a leading expert. If it could be used for all relevant cases it would save substantial costs, commonly costs borne by the taxpayer in group actions funded primarily by legal aid. If experts were allowed to publish their findings, all consumers who may have been injured by the same product would know that they may have a claim which is supported by readily available expert evidence. Settlements in subsequent cases could also be encouraged as both sides would start out with a clearer idea of their positions.

New rules governing the involvement of expert witnesses in litigation are being introduced. They will require the expert to address the report to the Court and to certify his/her independence. This change is mainly intended to ensure the impartiality of experts; it will still not permit use of a report on liability produced by an expert in another case on the same point.

But making the report the property of the Court might put it beyond the reach of secrecy clauses, a point that needs to be clarified by parliament or the courts. The treatment of reports produced by experts whose primary duty is to the Court and not to any party in the litigation needs to be consistent with the overriding objective of the new Rules of Court: to deal with cases justly. The Rules define 'justly' in part as ensuring equality of the parties and saving expense. Secrecy clauses foster neither outcome.

The harm done by secrecy clauses has long been neglected, and the GMC deserves credit for seeking to curb it. Expert witnesses should be aware that their reports may be of considerable public interest and that secrecy clauses do not necessarily bind them. In the case of recognised risk they probably do not bind them. Where other public interests need to be weighed against commercial interests, the choice is less clear. Parliament and the courts must decide how the scales will be tipped.

Andrew Herxheimer

9 Park Crescent, London N3 2NL

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1. General Medical Council News Winter 1998 (issue 4): 7.
2. Herxheimer A. Side effects: freedom of information and the communication of doubt. *Int J Risk & Safety in Medicine* 1996; 9: 201-210.

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HEALTH FAIRS: Cures for sale in Belfast

HealthWatch member Harriett Moore reports on a Belfast 'Health & Food Fair' she attended in January.

The fair was publicised in our main evening newspaper, The Belfast Telegraph, with articles and a large colour photograph of an attractive female posing with some crystals in her hands.

Doors opened at noon, and I arrived early with a friend to be confronted with a long queue. We joined and waited. Hardly had we gotten inside—admission cost £2.50—when we were offered programmes for sale, and draw forms to complete. I never managed to establish what the draw was for, or when the winner would be announced, but I suspect that the 'draw forms' were a system of acquiring names and addresses for future events.

The atmosphere was buzzing and the place got quite crowded very quickly. There were about 100 traders altogether representing a virtual A-Z of Alternative Medicine from Acupuncture to Zero Balancing. I really did not expect to find such a vast array of nonscience and only two or three stalls that could be described as representing anything conventional. These included BUPA, ACCEPT (a retraining programme for people with mental health problems) and some organic foods.

We wandered along collecting leaflets which I read later when I returned home. Most included references to "arthritis", "cancer", "diabetes", "MS", "healing"; and the claims "may be effective", "has been shown to be useful for...", "is believed to assist in treating...". Of course references to treatments having an "exotic tradition", and "natural" being "good", appeared frequently. And a leaflet about Crystal Therapy stated that this forgotten therapy had been re-discovered 150 years ago! Now, maybe I am missing some vital point here, but if it's forgotten and there are no records then how can it be "re-discovered"? Despite all these traders offering and selling purported cures, preventatives or treatments, we did not hear, nor read in any of the literature we picked up, advice to prospective clients to check with their doctor or GP about their condition. The emphasis was frequently anti-science, against fluoridation, against food preservatives, against medications and just occasionally anti-vaccination and, in one case, we saw a written statement that traditional Chinese Medicine could be used instead of conventional means for the successful reduction of fractures! (this from Ri Fang Ho, Doctor of Chinese

Medicine and Member of the British Acupuncture Council).

We left when our carrier bag was about to burst with leaflets. Although I have been to many exhibitions and fairs over the years I was astonished by the queues of people lining up to pay sums upwards of £15 for on-the-spot tests at the various stalls.

There are, of course, strict regulations in place controlling the type of claims that can be made with regard to health treatments, so that consumers may be protected from ineffective or potentially dangerous purchases. Our local Trading Standards officer, who is currently scrutinising some of the literature offered at the exhibition for evidence of illegal claims, will no doubt be busy for some time to come.

Harriett Moore

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MEETING REPORT: Indian Grass Therapy

Dr Thurstan Brewin never ceases to be amazed by the public's fascination with wild and wacky health treatments. Here he reports on his experiences at a Health Show in Birmingham.

When BBC television's magazine programme, *Here and Now*, heard about a big Health Show in Birmingham they invited HealthWatch to send someone to walk round the stands, talk to sellers and buyers and comment. They also decided (their idea, not ours) to arrange a spoof exhibit of ordinary grass and to call it Indian Grass Therapy.

This aroused great interest among those attending the show. Unbelievably, nobody seemed to suspect for a minute that it might be completely bogus. The leaflet that went with it for all to read was a delight. "Keep for use in times of stress," it said. "Just open the bag of grass and inhale...full of nature's own powerhouse ingredient, working holistically to give feelings of renewal...this is an innovative veganbiophysics product available without prescription." Available without prescription? That's really something, isn't it? Later the presenter interviewed the organisers and asked them how they could justify accepting something like this from someone who just walked in with no credentials whatever. They said that they usually expected membership of some organisation.

I never saw the slightest indication that any of those flocking to this vast, popular exhibition (hundreds and hundreds of them, nearly all women between the ages of 30 and 50 when I was there) were doing anything but trusting what they were being asked to trust. Perhaps some were allowing for a little exaggeration, but that's all. Every vestige of critical faculty, of healthy scepticism, of doubt or of humour seemed to have been left at the door when they entered the exhibition hall.

It was a rather different story with those who manned the stalls and exhibits. Some seemed very sincere about the supposed value of their product, but I soon found that others, whether men or women, did not need a lot of encouragement to make it privately crystal clear, perhaps with a nudge and a wink, that they knew perfectly well that it was all a bit of a joke, but if so many of their customers were happy to spend their money in this way, who were they to stop them? As with your typical high street health shop, it was striking how much was being sold not as a remedy, but as something that normal healthy people were being urged to take indefinitely if they were to stand any reasonable chance of keeping well.

It was the usual heady mixture of trendy jargon, pseudo science and ancient mysticism. Everybody was urged to "power up their immune system". And it seems that our atmosphere is now so loaded with pollutants that the need for high quality antioxidants is greater than ever before. Free radicals can destroy healthy tissues both internally and externally, but luckily the "Forever Young" brand of antioxidants can stop this.

Did you know that "research has shown" (a popular phrase at many stalls) that oxygen deficiency can be the single greatest cause of disease, that hostile microbes and viruses are unable to survive in the presence of oxygen, and that normal breathing definitely does not supply us with enough of it? No wonder we all need to take—two or three times a day for the rest of our lives—a solution containing "buffered and stabilised oxygen waiting to be released into a bioactive environment".

Giving the mysterious East a rest for a bit, the ancient remedies of South America were much in evidence. I must say I never thought of the health of the Peruvian and Brazilian rain forest tribes as being particularly good, that's not my impression from what I've read. but here in Birmingham you could buy what these rain forest people "have been harvesting for centuries to help keep them vibrant". And did you know that the bark of the Jatoba tree has been used for hundreds of years by lumberjacks in Brazil to keep their prostate glands healthy? I just mention it in case you are interested.

For £20 a month or so you can take what they have been taking in India for thousands of years to improve their memory. For only £7 a simple hand-held massage machine consisting of six rotating balls—also "used in the East for several thousand years"—was selling well. Meanwhile a copper bracelet would not only help cleanse the body of toxins, it would also replace any copper loss in the body. And a natural "age reversing miracle" was also available. And several "stress busters".

Osteopathy and homeopathy were nowhere to be seen. Perhaps they were wise enough to regard this exhibition as beneath their dignity. But acupuncture, reflexology, iridology, and "healing astrology" were all there.

Almost the only sign of mainstream medicine was a sensible stall manned by the National Pharmaceutical Association, and a London plastic surgeon advertising himself and his cosmetic surgery.

Thurstan Brewin

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MEDIA: Gingko biloba and a free lunch

HealthWatch was pleased to be invited to a presentation of "exclusive insights" into an exciting double-blind trial on the effect of Ginkgo biloba on short-term memory. But we didn't learn as much as we expected to. John Garrow reports.

Ginkgo has been shown by randomised double-blind placebo-controlled trial to be a useful symptomatic herbal therapy for dementia of the Alzheimer and multi-infarct type [1, 2]. It may have this effect by enhancing cerebral circulation, reducing free radicals or by action on the muscarinic cholinergic system [3].

The investigator who was to present his research findings was Ian Hindmarch, Professor of Human Psychopharmacology at the University of Surrey. The host was Pegasus Publications, on behalf of LichtwerPharma who market Ginkyo, a concentrated extract of Ginkgo. The venue was the Ivy Restaurant in London WC2, which is highly rated by gastronomic cognoscenti. The event was billed as an "expert lunch". Not all the journalists present were very expert, though—a features editor who worked for the Womens' Institute asked us what was meant by a "double-blind trial".

We were provided with press packs which extolled the merits of Ginkgo in general, and the LichtwerPharma extract in particular. There were several citations to literature about the efficacy of Ginkgo including reference1, but not reference2 which evidently used a different preparation of Ginkgo.

The proceedings were opened by Mr Peter Josling of the Ginkgo Information Centre who emphasised the antiquity of the Ginkgo tree, and the importance of using the correct commercial preparation to obtain the greatest benefit. His centre was an independent and reliable source of information on this subject.

What followed was something of an anticlimax. Professor Hindmarch explained that the promised exclusive insights into his double-blind research would not be offered because, although he valued press interest in his work, it would prejudice his chance of publishing this research in high-class scientific journals if he released the results to journalists such as ourselves. True to his word, the slides were brightly-coloured histograms with axes not labelled in any comprehensible manner but which, he assured us, showed that subjects given Ginkgo extract for 48 hours performed much better than controls. This impressed your HealthWatch representative, since the press pack stated "most people find that it takes up to 12 weeks to realise Ginkyo's optimum benefits". The nature of the benefit was not entirely clear: Professor Hindmarch demonstrated a hand-held device with which it was possible to measure critical flicker fusion threshold, but the relationship of this to short-term memory was not explained. The questions that we longed to put about the study design, methods of randomisation and power calculations were clearly not appropriate for this meeting. There was nothing from the audience which could have been termed critical questioning.

Lunch followed, with liberal quantities of very acceptable red or white wine. Starters was tomato and herbs on a pastry base, the main course roasted chicken which was delicious, but we cannot report on the dessert course since we made our excuses and left.

Later we called the Ginkgo Information Centre but were unable to obtain further information: there was a recorded message designed to facilitate those who wished to purchase supplies of Ginkyo.

Journalists have rightly exposed the potential for conflict of interest when pharmaceutical firms provide lavish entertainment for medical practitioners who may prescribe their products. It seems that healthcare journalists may be exposed to similar dangers with respect to non-prescription medication.

John Garrow

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More cancer hopes dashed

Last summer we reported on a much-hyped cancer "breakthrough", which was even claimed to mean that cancer would soon be a disease of the past (HealthWatch newsletter [issue 30, July 1998](#)).

Sadly, but not unexpectedly for those with more insight about how medical research actually works, the claims were premature. With rather less shouting than for the original story, the media reported that scientists are having difficulty replicating the effects of endostatin and angiostatin in causing the regression of tumours in mice ("Cancer drug hopes dashed", Observer 15 November 1998). The theory behind the research is good: these compounds affect blood supply in developing tissues, and if that supply fails the tissues die.

The findings have not yet been retracted, but that is still a possibility. There is nothing wrong with scientific retraction if the original findings were the result of honest work reported honestly. Sometimes science gets it wrong. What was wrong, and always will be wrong, is the premature announcement by the media of hope as fact.

Dr Neville W Goodman

Consultant Anaesthetist at Southmead Hospital, Bristol

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LETTER

Dr G S Plaut, a retired general practitioner of Halstead, Essex, writes:

Dear Sirs, There are many problems associated with cervical screening. Several years ago (admittedly before many of the modern refinements in the study of cervical smears) I wrote a paper on cervical screening in my general medical practice, and received a Rudolf Friedlaender Award for this work¹.

Sampling cannot give a 100% correct estimate. It is inevitable that an occasional abnormal cell is not seen; there are millions of cells in the cervix. Some cervical material will be absorbed by the wood of the sampling spatula. A small diseased region on the cervix may be missed completely during sampling. It is also conceivable that a very small area of diseased cells is completely scraped off by the spatula, so that this smear will show dysplasia but a smear taken later will be reported on as normal. In my series four patients had a second normal smear, although the first smear was doubtful. Such patients are, of course, followed up carefully. I remember one of these, who had a first positive, second negative and a third smear showing dysplasia, and then needed extensive—and successful—treatment.

The general practitioner who has taken the smear may have difficulty in informing the patient that treatment is required. One of my patients had an abnormal smear, but failed to telephone the surgery for the result. She did not reply to three letters I sent to her. She had moved and changed her name on marriage. Two years later she came back, and I told her that a repeat smear was imperative. She failed to make an appointment for this. She is a university graduate and could hardly have misunderstood me. I visited the home, but could get no reply as she and her husband were out, presumably at work. I finally found her husband at home on a Bank holiday. The matter was explained to him, and in due course the dysplastic region of the cervix was destroyed with laser therapy².

Yours faithfully

GUS PLAUT

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