Author's reply

EDITOR,—I agree with Michael Clark that the only truly effective way of assessing any measure designed to prevent pressure sores is in a well designed randomised clinical trial.

C McCOLLUM
Professor of surgery

Department of Surgery,
University Hospital of South Manchester,
Manchester M20 8LR

Evening primrose oil

Does not show promise in atopic dermatitis

EDITOR,—We agree with Jos Kleijnen that evening primrose oil has not been proved effective in clinical trials but are surprised that he thinks that this treatment shows promise in atopic dermatitis.¹ As he points out, three trials of appropriate size have been published. The first indeed showed promise.² Two subsequent studies, however, both larger than the first, have not confirmed a response of atopic dermatitis to evening primrose oil, and the last of these, which we performed, was of the parallel group design that Kleijnen advocates.^{3,4}

JOHN BERTH-JONES
Consultant dermatologist

Walsgrave Hospital,
Coventry CV2 2DX

ROBIN A C GRAHAM-BROWN
Consultant dermatologist

Leicester Royal Infirmary,
Leicester LE1 5WW

- 1 Kleijnen J. Evening primrose oil. *BMJ* 1994;309:824-5. (1 October.)
- 2 Wright S, Burton JL. Oral evening-primrose-seed oil improves atopic eczema. *Lancet* 1982;ii:1120-3.
- 3 Bamford JTM, Gibson RW, Renier CM. Atopic eczema unresponsive to evening primrose oil (linoleic and gamma-linolenic acids). *J Am Acad Dermatol* 1985;13:959-65.
- 4 Berth-Jones J, Graham-Brown RAC. Essential fatty acid supplementation in atopic dermatitis: a placebo-controlled trial. *Lancet* 1993;341:1557-60.

Author's reply

EDITOR,—John Berth-Jones and Robin A C Graham-Brown believe that the current evidence does not accord with my opinion that evening primrose oil is a promising treatment in atopic dermatitis. They consider only the three largest trials, of which two yielded negative results, and not eight small controlled trials with positive results. Interpretation of the evidence for the efficacy of treatments depends on prior beliefs (knowledge about mechanisms of action, clinical experience, and many other factors) and the quality and results of the new evidence. In the editorial I discussed the many reservations that I have about the available evidence; this should make it clear that in my opinion, for the indications mentioned, further evidence is warranted but that for the moment I do not recommend treatment with evening primrose oil in any disease. Berth-Jones and Graham-Brown either started with different prior beliefs or have weighted the evidence differently, or both, as they apparently consider that the case is clear already; maybe time will show that they are right. For the premenstrual syndrome, my belief has changed a little since my attention was drawn to a further (small) crossover trial with negative results.¹

JOS KLEIJNEN
Clinical epidemiologist

Academic Medical Centre,
University of Amsterdam,
Department of Clinical Epidemiology and Biostatistics,
Amsterdam,
The Netherlands

- 1 Collins A, Cerin A, Coleman G, Landgren BM. Essential fatty acids in the treatment of premenstrual syndrome. *Obstet Gynecol* 1993;81:93-8.

Health information for the developing world

Obsession with high technology

EDITOR,—As a participant, I found the conference on getting information from the developed world to the developing world interesting but disappointing.¹ Interesting because I had no idea that there were so many organisations in this field; disappointing because many contributors seemed to be obsessed with high technology. I have seen no evidence of the activities of any of the organisations represented at the conference in the developing countries that I have visited recently. In the papers presented and in the discussions at the conference there seemed to be no awareness of the practical difficulties in reaching the places that really matter—district general hospitals.

As was emphasised at the conference, the journals and textbooks that doctors and other health workers want and need must be established. I hope, though, that it is not patronising to say that these requirements may need editing because they are often unrealistic in terms of expense and appropriateness. Doctors and health administrators find it hard to admit in writing to foreigners just how inadequate their facilities are; there is no substitute for a visit to see conditions at first hand and to discuss solutions to the difficulties.

Some of the impediments that I have discovered are as follows.

Firstly, the postal services may be unreliable. The best indication of this is to receive a letter from a developing country that has been posted outside that country. In some countries only registered or express letters seem to get through, in either direction. Before sending books or journals in any quantity through the post it is best to send a few trial packages to see if they get through; an international reply coupon should be sent initially. Some countries will send small parcels of journals through their diplomatic bag. Organisations in developed countries may find that their country's diplomatic service will help—for example, the British diplomatic service can sometimes be persuaded to deliver material to the British embassy or consulate in a developing country and to be responsible for its delivery.

Secondly, maldistribution may occur after arrival. Boxes or parcels should be clearly labelled with the name and address of someone who can be relied on to distribute the contents efficiently and fairly. Otherwise, books may moulder in a warehouse for months.

Finally, translation may be necessary. On the assumption that problems with copyright and royalties can be surmounted, it is usually not difficult to find someone in the developed country with the necessary qualifications and skills to translate short texts into the required language.

JOHN BLACK
Retired consultant paediatrician

Framlingham,
Woodbridge,
Suffolk IP13 9EG

- 1 Kale R. Health information for the developing world. *BMJ* 1994;309:939-42. (8 October.)

Sending back issues is useful

EDITOR,—I represented the Nigerian Medical Forum at the conference on getting information from the developed to the developing world¹ and wish to mention some of the many difficulties encountered by the young and smaller charities such as the Nigeria Medical Forum. In our three years of existence we have contacted 18 publishers in Britain, of which two have replied and agreed to reduce subscription rates for their journals for Nigerian medical schools. Apart from the Nigeria High Commission in London, no government or

non-government agency has responded to our appeals, even though we have direct links with the 18 medical schools and all the teaching hospitals in Nigeria. As I pointed out during the conference, those publishers that assist the deprived libraries in the developing world at this time of want stand to be remembered when the same libraries are able to pay for subscriptions again.

A recipient at the University of Calabar Medical School recently wrote, "Our medical schools are short of journals/books and equipments. Any help that your organisation can render, no matter how simple it may appear to you, will be of great assistance." Therefore, although some people might believe that sending back issues of journals is a waste of time, we are satisfied that for the time being such issues are useful and can fill the vacuum that exists in medical libraries in the developing world until they can restock with current issues.

I hope that publishers and the Overseas Development Administration will use the local knowledge and networks of charities such as the Nigeria Medical Forum to get health information to developing countries.

JOSEPH N E ANA
Secretary general

Nigeria Medical Forum,
Luton,
Bedfordshire LU3 1PB

- 1 Kale R. Health information for the developing world. *BMJ* 1994;309:939-42. (8 October.)

Cigarette advertising

EDITOR,—In their article on Imperial Tobacco's advertising campaign for Regal cigarettes, which featured the character Reg, G B Hastings and colleagues refer to "the Advertising Standards Authority's decision to withdraw" the campaign.¹ The authority made no such decision. Having at an earlier stage rejected complaints by Action on Smoking and Health among others, and having approved (as it must) all the advertisements before they were published, the authority neither upheld nor rejected the Health Education Authority's well researched complaint but requested that the campaign should be discontinued.² The company then magnanimously complied—but not before producing a final farewell advertisement cocking a snook at the whole system of controls. This final shot also was approved by the Advertising Standards Authority before publication.

The entire episode shows once again why the tobacco companies have invariably favoured the so called voluntary agreement as a means of staving off a ban on tobacco advertising: they know that the misapplied talents of their advertising agencies will always find creative ways to reach children, their key target if dying and quitting smokers are to be replaced. Regrettably, the government has not yet learnt the lesson.

DAVID POLLOCK
Director

Action on Smoking and Health,
London W1H 3PH

- 1 Hastings GB, Ryan H, Teer P, MacKintosh AM. Cigarette advertising and children's smoking: why Reg was withdrawn. *BMJ* 1994;309:933-7. (8 October.)
- 2 Advertising Standards Authority. *Monthly report* 31. London: ASA, 1993:19.

Factors predicting smoking cessation

EDITOR,—Steven G Gourlay and colleagues' study of the factors influencing smoking cessation fails to consider the subjects' previous attempts to stop smoking.¹ The influence of this variable was investigated in a study that recruited 1446 smokers