In airing Schröder's work I am completely convinced that neither Kerr, Currie, Wyllie, Hopwood, nor Levison had any knowledge of it at the time their early papers were published. It has also escaped Muller's historical researches.

Independent and unwitting rediscovery is quite common: its benefits include fresh minds, new points of view, confirmation by repetition, and, often, greatly advanced techniques. It is not an occasion for shame. The contributions of the Australian and Scottish schools to the understanding of cell death have been imaginative, enthusiastic, and manifold. Schröder would reel in amazement at what they have uncovered; yet, perhaps felicitously, he has eliminated both schools from the claim to priority.

Muller would do well to study Schröder's paper, retrieve its incomplete reference,³ and perhaps reconsider his own views. Instead of inciting destructive rivalry, his historical inclinations might be employed more benevolently to promote a Robert Schröder Memorial Lecture at the next major meeting on cell death. In suitable hands, the story of Schröder's simple, useful, outstandingly reliable observation might enrich, inspire, and even graciously redress, a debt long overdue.

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Nocturnal ambulatory blood pressure measurement

Authors' reply

EDITOR,—If we have understood Shennan *et al*'s letter about our recent paper on ambulatory blood pressure during sleep² correctly, then the main problem is that they have assumed that the orienting reflex which is activated during arousal from sleep is due to the same physiological mechanism as the "white coat effect" while the subject is awake. There is no evidence to support this, and the time courses of the two vascular responses are very different. In addition, Shennan *et al* suggest that the haemodynamic response to ambulatory blood pressure measurement during the day is less likely to habituate to repetition than the haemodynamic response to measurements during sleep. This is incorrect, since the autonomic effects of arousal from sleep do not habituate with repetition at all (see references 4, 11, and 12 in our original paper), while the "white coat effect" does.

What our paper does show is that ambulatory cuff measurements raise the sleeping blood pressure variably between recording machines and subjects. Therefore they do not measure undisturbed sleeping blood pressure, but a combination of sleeping blood pressure plus an arousal component whose influencing factors and relevance to vascular risk are not yet adequately understood. The severity of this arousal component may be an important vascular risk factor, but it should be seen for what it is and not confused with an attenuated fall in blood pressure overnight.

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Periocular steroid ointments may cause ocular damage

EDITOR,—Jeremy M Butcher and colleagues point out the dangers of long term unsupervised use of topical steroid drops but only briefly refer to topical, periocular steroid ointments as a potential source of ocular damage.¹ Several reports have implicated periocular steroid preparations in the genesis of raised intraocular pressure and glaucomatous damage²⁻⁴ as well as the formation of cataracts.⁵ Although most of these cases have resulted from long term, periocular use of strong steroid ointments, Aggarwal *et al* reported a case of extensive visual loss after long term periocular use of 1% hydrocortisone ointment.⁴ This is particularly alarming as such a preparation is available from pharmacies without a prescription.

As Butcher and colleagues point out, the *British National Formulary* warns that topical steroid preparations should be used only under expert supervision. It should be made clear that the warning applies to both steroid drops and periocular ointments. Pharmacists dispensing 1% hydrocortisone ointment over the counter to unsupervised patients should warn them not to use the preparation periocularly for more than two weeks.

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- 1 Butcher JM, Austin M, McGalliard J, Bourke RD. Bilateral cataracts and glaucoma induced by long term use of steroid eye drops. *BMJ* 1994;309:43. (2 July.)
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Complementary medicine in Germany

EDITOR,—In their overview of the diverse situation regarding complementary medicine in Europe Peter Fisher and Adam Ward mention the German "Heilpraktiker" (health practitioner), stating that these practitioners "have passed an examination in basic medical knowledge."¹ This is misleading.

There is no mandatory training to become a Heilpraktiker, and, even though every candidate has to pass a test, the Heilpraktiker's qualifications are pitifully low.^{2,4} The only guideline for the test is to "exclude danger to the health of the nation."³ If a candidate fails the test he or she can take it again, at the same place or elsewhere, as often as desired. Failure rates vary from 0 to 100%, with an average of around 60%.³ Thus a thriving "examination tourism" has developed to those authorities with high average pass rates.³ The test may be oral or written, lasts from 20 minutes to five hours, and covers mostly legislation; essentially, candidates

must know which procedures they are not legally allowed to perform. Medical knowledge is rarely included.³

A Heilpraktiker practises predominantly (but by no means solely) methods that are unlikely to cause direct harm (there is, however, much concern about indirect risks—that is, missed diagnoses and otherwise incompetent behaviour). While complementary practitioners in Britain usually specialise in one or two complementary treatments, Heilpraktiker normally use many or all such treatments as well as diagnostic techniques of unproved or disproved validity. Heilpraktiker may also give subcutaneous and intramuscular injections. Complications and deaths occur.⁵

In Britain the call for registration of and control over providers of complementary medicine is becoming louder. The Osteopaths' Bill and the proposed Chiropractors' Bill are important steps towards control over educational and professional standards. The example of the Heilpraktiker suggests that registration without proper training (which should mean not merely a minimal amount of knowledge but also the right sort of knowledge) will not lead to acceptable standards of safety. Even an intrinsically safe remedy may become unsafe when not applied with competence. Thus professional competence is essential and must be considered when complementary medicine is discussed.

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Hopeful newspaper article was justified

EDITOR,—John R Petrie argues that an article by me in the *Times* drawing attention to a new cancer drug that is undergoing phase III trials in 26 centres in Britain and elsewhere in Europe is an example of "sensational reporting by poorly informed journalists."¹ Petrie is from Scotland; it is unfortunate that before writing his article he did not consult colleagues at Glasgow Royal Infirmary, Aberdeen Royal Infirmary, and Ninewells Hospital in Dundee, all of which hospitals are participating in the phase III study of lithium gammalinolenate in pancreatic cancer.

It is also a pity that the databases Petrie consulted during his literature search seem to have failed him. I can provide a list of more than 25 studies of lithium gammalinolenic acid in cancer, several of which are in well known publications such as the *Journal of the National Cancer Institute*. A phase II trial of lithium gammalinolenate in pancreatic cancer has been conducted in 48 patients at Edinburgh Royal Infirmary and Addenbrooke's Hospital in Cambridge. Partial results from this study were presented at a meeting of the American Association for Cancer Research last May and at a joint conference on cancer held by the National Cancer Institute and the European Organisation for Research and Treatment of Cancer in Amsterdam in March. The results of this phase II study were summarised in an earlier article in the *Times*, to which I would happily have referred Petrie had he contacted me.

As I reported, the phase II trial shows that, depending on the subgroup, patients with inoperable pancreatic cancer have a threefold to sixfold dose related improvement in survival. None of the common toxic effects of chemotherapy for cancer were observed. These dose related effects, the investigators report, are "relatively robust with high degrees of statistical significance." This work seemed to be of great interest, partly because there are no effective treatments for pancreatic cancer and partly because of the lack of toxicity of lithium gammalinolenate given intravenously over two weeks. Readers of the *Times* were aware of this work, even if Petrie was not.

Petrie complains that the article gives the impression that the treatment is a simple dietary supplement. This is not stated or implied anywhere in the article. Lithium gammalinolenate has now been given to around 150 patients with otherwise untreatable cancers. More than 70 people who, like Petrie, approached Scotia Pharmaceuticals for information have been offered full information on the drug and, when appropriate, supplies of it on compassionate grounds. With the exception of Petrie, all seem to have appreciated the information.

Medical journalists have a tricky task in balancing hope against discouragement. Many hopeful stories are published when no studies other than those in the laboratory or in animals have been completed. I need make no apology for reporting on lithium gammalinolenate, given the completed phase II trials, the start of phase III trials, and the low toxicity of the drug—a rare combination.

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1 Petrie JR. The cruelty of false hope. *BMJ* 1994;308:1723. (25 June.)

Fatty acids for treating pancreatic cancer

EDITOR,—John R Petrie has expressed his concern over the overstatement by the *Times* of the therapeutic role of essential fatty acids in the treatment of pancreatic cancer. Although we share his opinion, we would like to make it clear that they do have a potential role in the treatment of advanced pancreatic cancer based on sound scientific evidence. The interest in both gammalinolenic acid and eicosapentaenoic acid lies in their possible palliative role as anti-cachexia agents. Pancreatic cancer is often associated with profound weight loss, which in turn is associated with increased morbidity and mortality. This weight loss cannot be explained solely by reduced nutritional intake and has been associated with a persistent activation of the hepatic acute phase response and raised resting energy expenditure.²

The hypothesis underlying the use of these fatty acids as anti-inflammatory drugs derives from their effects on altering prostaglandin synthesis. They compete with arachidonic acid for the cyclooxygenase and lipoxygenase enzymes and divert prostaglandin production away from the 2 series toward the 3 series (eicosapentaenoic acid) and 1 series (gammalinolenic acid).³ This alteration of prostaglandin synthesis seems to be associated with abrogation of the inflammatory response. The fatty acids have been shown to reduce weight loss significantly in animal cancer models.⁴ The potential to downregulate the hepatic acute phase response and energy expenditure with fatty acids might increase survival in pancreatic cancer patients who are losing weight. We make the experimental nature of these drugs quite clear to our patients, and, although there is some evidence of *in vitro* tumour cell killing,⁵ we emphasise that we consider these treatments to be palliative anti-

cachexia agents. It should also be mentioned that the toxicity profiles of both drugs are significantly better than those associated with conventional chemotherapy, which is an important consideration in patients who have a limited life expectancy.

The overstatement of medical data in the press may serve to undermine the confidence of patients and of practitioners responsible for their care.

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Informal complaints procedure in general practice

EDITOR,—P C Pietroni and S de Uray-Ura's paper reporting their experience of an informal complaints procedure in general practice raises several issues.¹ Firstly, a patient liaison worker was chosen to handle the complaints, and this person may have been viewed as a member of the practice team. The patients may have wondered whether complaints would be resolved impartially.

Secondly, although the paper records the outcomes of the complaints, it does not mention the degree of satisfaction felt by the patients. The end point of the complaints procedure was decided by the patient liaison worker, not by the patients.

Thirdly, although complaints by staff were addressed, no explanation is given about what action could be taken if the member of staff was not satisfied with the outcome. Being able to air a grievance is often of therapeutic value, but if no positive steps can be taken it may lead to disillusionment with the procedure.

Fourthly, the cost implications of introducing the procedure are reported as having been minimal, but there is no evidence to show this in the article. I wonder whether it would be so easy to set up such a procedure in an already overstretched general practice.

Finally, I am concerned to see such a large rise in the number of complaints compared with previous years. Were these complaints made for the sake of complaining or were they genuine? I also wonder whether the cumulative effect (on stress levels and morale) of several small complaints dealt with at local level exceeds the effect caused by far fewer complaints that take longer to resolve. Although we must all persevere to provide a better service to our patients, I believe that we should not encourage complaints or forget our own wellbeing in trying to provide this service.

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- 1 Pietroni PC, de Uray-Ura S. Informal complaints procedure in general practice: first year's experience. *BMJ* 1994;308: 1546-8. (11 June.)

Airline's magazine promotes production of tobacco products

EDITOR,—During a recent British Airways flight we were appalled to read, in the company's *Business Life* magazine, an article celebrating the profits to be made from producing tobacco products in eastern Europe.¹ The article described in glowing terms how one entrepreneur had negotiated a licence to produce tobacco products in an eastern European country and, through careful tax planning, had enabled profits to be brought back to western Europe.

Perhaps British Airways is not aware that mortality and morbidity in eastern Europe are increasing and that one of the main reasons for this is the increase in cigarette smoking. Furthermore, health care services in the new democracies have been severely weakened by reduced tax receipts, and this has contributed to the increase in mortality.² The ethics of encouraging the production of tobacco products and (albeit legal) minimising of tax are therefore dubious. We expect better from "the world's favourite airline."

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- 2 Unicef. *Public policy and social conditions*. Florence: Unicef International Child Development Centre, 1993. (Regional monitoring report No 1.)

British Airways' response

EDITOR,—Neither British Airways nor its publishers, Premier Magazines, had any intention of condoning cigarette smoking in eastern Europe or encouraging tax evasion. The point of the article, which was written by a well known tax lawyer, was to reveal to interested businessmen and businesswomen the pitfalls that exist for newcomers to this area of tumultuous change. In writing about the entrepreneur who dealt in tobacco products the author merely wanted to give readers an indication of business dealings in a market very different from that of western Europe. The practice of dealing in tobacco products was neither condoned nor encouraged, but to pretend that such practice does not exist would be to ignore an undeniable fact of eastern European life.

Business Life's brief is to give its readers an accurate and informed view of what is happening in European business, in both the East and the West, and to offer guidance when possible. The article included not only a six point guide on how to conduct business effectively and legally while keeping an eye out for local customs but a further reference to major sources of reliable business information on central and eastern Europe.

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Correction

Doctors should supervise administration of methadone

An editorial error occurred in this letter by P D Thomas (2 July, pp 53-4). The last line of the letter should read, "It now seems that pharmacists in maintenance programmes have far more to offer than doctors concerned, so perhaps we will soon hear of the deregulation of methadone to pharmacy list status."