In this way, more data and findings from many countries will become available to researchers and practitioners worldwide. It will then be possible to surf across languages on home pages on the Internet.

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- 1 Global Health Network Task Force. Towards a global health network. *Current Issues in Public Health* 1995;1:160-4.
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Pancreatitis may occur with a normal amylase concentration in hypertriglyceridaemia

EDITOR,—Johan Hedström and colleagues report that the trypsin 2- α_1 antitrypsin complex is a diagnostic marker of pancreatitis.¹ This reminds us of a diagnostic problem that arose when only the serum amylase concentration was considered in a patient with severe abdominal pain.

A 39 year old Muslim man presented with severe generalised abdominal pain. The surgical team concluded that his amylase concentration (57 IU/l; normal 0-90 IU/l) excluded acute pancreatitis. He had non-insulin dependent diabetes, smoked 20 cigarettes a day, and rarely drank alcohol. He had bilateral supraorbital xanthelasma and a tender but soft abdomen. Investigations showed a random blood glucose concentration of 13.3 mmol/l, total cholesterol 14.7 mmol/l, and triglycerides >53 mmol/l in a non-fasting sample. An uncuffed calcium concentration was 2.04 mmol/l and plasma albumin 34 g/l. Triglyceride concentrations were subsequently measured in fasting samples (table 1).

Abdominal computed tomography confirmed pancreatic oedema associated with chronic pancreatitis. Pancreatitis secondary to hypertriglyceridaemia was diagnosed despite the normal plasma amylase concentration. After the administration of heparin (10 000 IU/24 h) his plasma amylase concentration rose and cholesterol and triglyceride concentrations fell. The fractional amylase:creatinine clearance ratio was 13.6% (normal 1-5%). Liver function and the clotting profile remained normal throughout. Ciprofibrate (100 mg daily) was given to reduce circulating triglyceride concentrations further by stimulating lipoprotein lipase.

Acute pancreatitis is diagnosed clinically, but the diagnosis often depends on the continued biochemical finding of an increased serum amylase concentration. In conditions with extensive pancre-

atic necrosis (acute fulminant or acute on chronic pancreatitis) or in the presence of hypertriglyceridaemia the amylase concentration may be normal or low.² The amylase:creatinine clearance ratio may be a more sensitive indicator of acute pancreatitis than serum or urine concentrations alone.

Low dose heparin (5000-10 000 IU/ml) stimulates lipase activity and reduces very low density lipoprotein and triglyceride concentrations through release of lipoprotein lipase bound to the epithelium, which metabolises circulating very low density lipoprotein particles. Although repeated heparin doses reduce plasma triglyceride concentrations,³ use of heparin in reducing hypertriglyceridaemia in the short term is not well recognised. In the short term heparin is responsible for release of lipoprotein lipase into the circulation, but prolonged use may result in a profound disturbance of lipoprotein metabolism and, paradoxically, hypertriglyceridaemia.^{4,5} In our patient continuous intravenous infusion of low dose heparin reduced the total triglyceride concentration from 53 mmol/l to 26.2 mmol/l within 12 hours.

We agree that clinical suspicion of pancreatitis should remain in patients with a normal serum amylase concentration,¹ particularly in the presence of hypertriglyceridaemia. Short term treatment with low dose heparin reduces the hypertriglyceridaemia.

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- 1 Hedström J, Sainio V, Kempainen E, Haapiainen R, Kivilaakso E, Schröder T, et al. Serum complex of trypsin 2 and α_1 antitrypsin as diagnostic and prognostic marker of acute pancreatitis: clinical study in consecutive patients. *BMJ* 1996;313:333-7. (10 August.)
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Getting a mummy's consent

Perhaps consent came from a relative ...

EDITOR,—Patrick D Horne and colleagues report the earliest published case of aspergillosis.¹ We note that the specimen featured in the photomicrograph was from Egypt, circa 1450 BC. Because the report was followed by Minerva's

statement that such submissions should include signed consent to publication from the patient we wonder whether Minerva received such consent in this case. If not, was it provided by the next of kin—perhaps the mummy's mummy?

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- 1 Horne PD, Summerbell RC, Redford S. Minerva. *BMJ* 1996;313:240. (27 July.)

... or was in hieroglyphics

EDITOR,—I was impressed that the authors managed to obtain the signature of a mummy recovered from the 1450 BC tomb of Parennefer at Luxor¹: was it in hieroglyphics?

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- 1 Horne PD, Summerbell RC, Redford S. Minerva. *BMJ* 1996;313:240. (27 July.)

Persistence sometimes pays off

EDITOR,—As an admirer of Minerva, I was disappointed with her lack of rigour in requesting consent to publication from an Egyptian mummy taken from the tomb of Parennefer.¹ In contrast, the persistence of two American agronomists, as recounted by Dean Griffin of St Patrick's Cathedral, Dublin, is exemplary.² Shortly after his election the dean received a letter from the two Americans addressed to a Dr Jonathan Swift. They requested permission to quote "from your recently published book *Gulliver's Travels*, New York, 1964." The dean, sensing a practical joke, ignored the plea.

Three weeks later a second, more urgent, mis-sive arrived, imploring Dean Swift to respond "as our publishers are pressing us with a view to securing a firm publication date." The dean replied: "Dear Agronomists, Jonathan Swift left this place in 1745, leaving no forwarding address. Where he is now God alone knows. However, in his place as Dean I am happy to give the permission you require."

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- 1 Horne PD, Summerbell RC, Redford S. Minerva. *BMJ* 1996;313:240. (27 July.)

- 2 *St Patrick's pantry: a recipe collection*. Dublin: St Patrick's Cathedral, 1991:122.

A dead man can't argue

EDITOR,—I read with interest the claim to the earliest published case of aspergillosis, in a mummy.¹ How remarkable that this mummy was able to give signed consent for publication of this submission. Perhaps the authors can provide some useful tips for those of us who are involved in tortuous dealings with ethical committees. But then again, a dead man can't argue....

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- 1 Horne PD, Summerbell RC, Redford S. Minerva. *BMJ* 1996;313:240. (27 July.)

Table 1—Biochemical results in patient with pancreatitis and hypertriglyceridaemia who was treated with heparin

	Amylase (IU/l)	Cholesterol (mmol/l)	Triglyceride (mmol/l)	Glucose (mmol/l)
On admission	57	14.7	>53	13.3
At 12 hours	ND	11.2	26.2	ND
Day 2	464	12.3	18.9	6.5
Day 3	56	10.4	9.9	4.9
Day 6	98	7.2	6.4	5.1

ND = Not done.