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 Gujuratis, Hindu Punjabi, Ismailis, and Pakistanis. Intermarriage, 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. 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. 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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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 treated.

Convincing evidence of efficacy in double blind placebo controlled trials exists for ragweed hay fever (a problem in the USA) and allergy to bee and wasp venom (but only when pure venom extracts are used) and probably for grass pollen allergic rhinitis. 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 controversial and practice varies widely. In house dust mite allergy in adults conflicting results have been obtained, but overall there is no convincing evidence for or against desensitisation in children. 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 rhinitis in children, desensitisation is still carried out. 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.
