

Newsletter no 46: July 2002

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Error message

The editor is grateful to readers who pointed out the following errors in this issue of the Newsletter, and offers her apologies.

In Michael Henk's article on [prostate screening](#) the editor of the Western Medical Journal is in fact Gavin Yamey, and not Lamey or Vamey as referred to in places; [on page 2](#), the originator of biodynamic farming was Rudolf, not Joseph, Steiner; and on the [letters](#) page we incorrectly referred to Iain Chalmers, of the Cochrane Collaboration, as Professor. He is, of course, a knight.

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Baum to receive award

HealthWatch is delighted that Michael Baum, one of the country's leading cancer surgeons and an outspoken campaigner for informed consent in breast screening, will accept the HealthWatch Award at this year's Annual General Meeting.

Professor Baum was one of the originators of HealthWatch when, 12 years ago, he told Nick Ross of tragic cases he had seen at his cancer clinic-patients whose condition had deteriorated to a horrific degree after shunning conventional treatment in favour of alternative therapies.

Now Professor Emeritus of Surgery at University College London and Chairman of the Cancer Research Campaign's breast cancer trials group he is fearlessly controversial in his criticism of the quality of information currently available to women considering breast screening. The title of his talk will be "Breast Screening-a cruel deception?"

This year's AGM will be at 6.30 pm on Wednesday 30th October at the Medical Society of London, Lettsom House, 11 Chandos Street London W1.

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Entrants invited for HealthWatch protocols competition

Training colleges up and down the country are inviting students of medicine, nursing and complementary medicine to prove their research and evaluation skills by entering the first HealthWatch competition.

The HealthWatch Prize for Critical Appraisal of Clinical Trials Protocols offers first prizes of £500 and five £100 runner-up prizes to undergraduates in each of the three categories named above.

Potential entrants are invited to download the competition entry form from the HealthWatch website (or apply by post to Dr Joan Gandy, PO Box 246, Pinner, Middx HA5 3WD). They will receive protocols, drawn up by an eminent panel of judges, for clinical trials of four very different complementary therapies including biomagnetic

necklaces, and lotions for spot-reduction of fat. The entrants' task is to identify flaws in the trial design, suggest improvements or, where appropriate, explain why a trial is fatally flawed.

This award is sponsored by a grant from the AJAHMA Charitable Trust, Registered Charity 273823.

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Why can't CAM be researched properly?

Anyone who believes that the principles of science and evidence-based medicine cannot be applied to complementary and alternative treatments would be hard pressed to explain why after reading a paper by Edzard Ernst published recently in the Journal of the Royal Society of Medicine.

Professor Ernst, who heads the Department of Complementary Medicine at the University of Exeter, has taken the eight most common objections to subjecting CAM practices to clinical trial and, one by one, explained why he believes they are unfounded. This armoury of persuasive answers to views commonly expressed by proponents of CAM will be welcomed by HealthWatch members keen to defend our organisation's aims.

Journal of the Royal Society of Medicine 2002; 95 (April): 211-213.

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New clinical trials web resource

The British Medical Association has recently added to their website a resource page on clinical trials. Its aim is to improve general knowledge about trials and increase participation of both doctors and patients. Readers are linked to appropriate organisations for more detailed information, and HealthWatch were pleased to be approached recently to be included on its list of useful websites. Visit the new page on <http://www.bma.org.uk/ap.nsf/Content/ClinicalTrialsWebsites>

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News and comment

Understanding the public's MMR fears by Neville Goodman

The MMR debate has gone quiet, but it won't stay that way. No debate better illustrates the gap between the careful consideration of medical evidence and its emotional rejection. Similarly, the debate shows how medical evidence looks quite different through different eyes. Some would say it also shows the uncertainty of the evidence, because they reject it. The correspondence columns of the newspapers and medical journals, especially the electronic letters to the British Medical Journal every time any article appears on the subject, are full of letters from parents of damaged children and other single issue advocates, who, I fear, will never be swayed by any evidence, however compelling.

When every official body and society that has an interest supports the MMR vaccine as the best way to protect our children, rejecting it is to imagine a deep conspiracy. But fearing MMR does have a logical basis, which doctors must not overlook. Whichever way one looks at it, and however it is presented, giving consent to a vaccine puts one's child at risk for no obvious benefit to the child. Standing back, the risk-benefit to society is clearly in favour of MMR, but parents can have difficulty standing back. After all, herd immunity-which is the benefit-depends on a take-up of 95%; if one can be one of that 5%, then the benefit is gained without the risk.

Science is at the heart of the MMR debate, as it is of the debate about whether screening mammography saves lives. Sense will be made only if the media and the public understand the nature of scientific knowledge, and understand that the truth (or the closest approximation to it) does not depend on who can shout loudest or longest, or write the most letters to the newspapers. This gives scientists and doctors a large responsibility, and recent developments may not bode well. Newspapers, whether for the general public or for the medical profession, select and edit what is said to them. According a Hospital Doctor story titled "Call for 'radical rethink' on medical education" (6 June 2002), Professor George Alberti, soon-to-retire President of the Royal College of Physicians, said that the current science-based model did not train doctors to put patients first. This statement is, of course, taken out of context, but it is as alarming as it is meaningless. What does "putting patients first" mean? Does it mean allowing parents to have their children inoculated with single vaccines? And if there is less science, how will future doctors be able to advise their patients which treatments are best?

Nor do I agree that a "radical rethink" is necessary. It is not long ago that the GMC heavily revised its ideas on the medical curriculum. We are in the process of expanding the numbers of medical students in the established medical schools, as well as setting up a number of new medical schools. It is already unclear exactly who will teach them. What with all the other upheavals in the NHS-a new one seems to be announced monthly by the government-the last thing we need at the moment is radical anything. We just need to work on what we've got, and convincing parents of the best way to protect all our children from diseases that kill and maim is a good

place to start.

Neville Goodman
Consultant Anaesthetist
Southmeads Hospital, Bristol

See the on-line review of the evidence: [MMR and Autism - can a controversy be more one-sided?](#) by Michael E Allen, HealthWatch Press and Information Officer

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NEWS IN BRIEF

Georges Charpak, winner of the 1992 Nobel Prize for Physics, has co-authored a rapid guide to making a fortune out of a gullible public. He and co-author Henri Broch went to great lengths to convince themselves that all mystic arts were based on trickery, natural circumstances or mathematical probability. Fooling people is easy, according to the book *Devenez Sorciers, Devenez Savants (Become Wizards and Wise Men)*: just generalise. When a single astral chart was used to define the "individual characters" of students, 69% were convinced it was accurate: a better result than analyses by professional psychologists.

The Guardian, 5 June 2002

Train carriages might concentrate trapped radiation from cellphones. The electromagnetic field in some train carriages which in Japan are often packed with people surfing the web on their mobile phones-could exceed the maximum exposure level recommended by the International Committee for Non-Ionising Radiation (ICNIRP) even if the train is not crowded, says an expert from Tohoku University in Sendai, Japan currently based at Paris' Curie Institute. However a consultant from the British government's Stewart enquiry into mobile phones and health risks, while conceding that microwaves will bounce around inside carriages and boost field levels, says the increase should be minimal, because power drops off a short distance away from each 'phone.

New Scientist, 1 May 2002

The PLACEBO effect is so powerful that it could result in addiction. In a review in *Lancet Neurology* scientists at the University of British Columbia in Vancouver note that the placebo effect can be very powerful in neurological disorders such as pain, depression and Parkinson's disease. The effect is, as one would expect, related to the expectation of clinical benefit, and the evidence suggests that it is mediated by dopaminergic reward mechanisms in the human brain. Such a mechanism of action suggests that placebos could be valuable in long-term substitution programmes for the treatment of drug addiction. This implies the potential for placebo addiction but, add the authors, such a reduction in the use of illicit drugs would still be a major achievement for health and society.

Lancet Neurology 2002; 1: 85-91.

Organic farmers are receiving government grants to adopt a mystical approach which includes planting crops according to the moon's movement through the signs of the zodiac and burying a cow's horn in the earth twice yearly, says the *Sunday Times*. The number of farms in the country following the the biodynamic creed-a holistic approach championed by the Austrian-born philosopher Joseph Steiner-has doubled in the past four years. The Department for Environment, Food and Rural Affairs, which aims to triple the amount of land devoted to organic cultivation by 2006, now helps support many of our estimated 80 biodynamic farms.

Sunday Times, 28 April, 2002

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Opinion

MISTLETOE HAS FAILED THE CANCER TEST, BUT YOU MIGHT NEVER HAVE KNOWN IT

Dr Colin Brewer reports on a German study that failed to find any benefit from injecting mistletoe extract and considers the results are highly unlikely to be reported in the press

Like most doctors, especially those with an interest in medical history, I have nothing against plants or herbs. They have provided us with many useful compounds and will doubtless provide quite a few more. However I absolutely reject the notion that just because something is herbal it must be effective, and the allied notion that the more exotic the plant, the greater the efficacy. In short, I am all for plant science as opposed to plant magic. I am also a great fan and sometimes a deliberate user of the placebo effect but I believe the function of placebos is primarily to deceive patients, not their therapists.

Mistletoe is an obvious candidate for plant magic, deeply embedded as it is in our folk history and potentiated by its association with druidic mysteries on the one hand and yuletide lechery on the other. Perhaps because it is itself a kind of "growth" albeit on a tree, mistletoe extracts have been used and recommended for the treatment of cancer. As usual, enthusiasm for mistletoe by its advocates is inversely proportional to the amount of evidence for its effectiveness but it is a characteristic of alternative practitioners that they don't usually let anything as boring as evidence get in the way of a rattling good myth.

Of course, it's entirely possible that mistletoe contains a hitherto unrecognised anti-cancer drug of amazing potency and few side-effects. However, the null hypothesis requires us to start from the proposition that it has no beneficial effects at all. As always, only a clinical trial fairly comparing like with like can tell us whether the enthusiasm is justified.

A randomised multi-centre study¹ of mistletoe extract involving 495 patients has recently taken place in Germany, where mistletoe seems to be popular (possibly because in a fee-per-item medical system, treatments requiring frequent injections are nice little earners). The patients all had squamous cell carcinoma of the head and neck, which has the advantage of being much easier to observe and measure (and without special techniques) than cancer affecting internal organs. After having either surgery alone or surgery plus radiotherapy, they were randomised to either twice-weekly subcutaneous injections of mistletoe extract for four three-month cycles separated by four weeks, or to no mistletoe. Understandably, no placebo injections were given and therefore the study was not blinded. However, since largely objective outcome criteria were used, this is arguably not crucial. After all, you can hardly get any less subjective than death vs survival and if the placebo effect were important, one would expect it to favour the mistletoe group, especially since injected placebos are usually more effective than oral ones. Median follow-up was 40 months. The final result? "No statistically significant differences in disease-free survival, overall survival, immune system markers or quality of life could be detected."

One reason for writing this piece is that the ineffectiveness of mistletoe is unlikely to be headline news in the journals of the alternative medicine movement. They remind me of the people who wanted to publish a newspaper which contained only good news. They also remind me of the sort of people-rather numerous, now I come to think of it-who are happy to praise their particular deity when someone recovers from a serious illness or when there is a plentiful harvest but are oddly reluctant to curse him when someone dies or when famine and earthquakes devastate the land. For many people, alternative medicine clearly is a kind of religion but its benevolent deities reside in plants, meridians or homoeopathically diluted molecules, rather than in more theologically conventional abodes. Unfortunately, to paraphrase the Duke of Wellington, if you can believe in a benevolent deity, you can believe in anything. And you may have to, if the delusion is to be preserved intact.

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Reference: Steuer-Vogt M, Bonkowsky V, Scholz M, Arnold W. Plattenepithelkarzinome des Kopf-Hals-Bereichs. Mistletoe-1-normierte viscumtherapie. [ML-1 standardised mistletoe treatment in patients with head and neck squamous cell carcinoma.] *Arzteblatt* 2001 (16 Nov); 46, 2585-7.

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The screening debate

Daring to question the value of prostate screening

Oncologist Dr Michael Henk thrusts his head above the parapet to discuss the contentious issue of screening for prostate cancer. Much in demand by consumer groups, the PSA test is not, however, a reliable indicator of the presence of cancer or, more importantly, of a tumour's aggressive tendencies. What is more, the treatment is very often more harmful than the disease.

It is a brave man these days who dares to point out where politically correct received wisdom is not in accordance with scientific evidence. Bjorn Lomborg, in his excellent book "The Skeptical Environmentalist" pointed out how facts and figures were at variance with many of the commonly held views on environmental issues. He has been rewarded by verbal and physical abuse from the environmental lobby.

Similar vilification has been heaped upon Michael Wilkes and Gavin Vamey, editor and deputy editor of the *Western Medical Journal*, based in California, who reported their experiences in the *BMJ* in February this year¹. Their offence? They wrote an article in the *San Francisco Chronicle* in response to a news item that a manager of a baseball team had had surgery for prostate cancer diagnosed "after a routine blood test". They dared to point out that the US Preventive Services Taskforce did not recommend screening for prostate cancer, and explained why. They immediately received a torrent of abusive letters and e-mails prompted by prostate cancer charities, who urged their members to "write to their bosses at the University of California and tell them to sack these impostors".

Wilkes and Lamey said that they had stepped on the toes of a powerful pro-screening lobby that stands to make

money from encouraging men to get tested. On the other hand much of the righteous indignation was no doubt genuine. The medical profession have put a simplistic view of cancer screening into the mind of the general public. It is that cancer begins as a small localised tumour, which grows and eventually spreads. If the cancer can be detected and removed at an early stage before there has been any spread it can be cured. Therefore detection of early asymptomatic cancers will save lives. This is a nice idea, but does not necessarily apply in practice. John Garrow pointed out in the HealthWatch Newsletter recently ([Issue 45, April 2002](#)) that the value of mammographic screening for breast cancer is questionable. In the case of prostate cancer screening almost certainly does more harm than good.

The first problem with screening for prostate cancer is the reliability of the method. It depends on measuring the concentration in the blood of a chemical-prostate-specific antigen (PSA). A low concentration of PSA is present in the blood of normal men. Its level rises by a small amount in benign prostatic hyperplasia, and to a greater degree in prostate cancer. Unfortunately there is no clear-cut cut-off level above and below which one can say with any certainty that prostate cancer is or is not present. Moreover there is inter-laboratory variability in test reporting. Hence many men are told they have a "raised" PSA, but on further investigation the result proves to be false positive, i.e. they do not have prostate cancer. Also, some of the most aggressive poorly-differentiated tumours give a false negative result.

The second problem is the natural history of prostate cancer. Many men have the "disease" without knowing it: it causes no symptoms during their lifetime, but can show itself as a small rise in PSA. Only a minority of prostatic cancers are aggressive and likely to cause symptoms, metastases or death. PSA screening therefore detects a large number of tumours that do not in fact need treatment. However, if a man is told that his PSA result indicates possible cancer, he will expect, and demand, that something be done. Treatment for localised cancer is either by surgery or radiotherapy, both of which are unpleasant and carry high risks of morbidity. Therefore, for every case of aggressive cancer that benefits from early detection there will be many more cases of latent cancers that are treated radically but unnecessarily. Cancer statistics from USA confirm this: between 1968 and 1995 the reported age-adjusted average annual rate of prostate cancer per 100,000 population rose from 40 to 120 while the death rate scarcely changed. The deleterious effects of PSA screening in North America are beautifully described by Ian Tannock in an article in *Lancet Oncology* bearing the satirical title "Eradication of a disease: how we cured asymptomatic prostate cancer"². Prof Tannock stresses how a man's quality of life is impaired, firstly by the knowledge that he has "cancer", and secondly by the morbidity of radical treatment, when in all probability he would never have developed any symptoms during his lifetime if the tumour had not been detected.

Until last year PSA screening was not available in the NHS. On 4 July 2001 the Department of Health introduced a new policy. The NHS will still not be inviting men for testing, nor expecting GP's to raise the subject with asymptomatic men. However, if a patient requests the test he should be provided with full information about the advantages and disadvantages. If he then requests the test it should be done by a laboratory participating in the National External Laboratory Quality Assurance Scheme. An excellent patient information leaflet is available from <http://www.nelc.org.uk>.

There was a BBC Breakfast News item on prostate cancer on 27 May. The background is the launch of Everyman Male Cancer Awareness Month, and the announcement of an initiative by the Institute of Cancer Research to investigate methods of predicting the behaviour of a cancer, i.e. determining whether it is likely to progress and therefore should be treated, or likely to remain latent and should not. Laudably, the BBC pointed out that probably at least 70% of treatments currently given for the disease were unnecessary. However, they began by stating that in four years' time prostate cancer will overtake lung cancer as the commonest cancer in man (true but mainly the result of increased detection and demographic changes), and ended by stressing the importance of early diagnosis, all calculated to increase the demand for screening. The following day *The Times* carried two articles on the same theme. Their Medical Correspondent, Dr Thomas Stuttaford, appeared to favour PSA screening, as he concluded his article thus: "It is suggested that those who administer the NHS dread widespread PSA testing because of its cost, but there is as yet no other way of setting in train the diagnostic process".

There is another aspect to this problem in Britain, not the cost of the test itself, but the demand on limited NHS facilities acting to the detriment of patients with other more curable types of cancer. The BBC news item appeared against background film clips of a linear accelerator and a radiographer planning conformal radiotherapy. Thirty years ago radiotherapy was scarcely used for treating prostate cancer, except for palliation of painful bone metastases. Enthusiasm for irradiating primary tumours grew in the USA in the 1970's and gradually spread across the Atlantic. Prostate cancer is a relatively radio-resistant tumour, so to have any effect radiotherapy must be given to a high dose. Such treatment has unpleasant acute side effects and carries appreciable risks of subsequent bowel and bladder complications. In order to minimise complications, much effort is being put into development and use of refined methods to limit the radiation dosage to the normal tissues surrounding the tumour. Such techniques are demanding on the use of expensive high-tech equipment and on the time of skilled radiotherapy staff. Now 10-15% of the workload of many UK radiotherapy departments is devoted to prostate cancer.

Despite the enthusiasm, evidence that radiotherapy can improve survival rates of localised prostate cancer is yet to appear. Claims for efficacy in many reports are based on "biochemical response", i.e. the PSA level falls after treatment. So what? Ten-year disease specific survival rates of around 75% after radiotherapy have been

reported, but similar or even better figures have been seen in untreated patients. There is a need for large-scale controlled trials comparing surgery, radiotherapy, and observation. Recruitment to such trials is difficult in the current media climate, because it requires an open mind on the part of both clinician and patient. The Medical Research Council attempted just such a study a few years ago. It was closed because of poor recruitment; only 11 UK patients were entered in 3 years, despite an estimate that over 3000 patients would have been eligible during that period. Similar trials are now in progress in North America and Sweden, which hopefully will provide better evidence³. Meanwhile, referrals to UK radiotherapy centres continue to increase. Waiting times for radiotherapy in many parts of the country are now as long as three months: during such a delay the prognosis of more rapidly growing cancers such as squamous carcinoma can worsen appreciably.

It is hard to escape the conclusion that until it becomes possible to distinguish aggressive from non-aggressive prostate cancer at an early stage screening will continue to do more harm than good. Meanwhile, men with no urinary symptoms should be advised not to demand a PSA test.

Michael Henk
Consultant Clinical Oncologist
Royal Marsden Hospital, London

References

1. Yamey G, Wilkes M. The PSA storm. *BMJ* 2002; 324: 431.
2. Tannock IF. Eradication of a disease: how we cured asymptomatic prostate cancer. *Lancet Oncology* May 2000; 17-19.
3. Moffat I. Randomized trials in early prostate cancer: requiem or renaissance? *Clinical Oncology* 2000; 12:213-214

Tailpiece One of the accusations levelled at Drs Wilkes and Lamey quoted in the *BMJ* was that they were propagating "geriatricide". If such a word existed it would mean "killing an elderly doctor". Perhaps the prostate cancer screening industry would wish thus to eliminate this author?

See also the HealthWatch position paper: [screening and checkups for healthy adults](#)

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SITES TO SEE

Future Health Bulletin

A free monthly e-mail publication specialising in health issues and including dozens of useful web links could be of interest to anyone who likes to delve deeply into issues they've just read about. Headstar.com is a group of journalists and other media professionals specialising in web communications and their new Future Health Bulletin is a free monthly e-mail publication comprising in-depth text articles about topical consumer health issues. The March issue included a feature about the danger of herbal and other medicines sold over the Internet, along with a whole library of links to sources of related information.

A quick scan of the group's main web site makes it clear that the people behind the site are in the PR business and not medicine—the Bulletin states that any publication may take and reproduce the articles in full and without payment, that is, they are press releases—however there is no attempt to disguise commercial links, and all sponsorships are clearly listed. The articles are well written and very readable and, thanks to the web links, these seem to be a useful research source.

Details of how to subscribe to the Future Health Bulletin are given on Headstar's health web site, along with access to back issues. Log on at: <http://www.headstar.com/futurehealth>

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Book review

Intoxication in the Glen

The detox diet: eliminate chemical calories and restore your body's natural slimming system by Dr Paula Baillie-Hamilton

Published by Michael Joseph, London, 2002. 395 pages. ISBN 0-718-14545-3. Price £12.99 (paperback)

Dr Paula Baillie-Hamilton (PB-H for short) gained a London MB BS in 1987, and then did PhD research at Christ Church Oxford, first on breast cancer and then on human metabolism. She married a Scottish laird, and now lives in the Highlands with their two sons. Each of the 25 chapters of her book is followed by a list of references, and at the end there is a short "Recommended reading" list that includes a textbook to which I contributed a chapter

on the effect of diet on weight change. So the book has all the trappings of a scholarly work.

She believes that the current epidemic of obesity is caused by "synthetic chemicals" of which there are 150 billion kg produced annually in the US (p 18). Each of us has on average approximately 300-500 industrial chemicals in our body (p 38). Every day the synthetic chemicals are engaged in an increasingly one-sided battle with our natural Slimming System (p 62) which, left to itself, will burn off our excess fat. It does this by adjusting the levels of hormones (thyroid and catecholamines) that direct us what and when to eat, and how much exercise to take. If we accumulate too much fat, our body burns up large amounts of energy by raising body temperature to a higher level than normal, and the heat can then be easily dispersed (p 55). Unfortunately, many of these synthetic chemicals are growth-promoters used in livestock rearing to suppress the production of fat-burning hormones and make the animals fatter. So the more synthetic chemicals we are exposed to, the more our thyroid hormones are damaged, and the fatter we will become (p 34). Now that we are warned of this dastardly situation we will understand why lettuce is more fattening than avocado. Lettuce is a fragile crop that is sprayed repeatedly with fattening pesticides and preservatives, whereas avocado is not, so in terms of "chemical calories" lettuce is more fattening than avocado (p 92).

Her solution, of course, is to revitalise our natural Slimming System (SS), expel the synthetic chemicals from our body, and then be vigilant to prevent them creeping back. To repair the SS we need supplements of nutrients at a far higher level than that required to prevent deficiency (p 178). Expelling the toxic load of synthetic chemicals involves the little-known fat cycle (p 183). She explains that body fat is broken down, taking with it organochlorines from adipose fat stores, some of which is secreted into the gut in the gastric juices. To prevent these toxins from being reabsorbed special carriers are added to the diet that bind the toxins so they are excreted. Therefore the detox diet involves heroic quantities of vitamins, zinc, magnesium, iron, co-enzyme Q10, linseed oil, evening primrose oil, tyrosine, 5HTP, methionine, glutamine, soluble fibre, charcoal and clay (pp 204 and 205). Ensuring that your intake of chemical calories does not replace those you are expelling is equally demanding. Chapter 23 lists thirty top tips to keep these chemicals at bay. Of course we must eat only organically produced food and filtered or distilled tap water. But would you have thought to install a household water filter to reduce the chemicals you will absorb through the skin from bath or shower water (tip 7)? Or to keep plastic objects packed away in well-ventilated rooms when not in use (tip 20)? Or to avoid plastic coated non-stick frying pans (tip 28)?

Many of the statements in this book are supported by sound experimental evidence. Yes, obesity is a very serious and increasingly important public health problem. Yes, the production and use of synthetic chemicals has increased tremendously since 1940. Yes, some agro-chemicals present a toxic hazard-for example the water of the Great Lakes in North America is so contaminated that salmon from these lakes, when fed at high concentration to rats, causes behavioural abnormalities that are not seen in control rats fed equal quantities of Pacific Ocean salmon. Yes, obese people have a higher body load of pesticide residues than lean people, because pesticide residues are soluble in fat.

But this is not evidence that these agro-chemicals have caused the global epidemic of obesity, or that obese people have a slimming system damaged by any environmental toxin. Indeed most of the evidence is against it. Obese people do not have higher food conversion efficiency than normal-weight people. Maintaining body temperature is not a regulator of energy balance in large mammals like man, as it is in small mammals like some laboratory mice. Livestock farmers do not use chemicals to make animals fatter, but to decrease the fat relative to lean meat. My chapter in the textbook recommended by PB-H explains how changes in body composition respond predictably to changes in diet in both lean and obese people, and does not invoke any control system vulnerable to environmental toxins. So I do not accept her conclusions.

Scientists need hypotheses on which to focus their research, and the idea of "chemical calories" is obviously very dear to PB-H. I am sure that her supervisors in Oxford taught her that the duty of a researcher is to search diligently for evidence against your most precious hypothesis, yet she continues to scour the Internet for evidence to support her hypothesis. On her website (www.chemicalcalories.com) she promises "several more books" to bring her devotees her latest findings about chemical calories. Here is an evangelistic researcher, academically isolated in her Highland glen, who is intoxicated by her hypothesis. To restore her to sober judgement she needs to consider the possibility that she is wrong, but I fear her case is too far gone to permit this therapy. This book is being reviewed, serialised and treated as serious science in the media. Unfortunately, people guided by her advice will avoid some nutritionally valuable foods (notably fruit, vegetables and fatty fish) for fear of ingesting "chemical calories", and will waste a lot of time and money trying to free themselves from hypothetical toxins.

John Garrow
Emeritus Professor of Human Nutrition
University of London

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Letters

Are orthodontists rejecting more effective alternatives?

From John Mew, specialist orthodontist and Clinical Director of the London School of Facial Orthotropics:

Dear Sirs,

I have really enjoyed the intellectual level of debate in recent Health Watch newsletters. I used to think it was leaning slightly too far towards orthodox medicine but recently I have been reassured that you have got the balance about right. Neither side should be blind to the merits of the other. In this respect I have concerns about certain aspects of current orthodontic treatment.

1. Most orthodontists feel there is little that can be done to change the facial bones other than by surgery; therefore they make few attempts to do so. As a result many children receive major jaw operations that might have been avoided. The evidence for this is that dozens who had been told, "there is no other option", have been successfully treated by alternate methods (case histories available on request). In many instances the results were clearly better than could have been achieved by surgery in the first place. The sad spin-off from this is that many other children who feel scared of operations, refuse orthodontic assistance and have to live with their disadvantage.

2. Most conventional orthodontic treatment is directed towards achieving straight teeth, but there is a risk that this can cause unattractive lengthening of the face. The evidence for this is overwhelming, although its extent may only be slight^{1, 2}. However in about 20% of cases, there is good reason to suppose that the patient's face looks noticeably worse following treatment.

3. Although most orthodontists do not accept that the growth of the jaws can be influenced, they would all agree that if it were possible, treatment should start by eight or nine years of age. However treatment is usually postponed until eleven or twelve by when it may be too late to avoid extractions or surgery.

4. Despite the above, the orthodontic lobby is so strong that the General Dental Council who are responsible for representing the public's interest, has refused to take any action although they are aware that only about ten percent of orthodontists warn their patients that there is a risk of facial damage and only about five percent inform them that alternative methods exist³. Who, one might ask, is going to tell the public?

The orthodontic establishment do not seriously contest these views but are angry that they are being raised outside the profession. I myself had a fairly conventional training, however I came to see the logic behind some of the alternate methods. It goes like this; "Apart from accidental damage, disproportionate jaws were virtually unknown amongst our direct ancestors of 20,000 years ago although they are common amongst all industrialized populations now". There is little doubt that faulty jaw growth is a lifestyle problem and my work is now based on assisting patients to overcome this. It is very difficult to change life-style, and treatment based on achieving this is highly dependent on the co-operation of both the child and their parents with the result that I have many failures. However this is no reason to close our eyes to the possibilities. Given the co-operation, the research has shown that the successful results go way beyond those achieved by conventional means.

If anyone is interested in further information I can be contacted on john.mew@virgin.net, or fax 01435 862445.

Yours sincerely
John Mew

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2. Lundstrom A and Woodside DG. European Journal of Orthodontics 1980; 2: 65-79.
3. 1998 research by Audience Selection, 14-17 St John's Sq, EC1M 4HE.

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Letters

Evenhandedness debate continues

David L. Crosby, Honorary Consultant Surgeon at the University Hospital of Wales, writes in response to a letter from Professor Iain Chalmers of the UK Cochrane Centre, which appeared in [issue 45](#):

Dear Editor

Professor Iain Chalmers is right. We should not have double standards when we criticise complementary and alternative medicine that is bereft of any sound evidence of its effectiveness. Much "orthodox" clinical practice is similarly deficient-counselling, health visiting, physiotherapy and health screening-to mention but a few. However, that is no justification to accommodate CAM within the NHS, which unfortunately has already been happening on an unprecedented scale. Indulging in CAM is plainly an individual's privilege and choice, but it should not be at the tax payer's expense. We should also continue also to support the view that treatment already provided on the NHS should be subjected to ongoing vigorous scrutiny. Dr John Garrow's recent article on

screening (HealthWatch Newsletter issue 45) was an excellent example.

Yours sincerely
David L Crosby

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Letters

Breast cancer: survival rate figures can be misleading

In the personal correspondence that followed a recent HealthWatch Newsletter article on the subject of breast cancer, Sir Iain Chalmers made a point that we felt would clarify an important issue for readers:

Dear Editor

It is important to distinguish between prognosis and the extent to which treatment affects prognosis. A reference to "regular treatment with its 80 or 90 per cent chance of survival" implies that the treatment is responsible for these high chances of survival. Although treatment contributes to this prognosis, it is grossly misleading to imply that it is responsible for preventing death in all but 10-20 percent of women with breast cancer.

Yours sincerely
IAIN CHALMERS

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Last word

On-line healing

According to the web site, electronic healing is "a new complementary therapy for diagnosing and healing energetic imbalances in the human body". It is a "computer based therapy to dispense natural medicines...and synthesize them with colour, light and sound treatment into a hybrid electronic pill (e-pill). The medicine is compiled into e-Capsules which are multimedia treatments sent over the Internet to be taken on a computer." Being interested in the uses of computers in teaching medical and other students, HealthWatch committee member David Bender could not resist investigating further.

This really sounds impressive - we are told that electronic medicine combines a number of therapies into one complete system: homoeopathy, radionics, flower remedies, Chinese herbal medicine, colour and gem therapy, sound treatment, nutrition and vitamin testing, allergy and toxic scanning and kinesiology. The process depends on a "Harmonic Treatment System", which we are told is a psionic device that became available in June 2001 - and elsewhere on the web site the helpful glossary tells us that a psionic device is a tool for the manipulation of energy. After the diagnosis is complete, and the treatment has been created, the Harmonic Treatment System outputs the treatment in the form of frequency shifted synthesized sound (homoeopathic information is impressed on the sound), colour and shifting fractal graphics.

You do not even need a computer; the medicine can be taken as an e-Capsule sent by email, as a homoeopathic in tablet or water form, recorded onto an audio or video tape to use with a TV and VTR, or as a traditional Radionic treatment at a distance. This last method of dispensing worries me - how does the treatment get only to me and not to others in the path of the transmission?

I was intrigued by the thought of diagnosis from my computer to detect energetic imbalances in my mind, body and "subtle information structures", as well as energetically analysing my organs and organ systems, and running toxicity and nutritional scans. I was disappointed. If you want a diagnosis you have to send a hair sample in a new envelope by old-fashioned mail to an address in Brighton (together with a cheque for £30, although you can pay on-line). You also have to give your date of birth, say what is your vocation, and describe your condition and any current treatment. Obviously this information is important to reach a correct diagnosis based on a hair sample, and personalise the electronic treatment.

All was not lost. You can download the e-Dispenser and a sample treatment. There is a warning that this will take quite a long time, since the e-Dispenser is a very large file (7.31 MB); it installed painlessly on my computer, although it did add a number of system files.

On running the e-dispenser I was treated to a small window showing a pattern of coloured squares; this is presumably the colour and shifting fractal graphics, and a haunting but rather repetitive flute melody (this is presumably the frequency shifted synthesized sound, it could well have been generated by a sound synthesizer). I am afraid I was unimpressed, Windows media player produces very much more impressive colour patterns to accompany music.

Three free demonstration e-pills are available: detoxification, chakra balance and organ regeneration. I opted for

organ regeneration. I did not know which of my organs was in need of regeneration, but perhaps the program only regenerates organs that need it. I ran the e-dispenser about 3 weeks ago; to date I have not observed any changes in body function or mood. Of course, this may not have been a fair test of electronic healing, since I did not think I was in need of healing in the first place, and had I been ill or in a state of energy imbalance it might have helped.

David Bender
Senior Lecturer in Biochemistry
University College London

More in the interests of thorough reporting than promoting the site, the address is: <http://www.electronichealing.co.uk>

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