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## The new nutritional nonsense

*There seems to be a constant flow of "number one best sellers" in the nutritional "non-science" market, but a new entry—"Living Food For Health" by Dr Gillian McKeith, breaks new ground, according to Professor John Garrow. So certain is he that some of her claims are unfounded that he hereby issues her a challenge to subject one of her treatments to a simple clinical test. Prove it works and he'll apologise and pay her £1000...but if it fails the test, she should honorably withdraw the claims. Will she take up the gauntlet? Human nutrition must be the least exact of the sciences. In general, sciences progress by setting up testable hypotheses, and testing them. Animal nutritionists are able to do this: if someone suggests that it is more profitable to rear a particular strain of pig on a diet with 17% protein rather than 14% protein, an experiment comparing the two diets can easily be set up, and the answer will be available quite soon (i.e. within a year or so). But we human nutritionists are faced with questions that are not so easily answered.*

Is a person less likely to develop osteoporosis at age 70 if their previous daily intake of calcium has been 1200 mg/d rather than 600 mg/d? Does a doubling of the average intake of anti-oxidant vitamins confer protection against cancer or heart disease in later life? Perhaps, but we cannot know for certain, because we cannot recruit volunteers who differ only in their habitual calcium, or vitamin, intake, but do not differ in all the other factors which affect the risk of osteoporosis, or cancer, or heart disease. Most (but not all) human nutritional scientists are rather humble, diffident people, since they are aware of the flimsy experimental basis on which most of their knowledge rests. However this diffidence does not inhibit certain non-scientists who presume to advise the public on nutritional matters. The first nutritional nonsense book I read was *Eat Fat and Grow Slim* written by Dr Richard Mackarness MB BS in 1958. He had misinterpreted the work of Kekwick and Pawan at the Middlesex Hospital, and was convinced that fat people had a metabolic defect that caused them to make fat out of dietary carbohydrate. The solution was to get them to eat fat and (counter-intuitively) they would grow slim! Thus the diet proposed by in 1862 by William Banting, an obese London undertaker, was given a new lease of life.

The recent epidemic of nutritional nonsense books probably began with the publication in 1981 of *The Beverly Hills Diet*, by Judy Mazel. In the introduction she writes "I do not purport to be a medical doctor" (indeed, she told me her university degree was in drama, which I could easily believe) but she felt impelled to reveal metabolic secrets hitherto closely guarded by film stars. The key to the diet (p 24) is that if something is wrong with digestion of food "it gets stuck in your body—and turns into fat!". The key to digestion is enzymes, so if you conscientiously follow her rather complicated rules about what foods to combine with which, your enzymes will work optimally, and danger of fat storage will be averted. If you contravene the food combining rules you must then fast for some hours, followed by a meal of particularly enzyme-rich fruit, such as pineapple or strawberries, thus setting up your digestion to do its duty. It seems likely that the penitential fast to atone for error is the component of this regimen that chiefly accounts for any weight loss.

The idea that food is digested better if eaten in a certain sequence was promulgated by Dr William Howard Hay in *Health via Food* (1935). The rationale is at least plausible: protein is digested by enzymes that require acid conditions, whereas carbohydrate-splitting enzymes require alkaline conditions. How then can digestion cope with a meal that contains both protein and carbohydrate? The answer is that mammalian digestion is a sequential process involving enzymes from saliva, gastric juice, bile, various intestinal enzymes and eventually bacteria in the colon. At each stage the acidity is adjusted so the enzymes can do their work. Therefore it is unnecessary (and in practice impossible) to eat meals which are solely protein, carbohydrate or fat. I do not know who should be credited (if that is the correct term) with the highly implausible ideas that fat is deposited because digestion of food is incomplete, or that enzymes in food can contribute to the digestive process in the gut. Enzymes are

themselves proteins, and enzymes in food are rapidly inactivated by the action of gastric juice, so they cease to be enzymes. However, many non-scientists have followed Judy Mazel's teaching as described above. Leslie Kenton in *Raw Energy* (1984), and *The Biogenic Diet* (1986), and Kathryn Marsden in *The Food Combining Diet* (1993) are devout followers of Dr Hay, and Ms Kenton helpfully explains why it is better to eat raw food than cooked food. She quotes Dr John Douglass who says "Optimal electron transport speed...may not occur in denatured protein, since the molecular matrix is altered. Cooking, of course, denatures protein." (*Raw Energy* p 47). In her introduction Ms Kenton modestly declares "I am only a reporter", which is fortunate for her. I do not understand what the quote from Douglass means, nor can my biochemist friends enlighten me. Neither do I understand why it is nutritionally worse for protein to be denatured by cooking than by the action of gastric juice. Although there appears to be a constant flow of new "No 1 best sellers" in the nutritional nonsense market, in fact books are recycled. For example *The New Biogenic Diet* (1995) by Leslie Kenton is remarkably similar to the 1986 version. The most striking changes I found were a new cover, and an embarrassing passage in the 1986 book (p 6) which described free amino acids as "nature's most recently discovered wonderworkers—which can be employed to encourage fat metabolism" has now been deleted.

However, new ground has been broken by Dr Gillian McKeith's *Living Food For Health* (2000). She is no mere reporter: she has a Doctorate in Clinical Nutrition (p 2) from the University of Pennsylvania, and at least one serious broadsheet (Reality in *The Independent* on Sunday, 7th May, p 30) is prepared to accept her at her publisher's (Piatkus) deferential assessment: she is "the internationally renowned clinical nutritionist" whose "patients include professional athletes, members of the Royal Family and Hollywood stars." She has some 1500 people on her waiting list and it takes more than two years for new patients to get an appointment.

Fortunately we do not have to wait that long to learn how to "boost your energy, heal your organs and cells, detoxify your body, strengthen your kidneys, improve your digestion, strengthen your immune system, reduce cholesterol and high blood pressure, break down fat, cellulose and starch, activate the enzyme energies of your body, strengthen your spleen and liver function, increase mental and physical endurance, regulate your blood sugar, and lessen hunger cravings and lose weight." How to do this is all in her book (£6.99 paperback, 218 pp). She is "on a divine mission to share this essential information with as many people as possible for the good of civilisation" so she continues "every day to research, test and write furiously so that you may benefit." (p 6). Her passion and sincerity shine out from every page, but the originality and scientific rigour of her research is open to question. Her thesis is that the benefits listed above derive from a diet which is rich in enzymes from live raw food—fruit, vegetables, seeds, nuts, and especially live sprouts which "are the food sources of digestive enzymes" (p 9). Since her patients were often not willing to adopt these as a staple diet, "I developed a combination living food powder for clinical purposes" which "was perfectly and synergistically harmonised to provide a biochemical benefit to each organ and each meridian of the body" (p 19) and used these for clinical trials with patients at her clinic. The results of the research are reported as individual case studies, all of which had excellent outcomes. However there is no mention of any control series, or explanation of how these cases were selected from the great number of patients she has treated.

I also am a clinical nutritionist, and I believe that many of the statements in this book are wrong. My hypothesis is that any benefits which Dr McKeith has observed in her patients who take her living food powder have nothing to do with their enzyme content. If I am correct then patients given powder which has been heated above 118oF for 20 minutes will do just as well as patients given the active powder. This amount of heat would destroy all enzymes, but make little change to other nutrients apart from vitamin C, so both groups of patients should receive a small supplement of vitamin C (say 60mg/day). However, if Dr McKeith is correct, it should be easy to deduce from the boosting of energy, etc. which patients received the active powder and which the inactivated one.

Here then is a testable hypothesis by which nutritional science might be advanced. I hope that Dr McKeith's instincts, as a fellow-scientist, will impell her to accept this challenge. As a further inducement I suggest we each post, say, £1000, with an independent stake-holder. If we carry out the test, and I am proved wrong, she will, of course collect my stake, and I will publish a fulsome apology in this Newsletter. If the results show that she is wrong I will donate her stake to HealthWatch, and suggest that she should tell the 1500 patients on her waiting list that further research has shown that the claimed benefits of her diet have not been observed under controlled conditions. We scientists have a noble tradition of formally withdrawing our publications if subsequent research shows the results are not reproducible—don't we?.

John Garrow, Emeritus Professor of Human Nutrition University of London

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## MEETING REPORT

### Does medical journalism kill?

***Annabel Ferriman, medical journalist and winner of the 1997 HealthWatch award, attended a debate recently hosted by the Medical Journalists Association. Her report, which appeared in the June issue of the Journal of the MJA, is reproduced here with her kind permission.***

Dr Robert Aston is a brave man. He took on a roomful of medical journalists on May 9th to propose the motion: "Medical journalism distorts the truth".

But then the doctor, who is a consultant in communicable disease control in Wigan and Bolton Health Authority, is an old hand at controversy. On "Kilroy: and other television shows, he has taken on television studios full of parents with vaccine damaged children to plead the cause of immunisation.

"I can't win when I appear on a programme opposite a mother with a vaccine damaged child on her knee, because the whole audience is already in tears," he told the MJA debate, which was held at the King's Fund. But, as a passionate supporter of immunisation and preventive medicine, he believes he still has to try. In pointing out how journalists distort the truth, he cited numerous examples, but concentrated in particular on two that occurred in the last 12 months.

He criticised the Evening Standard for a story it carried last June with the headline, "New alert on measles jabs for children". The piece re-hashed an article that had appeared two months before in the journal Gastroenterology, which said that children who had had measles and mumps close together—the diseases, not the vaccinations against them—might be at increased risk of inflammatory bowel disease.

The Evening Standard piece completely distorted the truth by suggesting that the research published in Gastroenterology showed that the MMR vaccine was dangerous, when in actual fact it showed the complete opposite, Dr Aston said. By protecting the children against measles and mumps, the vaccine lowered the risk of children developing inflammatory bowel. Unfortunately, the Standard's story with its incorrect message was followed up by almost all the national daily newspapers.

His second example of distortion focussed on a story on the front page of The Mail on Sunday in April this year. The story carried the headline, "Measles jab: new link to brain damage". Dr Aston pointed out that the article, which suggested that the measles vaccination increased the risk of a child developing autism, was utterly misleading, because there had been absolutely no new published evidence demonstrating any such link.

The story was prompted by a Congressional hearing on the subject of autism in the US. Andrew Wakefield, the researcher at the Royal Free Hospital, London, who had first suggested a link between the MMR vaccine and autism in 1998, presented some of his research to the hearing, which had been called by a Senator, whose grandchild suffered from the disorder. The Mail on Sunday merely repeated the old allegations.

Dr Aston believes that doctors should work with journalists to try to get accurate and important messages across to the public. He thinks some of the distortions produced by journalists are unintentional and result from journalists not understanding certain scientific principles, such as the difference between relative and absolute risk.

He thought that good medical journalists reported on the balance of evidence on medical issues as it actually existed and did not concentrate on reproducing the ideas of mavericks, eccentrics and those with an axe to grind. "You can always find a paper somewhere in the whole literature of medicine that will support your point of view, but that is not science," he said.

Jeremy Laurance, health editor of The Independent, opposed the motion. He claimed that medical journalists were "more sinned against than sinning"—more the victims of distortion rather than the perpetrators of it. He said that commercial companies, charities, pressure groups, institutions and ordinary members of the public were always trying to "sell" stories to journalists, who had a difficult job in sifting the wheat from the chaff. In trying to sell their products or ideas to the press, these interest groups often exaggerated the truth to grab the journalist's attention.

Laurance illustrated his point by showing the audience some press releases from organisations, which had "spun" the truth. One classic case was a press release from Cancer Research Campaign, which carried the headline "End to Cancer in Sight as charity reveals new statistics on disease". The press officers who had put it together were particularly canny because they chose to release the story on the morning of January 4, 2000, ensuring maximum coverage, since after the long quiet period over Christmas and the millennium celebrations journalists were not likely to have anything to write about. Sure enough, it was followed up in most daily newspapers.

Laurance also defended the press's role in publicising the alleged link between the MMR vaccine and autism. He himself had attended the press conference in February, 1998, when Richard Wakefield had presented his findings suggesting that children who had been vaccinated were more likely to have developed autism than those who had not. Despite the fact that his study involved only a very small number of children, Laurance felt that he and the other reporters could not ignore the report because it had appeared in a prestigious, peer-reviewed learned journal, The Lancet.

Laurance blamed some of the distortions that appeared in the media on the fact that the newspaper industry was a commercial concern. Newspapers that did not sell copies were destined to fold; journalists who did not get their stories into their newspapers were destined to lose their job.

The 40-strong audience did not vote on the motion at the end of the debate and it was not clear how we would have voted if we had had the chance. Dr Aston asked us at the end of his talk: "Can you honestly say that your work has always accurately presented the balance of the scientific evidence?" Those of us who could have

answered "Yes" were probably few—and dishonest or deluded.

Annabel Ferriman, MJA

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## NEWS

### A dedicated web address for HealthWatch

**The HealthWatch web pages now have their own site on the world wide web. The new address is: <http://www.healthwatch-uk.org>.**

Easier to remember! Regular visitors who have bookmarked the old site address will, for the time being, be greeted with a welcome page and a link to the new site.

The site's popularity is growing. We broke through the 1,000 hit-a-month barrier in February, and received 1,200 hits in March..

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### Nick Ross to help transform the NHS

***HealthWatch's chairman is to be drafted in to help Alan Milburn transform the NHS. Nick Ross will join one of six action committees announced by the Health Secretary recently to draw up a national plan for the NHS, to be published this summer.***

Nick Ross, a founder member of HealthWatch and a leading broadcaster, will be working on a team studying how professional boundaries can be removed.

Nick Ross has been chosen largely to represent the public. As well as his association with HealthWatch, he is known as a crusader on social issues and is a patron of a number of committees dealing with issues including gene therapy, road safety, youth and crime.

He will be working with 30 health professionals and experts including Don Berwick, a former adviser to President Clinton on health policy, and Bob Abberley, head of health at Unison, the public sector union.

Others chosen to represent the patient and the public include Melinda Letts, chairman of the Long Term Medical Conditions Alliance, and Rabbi Julia Neuberger, chief of the Kings Fund..

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### Award for John Diamond at HealthWatch AGM 2000

The journalist John Diamond has been chosen to receive this year's HealthWatch award, to be presented at the Annual General Meeting.

The AGM will take place on Thursday 24th October, at the Medical Society of London, as last year. The address is Lettsom House, 11 Chandos Street, Cavendish Square, London W1M 0EB.

Further information will be available nearer the date.

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### Complaint against ABPI ad not upheld

***The Association of the British Pharmaceutical Industry was successful in defending itself when a number of complainants challenged a claim it made in a national press advertisement.***

The claim questioned was,

"This year, the National Health Service will spend £6 billion on medicines...In return the pharmaceutical industry will re-invest some 20% of its annual turnover in the search for new and improved medicines. This investment will benefit the National Health Service by helping to reduce hospital admissions and saving £10 billion a year on patient care".

Complainants, challenging whether the pharmaceutical industry's investment would indeed reduce hospital admissions, cited US research showing that adverse drug reaction was a major cause of death.

In its defence, the ABPI said that some conditions that had traditionally required hospital treatment could now be

treated by drugs alone. They cited 12 categories of illness including HIV and AIDS, epilepsy, osteoporosis, asthma and kidney failure. They also pointed out that the American research cited by the complainants was seriously flawed, and supported this by submitting letters from leading medical scientists that had been published in the Journal of the American Medical Association in response to the original research paper.

The ASA accepted that the number of hospital beds allocated for the treatment of the 12 disease categories since 1957 had fallen, saving the NHS £9.666 billion, and that the treatment of these diseases had improved because of the development and increased use of pharmaceuticals. They also acknowledged the division of informed opinion on the JAMA paper and accepted an estimate of £0.27£0.71billion for the cost of treating ADRs in the UK.

The objection was not upheld—the ASA accepted that drug treatments led to a decrease in hospital admissions, a saving in Health Service spending and that the costs resulting from adverse drug reactions did not significantly diminish that amount. The Authority did, however, consider that the ABPI had not justified the £10 billion figure and advised the advertisers either not to use it again or to ensure they had full substantiation for it.

ASA Monthly Report, June 2000

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## Consultants are “treated like gods”

*The following letter appeared in The Times on 6th June 2000 and is reproduced here with kind permission of Professor Michael Baum, a founder member of HealthWatch.*

Sir,

After 30 years as a consultant surgeon I can confirm that consultants are in fact treated like gods (reports and leading article, June 2). Like gods we are expected to work miracles, and like gods we are expected to materialise in several places at the same time.

The miracles we are expected to work include responding to increased political demands and heightened public expectations with no increase in beds or operating time. The gift in appearing in more than one place at a time was exemplified last year when I was expected to conduct an outpatient clinic, attend a statutory audit session and chair a committee on cancer services, all on the same morning.

I have just taken early retirement from the NHS having recognised that my miraculous powers have deserted me. I was dismayed to discover that I was unable to see every patient suspected of having breast cancer within two weeks of the GP's referral with no increase in manpower in the clinics.

Yours sincerely,  
Michael Baum

(Professor Emeritus of Surgery; Visiting Professor in Medical Humanities,  
University College London),  
Department of Oncology, Royal Free and University College Medical School  
48 Riding House Street, W1P 7PL.

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## CONFERENCE NOTIFICATION

### Nanobiotechnology, Life Extension and the Treatment of Congenital and Degenerative Disease

**23 November 2000, Glasgow.**

This conference brings together the world's top researchers to examine how biological techniques, better use of drug therapies and a knowledge of the causes of the ageing process is already leading to improved treatment and prevention of some of the causes of disability and ill health in old age.

- Topics Include: Stem Cell Therapy and Degenerative Disease
- DNA Sequencing,
- Pharmacogenetics and the Personalisation of Drug Therapies Gene Therapy—A Future Treatment or a Discredited Technology?
- Treating the causes—Identifying the Genetic Propensity for Cancer

For further details please contact Julie Hutcheon

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or see our website <http://www.nano.org.uk>

Organised by The Institute of Nanotechnology

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## FAVOURITE QUOTES

**"Nothing is too wonderful to be true, if it be consistent with the laws of nature, and in such things as these, experiment is the best test of such consistency."**

These words appear in the diary entry (March 19, 1849) of Michael Faraday (1791-1867), reflecting his thoughts shortly after he began to think that a relation existed between gravity and electricity.

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## CONSUMER ISSUES

### Fluoride: are concerns justified?

*We come into contact with fluoride every day through our toothpastes and—in many parts of the country—through our water supply. Is it safe? Not everyone thinks so. HealthWatch member Dr Karel de Pauw, a consultant and senior clinical lecturer in psychiatry at St James' University Hospital in Leeds, approached HealthWatch for advice on some information which appeared recently in the alternative health column of the Sunday Times. His correspondence with Dr David Bender follows.*

Dear Sirs

I was intrigued by the following in the "Style" supplement of today's *Sunday Times*: In her column, Hazel Courtney discusses the dangers of fluoride, claiming that:

- "Since 1997 the [FDA]...has required a poison label on all toothpastes containing fluoride"
- "In July 1997...the union of 1,500 government scientists working in the US [Environmental Protection Agency] issued a statement saying: 'Our review of the evidence...indicates a causal link between fluoridation and cancer, genetic damage and neurological impairment'"
- it's "...already in most toothpastes, mouthwashes, some medicines (Prozac is fluoxetine), anaesthetics, pesticides..."

As a clinical psychiatrist I was particularly intrigued by the latter claim.

She also refers concerned readers to National Pure Water Association (NPWA) website for "the huge body of evidence" on the dangers of fluoridation: <[www.npwa.freemove.co.uk](http://www.npwa.freemove.co.uk)> Her own views can be sought at <[www.channelhealth.net](http://www.channelhealth.net)>

Any comments?.

Karel de Pauw

### The reply we publish here is from Dr David Bender,

Dear Dr de Pauw,

Your email about fluoride toothpaste labelling in the USA has been passed on to me. They do seem to be concerned about ingestion of too much fluoride. It has long been known that while up to about 1 part per million of fluoride in drinking water gives protection against dental caries, in areas where the natural fluoride level is greater than about 10 parts per million there is a problem of dental fluorosis—brown mottling of the teeth—and at higher levels of intake there is also skeletal fluorosis, which can lead to fragile/brittle bones. I do not know of any evidence linking fluoride with cancer, genetic damage and neurological impairment. There have been a number of reports of an increased incidence of fluorosis associated with children given fluoride tablets, as well as using fluoride-containing toothpaste and having fluoridated drinking water. It is also relevant to note that since the widespread introduction of fluoride toothpaste in this country, there has been such a drop in dental decay (especially among children) that two London dental schools (the Royal in Leicester Square and the University College Dental School) have closed.

While FDA is concerned about excess fluoride intake, I note that the most recent US Dietary Reference Intakes for calcium, etc (Institute of Medicine, National Academy Press, Washington, 1997) devote considerable space to recommended levels of fluoride intake, followed by a warning about possible toxicity. The full FDA labelling document for fluoride-containing toothpaste, rinses, etc, can be downloaded from the FDA website

(<http://www.fda.gov>). The relevant part is reproduced below. I hate to think how they manage to get that on a toothpaste tube—let alone whether anyone reads it!

As to the National Pure Water Association—there has been a vociferous opposition to fluoridation of drinking water ever since it was first suggested (I think in the 1950s) when it was observed that children in areas where the drinking water naturally contained about 1 pp fluoride had less dental decay than those with lower fluoride intake..

### Prozac fears

You asked about the claim that fluoride is in medicines (including Prozac) and anaesthetics. This is incorrect, but an understandable mistake.

What is present in many anaesthetics and medicines such as Prozac (and many others) is the chemical element fluorine, as an integral part of the chemical structure of the drug. This is very different from either the fluoride ion (as in toothpaste, added as sodium or tin (stannous) fluoride) or fluorine gas (which is a highly corrosive gas, much worse than chlorine). Neither fluorine nor fluoride is released from such drugs when they are metabolised.

In passing, it is relatively common to introduce fluorine into chemical compounds being designed as drugs and medication by, usually in replacement for hydrogen, since it occupies the same space, and the resultant molecule fits naturally onto the receptor or enzyme that is being targeted, but behaves differently when bound.

I think that you can reassure your patients that there is no danger of fluoride poisoning from use of medicines containing fluorine as part of the structure, such as Prozac. In any case, the amounts are minute compared with the fluoride obtained from drinking tea (which is a rich source, regardless of whether or not it is made with fluoridated water.)

Yours  
David A Bender  
Dept of Biochemistry and Molecular Biology,  
University College London,  
Gower St, London WC1E 6BT

## The US FDA labelling regulations for fluoride-containing toothpaste and rinses:

### Labels must contain:

**For all fluoride dentifrice (gel, paste, and powder) products.** "Keep out of reach of children under 6 years of age. [highlighted in bold type] If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away." These warnings shall be used in place of the general warning statements required by Sec. 330.1(g) of this chapter.

**For all fluoride rinse and preventive treatment gel products.** "Keep out of reach of children. [highlighted in bold type] If more than used for (select appropriate word: 'brushing' or 'rinsing') is accidentally swallowed, get medical help or contact a Poison Control Center right away." These warnings shall be used in place of the general warning statements required by Sec. 330.1(g) of this chapter.

### Directions

**The labelling of the product contains the following statements under the heading Directions:**

**For anticaries dentifrice products** (i) Gel or paste dosage form with a theoretical total fluorine concentration of 850 to 1,150 ppm identified in Sec. 355.10(a)(1), (b)(1), and (c)(1). Adults and children 2 years of age and older: Brush teeth thoroughly, preferably after each meal or at least twice a day, or as directed by a dentist or doctor. Instruct children under 6 years of age in good brushing and rinsing habits (to minimize swallowing). Supervise children as necessary until capable of using without supervision. Children under 2 years of age: Consult a dentist or doctor.

**For acidulated phosphate fluoride solution** containing 0.01 percent fluoride ion and sodium fluoride 0.02 percent aqueous solution identified in Sec. 355.10(a)(3)(ii) and (a)(3)(iii). Adults and children 6 years of age and older: Use twice a day after brushing your teeth with a toothpaste. Vigorously swish 10 milliliters of rinse between your teeth for 1 minute and then spit out. Do not swallow the rinse. Do not eat or drink for 30 minutes after rinsing. Instruct children under 12 years of age in good rinsing habits (to minimize swallowing). Supervise children as necessary until capable of using without supervision. Children under 6 years of age: consult a dentist or doctor.

Source: FDA website (<http://www.fda.gov>).

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## MEDIA

### Could dental extraction really do more harm than good?

***A recent Channel 4 programme included the claim that at least 20% of the population had had their faces spoilt by orthodontic extractions. The programme caused much distress amongst patients undergoing orthodontic treatment involving the extraction of teeth, says consultant orthodontist Keith Isaacson. Yet the evidence to back up this and other alarming statements was lacking. Mr Isaacson attempts here to put the record straight.***

In a Channel 4 "Dispatches" programme on 2 December 1999, heralded by emotive comments such as "What can go wrong with your children's teeth," a Mr John Mew was interviewed giving his views on Orthodontic treatment. Mr Mew is a General Dental Practitioner. He challenges many of the current practices in Orthodontics, suggesting that damage can occur as a result of extraction of healthy permanent teeth.

To back his claim, he showed two twins, now adults, who had both had orthodontic treatment when they were children many years ago. One had had orthodontic treatment which included the extraction of permanent teeth, and the other had been treated with orthodontic appliances alone. Mr Mew claimed that as a result of this, the facial appearance of the twin who had had teeth extracted as part of their orthodontic treatment, had been spoiled. Although we were told that the twins were identical, Mr Mew himself admitted that their teeth were not identical at the start of treatment, and the initial documentary evidence was restricted to family-type photographs. Mr Mew's premise is that using functional appliances which stretch and widen the jaws, had the following advantages: The patient's jaws could be made to grow.

- The patient's breathing could be improved.
- Their facial appearance could be improved.

He made the claim that orthodontic extractions have an undesirable effect, namely:

- Headaches, possibly migraine.
- Pain of the jaw joint.
- Spoil the patient's appearance.

He showed, as an example, a photograph of Princess Anne, illustrating how her jaws would have been improved if she had had treatment carried out by himself implying that her facial appearance had been spoiled by the extraction of teeth for orthodontic purposes.

Mr Mew said that at least 20% of the population had had their faces spoilt by orthodontic extractions and when asked where his evidence was for this, he could but quote that he, "could see it anywhere by looking at people in buses, trains and in public places." In the programme, he was supported by two General Practitioners in the United Kingdom. Each showed a single patient who was experiencing headaches or jaw problems and each patient told us that this was as a result of having extractions for orthodontic treatment.

Throughout the whole of this first part of the interview, Mr Mew was treated with deference and respect by the interviewer. The view of the British Orthodontic Society was put forward by Dr Harradine, a Consultant at Bristol Dental Teaching Hospital. The attitude of the interviewer was clearly different and much more probing. Dr Harradine pointed out that the current teaching both in Britain and America is that extractions are required to relieve crowding in a number of children. On behalf of the programme, a survey had been carried out of 150 patients, children who had had orthodontic treatment and 56% of these had had extractions. This was a higher percentage of extractions than Dr Harradine had estimated. However, this was a patient-based survey and it is unlikely that patients would differentiate between the extraction of deciduous teeth (which are normally going to be shed in any case) and the extraction of permanent teeth.

At no time was Dr Harradine given any opportunity to show any patients treated by modern orthodontic means.

The programme was heavily biased in Mr Mew's favour with the emphasis being that there was an alternative form of treatment (not available on the Health Service) and that patients were being denied the choice of this alternative treatment by conventional Orthodontists. The fact that this is based on anecdotal evidence and not on, randomised, controlled studies and evidence-based dentistry, was completely ignored. This programme has caused much distress amongst patients who are currently having orthodontic treatment involving the extraction of permanent teeth. Considerable concern is also shown by new patients commencing treatment. Orthodontists all over the country have had to spend much time reassuring their patients. This is an example of how a television programme making unsubstantiated claims can cause problems and concern for many patients. It is extremely unlikely that there is a world wide conspiracy of all academic orthodontists, and that they are wrong and John Mew is correct.

Mr K G Isaacson FDS MOrth RCS  
Consultant in Orthodontics  
Mr R T Reed BDS FDSRCPGlasg FDS MOrthRCSEng  
Consultant in Orthodontics  
The North Hampshire Hospital  
Aldermaston Road



See also letter from Dr John Mew in [Newsletter no 40](#)

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## LETTER

### Cranial Osteopathy: detrimental effects a coincidence?

*Richard Pitcairn-Knowles, HealthWatch member and recently retired osteopath, writes:*

Sirs

The publication of the article "Therapeutic Adventures: Cranial Osteopathy" in the May issue of the Health Watch Newsletter ([Newsletter 37](#)) is well timed to coincide with the coming into force on 9th May of the Parliamentary Osteopaths Act (1993) and the establishment of the statutory register by the General Osteopathic Council (GOsC).

Every single osteopath in the country has undergone a rigorous investigation by the GOsC into his or her capabilities and qualifications before being accepted for registration, with the emphasis being on protection for the public.

The osteopathic profession has taken the lead and is the first in complementary medicine to achieve statutory registration. From 9th May anyone purporting to practise osteopathy and who is not listed on the GOsC register is committing a criminal offence.

One must have sympathy for Mr X but, as a member and keen supporter of Health Watch for many years, I was sorry to see this article at this time. But it does give the opportunity to discuss the efficacy of osteopathy.

Firstly though it must be pointed out that Mr X's observation, "I appeal to all readers to consider that therapeutic intervention may be worse—much worse—than useless" is sound advice to anyone considering any treatment. Over recent years this possibility has become displaced by the demand, "Something must be done." So much can now be done that patients' expectations are high, to say the least. Only with that very useful diagnostic tool, hindsight, can Mr X suggest that regular consultations twice a year with his GP might have helped him bear his suffering but I doubt that, "Knowing my GP would not forget me might have enabled me to stop my ears to the siren song of Fringe Therapy, and given me the strength to do nothing." Although Mr X had had pain on the right side of his face for 25 years when he consulted the nameless osteopath he apparently still had hopeful expectations, so much so that he continued treatment with this man for another four years in spite of the unpleasant effect of now having pain on both sides of his face. Why did both the therapist and the patient continue for so long treatment that was ineffective/detrimental? This osteopath was struck off the old Register of Osteopaths but could continue to practice as an unregistered osteopath until he died. Mr X will be glad to know that under the new Act of Parliament this would now be a criminal offence.

The nitty-gritty as far as Health Watch is concerned regarding this unfortunate story is...Is cranial technique used by osteopaths safe and effective? Many patients apparently achieve very successful outcomes. Shouts of "anecdotal!", "placebo!" Mr X received detrimental effects. May I reply "coincidence!?" Factual research is desperately needed but the one point I must make is that if cranial technique is ineffective why did it have such a disastrous effect on Mr X? If it is proved to be effective how can it be made safer? Remember always, any intervention, medication, surgery, osteopathy or whatever, will have a degree of risk which cannot be entirely eliminated.

Yours  
Richard Pitcairn-Knowles

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