herbal medicines are in fact the effects of other herbal material used in error. This type of mistake is typified by the irritatingly common practice of naming vincristine and related anticancer compounds as *Vinca* alkaloids although they are derived from *Catharanthus roseus*. Unfortunately, classical taxonomists and phytoanalysts do not have the same glamour and potential to attract money as some other scientists and so are an endangered species. Their demise will result in mistakes more serious than the one in the editorial.

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- 1 Linde K, Ramirez G, Mulrow CD, Pauls A, Weidenhammer W, Melchart D. St John's wort for depression—an overview and meta-analysis of randomised clinical trials. *BMJ* 1996;313:253-8. (3 August.)
- 2 De Smet PAGM, Nolen WA. St John's wort as an antidepressant. *BMJ* 1996;313:241-2. (3 August.)

Iron deficiency anaemia and febrile convulsions

Possible confounding factors include lead toxicity ...

EDITOR,—Alfredo Pisacane and colleagues report that they found an association between iron deficiency anaemia and febrile seizures in Neapolitan children.¹ They apparently failed, however, to consider the confounding possibility of lead poisoning in these children with hypochromic, microcytic anaemia and low serum iron concentrations.² lowers the seizure threshold,² and could easily account for the apparent association between "iron deficiency" and seizures in these children. Was this potential confounder adjusted for, or even considered, by the authors?

Additionally, the study began with 156 subjects, yet only 146 were commented on. What became of the missing 10 children? Were they excluded for some reason?

Finally, even if an association between iron deficiency anaemia and febrile seizures does exist, a case-control study cannot prove causation (which is hinted at in the concluding paragraph).

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- 1 Pisacane A, Sansone R, Impagliazzo N, Coppola A, Rolando P, D'Apuzzo A, et al. Iron deficiency anaemia and febrile convulsions: case-control study in children under 2 years. *BMJ* 1996;313:343. (10 August.)
- 2 Rudolph AM, ed. *Rudolph's pediatrics*. 20th ed. Stamford, CT: Appleton and Lange, 1996.
- 3 Johnson KB, ed. *The Harriet Lane handbook*. 13th ed. St Louis, MO: Mosby, 1993:222.

... and coeliac disease

EDITOR,—Alfredo Pisacane and colleagues report an increased incidence of iron deficiency anaemia in children under the age of 2 years presenting with febrile convulsions.¹ Although they considered confounding variables, they do not seem to have considered a known and linking condition for anaemia and fits. The literature, in both children^{2 3} and adults,⁴ documents an association between epilepsy, coeliac disease, and, intriguingly, intracerebral calcification. Some of this association may, of course, be due to the associated hypomagnesaemia and hypocalcaemia. Although the frequency of

coeliac disease in unselected patients with epilepsy is low (1%), we suspect that in an anaemic population it would be much higher. Because control of epilepsy improves with treatment,⁵ we would suggest that the authors screen the anaemic group for coeliac disease.

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- 1 Pisacane A, Sansone R, Impagliazzo N, Coppola A, Rolando P, D'Apuzzo A, et al. Iron deficiency anaemia and febrile convulsions: case-control study in children under 2 years. *BMJ* 1996;313:343. (10 August.)
- 2 Fois A, Vascotto M, Di Bartolo RM, Di Marco V. Celiac disease and epilepsy in pediatric patients. *Childs Nerv Syst* 1994;10:450-4.
- 3 Piattella L, Zamponi N, Cardinali C, Porfiri L, Tavoni MA. Endocranial calcifications, infantile celiac disease and epilepsy. *Childs Nerv Syst* 1993;9:172-5.
- 4 Ambrosetto G, Antonini L, Tassinari CA. Occipital lobe seizures related to clinically asymptomatic celiac disease in adulthood. *Epilepsia* 1992;33:476-81.
- 5 Cernibori A, Gobbi G. Partial seizures, cerebral calcifications and celiac disease. *Ital J Neurol Sci* 1995;16:187-91.

Authors' reply

EDITOR,—The suggestion that potential confounders such as lead poisoning and coeliac disease might be responsible for the association that we reported between iron deficiency anaemia and febrile convulsions is important. Because of the characteristics of our study, however, no data are available from the clinical records that might indicate whether lead poisoning or coeliac disease was present in some of the cases.

Nevertheless, even though iron deficiency anaemia has been associated with both these conditions, febrile convulsions have not. Seizures without fever can occur as a clinical manifestation of lead encephalopathy and of coeliac disease in association with cerebral calcification. However, children with febrile seizures are usually children who are well before and after the fit, and afebrile convulsions are uncommon among them.

We are now studying prospectively a large group of children admitted with their first febrile seizure to some hospitals in greater Naples. All of them had a good nutritional status both at the time of the seizure and one year later, with no clinical signs of lead poisoning or coeliac disease. Moreover, when only those children with a haemoglobin concentration of >110 g/l were considered, iron deficiency was considerably more common among cases than controls. That could mean that iron deficiency rather than anaemia is associated with febrile seizures. Obviously, the points raised in the letters about our report need attention, and no claim of causation should be made before more studies have been carried out.

Finally, we regret that the reason for the exclusion of 10 cases (the fact that no haematological data were available from the clinical records) did not appear in the final manuscript.

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Hormone replacement therapy for all?

Women must choose for themselves

EDITOR,—Philip Tooze-Hobson and Linda Cardozo assert that "there are three main reasons why many who would benefit do not take oestrogen supplementation," but they offer no evidence to support this assertion.¹ They then state that women who believe that the menopause is a natural event are wrong. Aside from being irrelevant to the merits or otherwise of using hormone replacement therapy, this view ignores the fact that the word "natural" has no defined meaning when applied as a descriptive epithet to biological processes. It simply conveys some of our health beliefs concerning the event. In other words, people may disagree about whether a process is natural or not according to what they understand by natural. The fact that the authors reject all other interpretations of the word but their own does not augur well for their sensitivity towards lay health beliefs or their patients' autonomy. My own belief is that to regard the biological processes of one phase of life as more or less normal than those of another is problematic. Indeed, recasting the menopause as a medical event by definition makes symptoms out of what might otherwise be experiences.

The central issue is whether the advantages of hormone replacement outweigh the disadvantages. It has been noted that the potential reduction in cardiovascular disease would have the greatest impact on health outcomes.² Clearly, relief of symptoms (if there are any symptoms and these are perceived as problematic) and a reduced incidence of stroke and fracture are also important. The disadvantages include possible increased risks of breast cancer, medicalisation, resumption of bleeding, and cost. People may be expected to give different weight to these risks and benefits, especially those concerning medicalisation. We should not be surprised that different women will make different choices or even disagree with our assessments. It is up to women to make these choices themselves. For clinicians to impose their view rather than to advise encroaches on patients' autonomy and exceeds the mandate of the doctor-patient relationship.

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- 1 Tooze-Hobson P, Cardozo L, Jacobs HS. Hormone replacement for all? *BMJ* 1996;313:350-2. (10 August.)
- 2 Daly E, Roche M, Barlow D, Gray A, McPherson K, Vessey M. HRT: an analysis of benefits, risks and costs. *Br Med Bull* 1992;48:368-400.

Arguments should be based on ratio of benefits to risks

EDITOR,—Philip Tooze-Hobson and Linda Cardozo assert that "some women believe that the menopause is a natural event and that taking medication (hormones) should be avoided. These women are wrong: oestrogen deficiency is the unnatural state."¹ Oestrogen concentrations normally change in childhood, the reproductive years, and postmenopausally, but nobody is suggesting that prepubertal girls are oestrogen deficient, so why should all older women be? It seems extraordinary that these gynaecologists wish to define all women over a certain age as being diseased and "wrong" if they do not concur with their diagnosis. The historical argument about increasing life expectancy is specious because the increase is largely due to falls in infant mortality, and women who have reached 50 have always had a life expectancy well beyond their menopause.