BRITISH MEDICAL JOURNAL

SATURDAY 25 JANUARY 1986

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6515 BRITISH MEDICAL JOURNAL 1986 VOLUME 292 221-286
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 292 (6515) 221-286 (1986)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

A false phoenix

SIR,—I was particularly interested in references in your leading article (21-28 December, p 1744) to homoeopathy, having been disappointed at the poor response from homoeopathic physicians to my challenge nearly six years ago[1] that they should subject their treatments to rigorous assessment similar to that required for orthodox medicines.

The problems of initiating such studies must not, however, be underestimated. Two basic tenets of homoeopathy—namely, "like cures like" and the concept of increasing potency achieved by increasing dilutions to produce infinitesimally small doses—are at such variance with contemporary clinical science that relatively few orthodox investigators have sufficiently open minds to be able to collaborate in controlled trials with interested homoeopathists.

A third homoeopathic principle must not be forgotten. An appropriate remedy is chosen only after detailed documentation of a patient's symptoms and signs in relation to his external and internal environments, and the training of a homoeopathist places great emphasis on this "individualisation" of patient treatment. Conventional randomised clinical trial designs do not necessarily exclude such careful selection of treatment for patients included in them, but the smaller the variability in clinical selection criteria and treatment procedures between patients in different groups the more convincing the conclusions. Indeed, such trials may often be criticised for reducing the flexibility in patient contact and therapeutic choice that should be the hallmark of good patient care. Nevertheless, to exclude this fundamentally important principle from trials of homoeopathic remedies will lead only to problems of interpretation by both sides if the results show inferior, or lack of, efficacy of these remedies.

Attention should, therefore, be given to the design of randomised controlled clinical trials of homoeopathic remedies which will permit the same attention to treatment selection for the individual patient, together with appropriate careful long term follow up and modification of treatment if necessary, as would occur in normal practice. Only in this way can we hope to be able to persuade the public, orthodox medical opinion, and our homoeopathic colleagues to accept the implications of the results of such trials.

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1 Turner P. Clinical trials of homoeopathic remedies. *Br J Clin Pharmacol* 1980;9:443-4.

Biochemical tests for acute pancreatitis

SIR,—Professor I A D Bouchier's statement (14 December 1985, p 1669) that endoscopic retrograde cholangiopancreatography is contraindicated in acute pancreatitis is perhaps a little misleading. Because endoscopic retrograde cholangiopancreatography may produce pancreatitis, particularly when performed on a normal pancreas, it had previously been considered to be contraindicated in acute pancreatitis. However, the procedure permits not only an organ specific diagnosis (pancreatitis) and a causal diagnosis (gall stones) but also a treatment (sphincterotomy). A review of published experience a year ago concluded that "endoscopic sphincterotomy within the first few days (of pancreatitis) appears to be safe."[1]

Endoscopic retrograde cholangiopancreatography has a considerable potential role in the full diagnosis and management of a patient with acute pancreatitis. This role remains to be fully evaluated but while the commonest cause of acute pancreatitis is gall stones and while these are often missed on ultrasound examination clinicians might at least consider endoscopic retrograde cholangiopancreatography and sphincterotomy in any patients suspected of having acute gall stone related pancreatitis.

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1 Williamson RCN. Early assessment of severity in acute pancreatitis. *Gut* 1984;25:1331-9.

**Professor Bouchier replies below.—ED, *BMJ*.

SIR,—A recent authoritative review of the place of endoscopic retrograde cholangiopancreatography and endoscopic therapy in pancreatitis concludes that "as a rule, acute non-biliary pancreatitis is a contraindication for ERCP,"[1] a conventional view which, I suspect, will be shared by many gastroenterologists. On the other hand, Dr Isaacs is correct when he writes that some authorities hold that the technique may have a diagnostic and therapeutic role in acute biliary pancreatitis,[2,3] although the issue is still strongly debated.[4]

The problem is how to be certain that the pancreatitis is due to associated gall stone disease;