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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the *BMJ*.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Differences among Asian patients

SIR,—The past few years have seen an increasing interest in disease patterns among British "non-white" communities. Dr J K Cruickshank (13 September, p 696) has recently raised the important issue of how inadequately we distinguish between subgroups among them. Terms such as "Asian" do not acknowledge the vast diversity of such a heterogeneous population, with their different religious and cultural practices. There is an urgent need, among both researchers and editors, to start defining such groups more precisely if future studies are to be useful and comparable.

Since January 1985, 13 papers and 12 letters in the *BMJ* have referred to "non-white" communities. We categorised them according to how accurately the population under study was defined and analysed. Only four of the 25 articles adequately defined their "non-white" populations in terms of religious, cultural, and demographic factors.

The issues raised are much broader than simply producing tidier studies. Despite pleas to the contrary, the last national census did not include a

question on ethnic origin. The political and sociological concerns inherent in such data collection are far less applicable to medical research. Our own experience has been that patients are usually happy to provide details of their exact ethnic origin. Thus researchers do not have to resort to guessing an individual's origin from his name—a method that fails to identify West Indians and Christian Asians.

It is becoming increasingly apparent, at least among those originating from the "Asian sub-continent," that, in addition to genetic factors, nutrition and culture are important in disease pathogenesis. The evidence is particularly strong for diabetes mellitus, ischaemic heart disease, vitamin D deficiency, carcinoma of the mouth and tongue, and Indian childhood cirrhosis. But it remains unclear what the exact incidence and prevalence of most of these diseases are among different subgroups—for example, Bangladeshis, Christian Asians, Hindu Gujaratis, Hindu Punjabis, Ismailis, and Pakistanis. Inter-marriage, for example, which is much commoner among related Moslems than among Hindus, must have an important bearing on genetic disease predisposition. Social and dietary habits, which can vary widely even within subgroups, have made many nutritional studies difficult to interpret. The problem is unlikely to disappear with adaptation to a Western lifestyle by the younger generation because of their adherence to traditional diets.¹ A recognition of such widely varying cultural and dietary practices among the different communities may well prove to be important in increasing our understanding of disease pathogenesis.

Although we acknowledge that distinguishing carefully between subgroups may not always be appropriate, we believe that it helps rather than hinders the interpretation of most studies. The *BMJ* has tried to increase the awareness of its

readers to the lifestyles of ethnic minorities in the UK.² It would be helpful if journals could now ensure that, when appropriate, articles relating to groups derived from the ethnic minorities accurately define and evaluate them according to criteria that reflect their different geographic origins, religions, cultures, and, if relevant, dietary habits.

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1 Wharton PA, Eaton PM, Day KC. Sorrento Asian food tables: food tables, recipes, and customs of mothers attending Sorrento Maternity Hospital, Birmingham, England. *Hum Nutr Appl Nutr* 1983;37A:378-402.

2 Black J. *Child health in ethnic minorities*. London: BMJ, 1985.

How accurately Asian study population was defined in *BMJ* papers and letters since January 1985

	Well defined and homogeneous*	Defined but not homogeneous†	Not defined
Papers	1	4	8
Letters	3	2	7
Total	4	6	15

*Groups defined during data collection were homogenous in demographic, cultural, and religious factors; analysis compared homogeneous subgroups with each other and white controls.

†Asian and non-Asian subgroups defined during data collection but were not homogeneous; analysis referred only to "Asians."

Desensitising vaccines: an allergist's view

SIR,—The statement on desensitisation from the Committee on Safety of Medicines (11 October, p 948) was much needed and has at last drawn the attention of all doctors to the potential dangers of desensitisation therapy. While we agree with the statement in general, further points need to be made.

The present widespread and uncritical use of

desensitisation in the UK is wrong and needs to be changed. It is used to treat disorders (such as asthma in adults) and against allergens where there is no convincing evidence for its efficacy. This is irresponsible in view of the potential risks. We now have drugs, particularly topical steroids, which give excellent control of symptoms in most patients and have revolutionised treatment. If desensitisation was (a) not used as first line therapy in allergic rhinitis and (b) considered only in conditions where it is of proved value few patients would need to be given it.

Convincing evidence of efficacy in double blind placebo controlled trials exists for ragweed hay fever¹ (a problem in the USA) and allergy to bee and wasp venom² (but only when pure venom extracts are used) and probably for grass pollen allergic rhinitis.³ A single study of a small number of patients does not necessarily provide convincing evidence of efficacy. In the case of insect sting allergy, although there is no doubt about efficacy, the indications for giving immunotherapy are controversial⁴ and practice varies widely. In house dust mite allergy in adults conflicting results have been obtained,^{5,6} but overall there is no convincing evidence of efficacy. While there is some evidence of efficacy in children,^{7,8} the indications for its use in children are unclear. This allergen is a major problem, being the commonest cause of perennial allergic rhinitis in the UK. A further problem is that even when "efficacy" has been shown there is no study showing long term cure. This is confirmed in clinical practice, where improvement on desensitisation usually means reduction in symptoms, not cure, and this is not a long term effect. Since effective antiallergic drugs have become available, long term cure must now be the main aim of desensitisation.

In spite of the absence of evidence of the efficacy of house dust mite extracts in the treatment of allergic asthma, these preparations are often given. It is important to note that of the 26 deaths from anaphylaxis mentioned in the CSM report, 16 were attributed to desensitising vaccines given as treatment for asthma. These patients therefore died as a result of inappropriate therapy. The CSM report does not state how the reactions were treated, possibly because the information was not available. The immediate use of adrenaline is usually highly effective in anaphylaxis, but it is often not given until antihistamines and steroids have been tried, by which time the patient may be moribund.

There is a place for desensitisation therapy, and if extracts of proved value are used appropriately in carefully selected patients and administered by doctors and nurses with experience most severe reactions and deaths could be avoided. The CSM statement is likely to lead to a virtual ban on the use of desensitising vaccines, whereas what is needed is critical reappraisal. The lack of specialists in allergy compounds this problem.

Finally, the CSM update states there is "convincing evidence of efficacy" for "vaccines used to protect against anaphylaxis induced by some antibiotics." We are not aware that this is an accepted practice of proved efficacy and would like to hear further evidence from the CSM on this point. No such product is licensed in the UK.

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1 Lichtenstein LM, Norman PS, Winkenwerder WL. A single year of immunotherapy for ragweed hay fever. *Ann Intern Med* 1971;75:663-71.

2 Hunt KJ, Valentine MD, Sobotka AK, Benton AW, Amodio FJ, Lichtenstein LM. A controlled trial of immunotherapy in insect hypersensitivity. *N Engl J Med* 1978;299:257-61.

3 Frankland AW, Augustin R. Prophylaxis of summer hay fever and asthma. *Lancet* 1954;i:1055-7.

- 4 Ewan PW. Allergy to insect stings: a review. *J R Soc Med* 1985;78:234-9.
- 5 British Tuberculosis Association. Treatment of house dust allergy. *Br Med J* 1968;iii:774-7.
- 6 Newton DAG, Maberley DJ, Wilson R. House dust mite hyposensitization. *Br J Dis Chest* 1978;72:21-8.
- 7 Mite Allergy Subcommittee of the Research Committee of the British Thoracic Association. A trial of house dust mite extract in bronchial asthma. *Br J Dis Chest* 1979;73:260-70.
- 8 D'Souza MF, Pepys J, Wells ID, et al. Hyposensitisation with Dermatophagoides pteronyssinus in house dust allergy: a controlled study of clinical and immunological effects. *Clin Allergy* 1973;3:177-93.
- 9 Warner JO, Price JF, Soothill JS, Hey EN. Controlled trial of hyposensitisation to Dermatophagoides pteronyssinus in children with asthma. *Lancet* 1978;ii:912-5.
- 10 Aas K. Hyposensitisation in house dust allergy asthma. A double blind controlled study with evaluation of the effect on bronchial sensitivity to house dust. *Acta Paediatr Scand* 1971;60:264-8.

SIR.—The update from the Committee on Safety of Medicines on desensitising vaccines reported 26 deaths from anaphylaxis induced by these agents since 1957, with an apparent increase in frequency since 1980. The information is disturbing and the CSM is right to draw our attention to it. We are concerned, however, about the possible consequences of its recommendations.

Their information indicates that asthmatics are particularly at risk of developing anaphylaxis and bronchospasm. Since there is no good evidence yet that desensitisation ameliorates asthma, most responsible practitioners would not normally use this form of treatment in asthma. It is likely, too, that adequate precautions, such as adrenaline and hydrocortisone already drawn into syringes and supervision for at least 30 minutes, are by no means always observed in general practice, where the vast majority of desensitisation takes place. In addition, it is probable that polyallergic patients have been injected with mixes of multiple allergens, a regimen which is extremely unlikely to result in a beneficial outcome. All of these factors, together with a paucity of information from controlled trials, weight the risk-benefit equation away from desensitisation treatment.

There is clearly an urgent need for controlled trials of the effects of desensitisation. The British Society for Immunology might well be the body to coordinate this, possibly with funding from the Medical Research Council or the pharmaceutical industry.

Our concern is that even properly selected and supervised desensitisation treatment may now be regarded as suspect by referring doctors and patients, and that the necessary research to clarify the situation may have been compromised by the CSM's recommendations. We suggest that further discussion between the CSM and appropriate specialists should take place, which may lead to alterations in the present recommendations.

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Doctors and the drug industry

SIR.—May I thank Dr Richard Smith for his concise review (11 October, p 905) of the relationship between doctors and drug companies. The issue is indeed pressing. Clear thought and honest practice in the matter are hampered both by the apparent acceptability and normality of the present relationship and by failure to appreciate the special role, in commercial terms, played by the prescribing doctor.

Drug companies' "hospitality" is so widely accepted that doctors who do not eat drug lunches are thought odd or unsociable: if the drug lunch

becomes a weekly social event in a hospital the pressures to participate and partake are great. But, as the Royal College of Physicians committee says, drug lunches do indeed degrade doctors. Surely we are well enough paid to buy our own food and retain the possibility of independent assessment of drug company products. There is no such thing as a free lunch—on either side: for the events also degrade the companies and cast doubt on the value of the products promoted. A good drug hardly acquires its value from the admixture of Muscadet and smoked salmon quiche.

But, it is said, this hospitality is simply normal commercial and business practice. There is, however, a major difference between the doctor-company relationship and the advertising of soap powder to the great clothes washing public. Doctors are not spending their own money but that of the payers of tax and prescription charges. They act, therefore, as buyers or agents. The person affected by the decision is not the prescriber. How much more, then, should we be making decisions unaffected by company "hospitality."

Doctors should be clear on these matters. We do not need gifts from the drug companies—ball point pens or Mediterranean holidays. Meetings to promote drugs should be just that—our principal sources of information on new and old drugs should be the *British National Formulary*, the *Prescribers' Journal*, and unsponsored reviews and research. Our patients and our professions cannot, ultimately, but benefit.

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SIR.—Dr Richard Smith's leading article was very critical of drug company lunches, dinners, teas, and sponsorship. These activities are accepted as harmless and not very important by most GPs. It is certainly in the interests of the advertising men that their hospitality is not taken too seriously or looked at too closely. Dr Smith concentrated on the bribery and corruption issue, and I think there is another important problem to be considered—the debilitating effect on the intellectual activities of GPs. When the status of learning for learning's sake has sunk so low that it has been renamed "postgraduate education" in horrid contemporary jargon I think we should worry.

A large proportion of the "education" of GPs takes place in the context of drug company hospitality of some sort. GPs, lured to a talk by a learned colleague, or more usually a company representative, take part with about as much dignity as a school child lured to do homework by promises of sweets or television programmes. The example set to young doctors is, "Only do it if you can get a free meal," and the moral for the savant is, "They'll only listen if you pay them." Why does it matter? Advertisements are a feature of most aspects of life, are they not? In fact we like to keep them out of things we think are really important, like unspoilt countryside and religion.

The drug company representatives do not deserve a life on the dole any more than steel workers or miners. To earn a crust they have to eat anonymous restaurant meals with strangers with whom they have to feign friendship, instead of in the intimacy of their own families. Family doctors should be the last people to encourage this sort of domestic disruption. One of the saddest aspects is that the real draw of the drug company dinner is probably the conviviality rather than the free meal. But alas for anyone who values friendship for its sincerity, or learning for its own sake. Most of us can live with very little dignity. We can live with the knowledge that we are being given a meal which many of our patients could not afford but which they would appreciate much more.