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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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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.

Differences among Asian patients

SIR,—The past few years have seen an increasing interest in disease patterns among British "non-white" communities. Dr J K Cruickshank (13 September, p 696) has recently raised the important issue of how inadequately we distinguish between subgroups among them. Terms such as "Asian" do not acknowledge the vast diversity of such a heterogeneous population, with their different religious and cultural practices. There is an urgent need, among both researchers and editors, to start defining such groups more precisely if future studies are to be useful and comparable.

Since January 1985, 13 papers and 12 letters in the *BMJ* have referred to "non-white" communities. We categorised them according to how accurately the population under study was defined and analysed. Only four of the 25 articles adequately defined their "non-white" populations in terms of religious, cultural, and demographic factors.

The issues raised are much broader than simply producing tidier studies. Despite pleas to the contrary, the last national census did not include a question on ethnic origin. The political and sociological concerns inherent in such data collection are far less applicable to medical research. Our own experience has been that patients are usually happy to provide details of their exact ethnic origin. Thus researchers do not have to resort to guessing an individual's origin from his name—a method that fails to identify West Indians and Christian Asians.

It is becoming increasingly apparent, at least among those originating from the "Asian subcontinent," that, in addition to genetic factors, nutrition and culture are important in disease pathogenesis. The evidence is particularly strong for diabetes mellitus, ischaemic heart disease, vitamin D deficiency, carcinoma of the mouth and tongue, and Indian childhood cirrhosis. But it remains unclear what the exact incidence and prevalence of most of these diseases are among different subgroups—for example, Bangladeshis, Christian Asians, Hindu Gujaratis, Hindu Punjabis, Ismailis, and Pakistanis. Intermarriage, for example, which is much commoner among related Moslems than among Hindus, must have an important bearing on genetic disease predisposition. Social and dietary habits, which can vary widely even within subgroups, have made many nutritional studies difficult to interpret. The problem is unlikely to disappear with adaptation to a Western lifestyle by the younger generation because of their adherence to traditional diets.[1] A recognition of such widely varying cultural and dietary practices among the different communities may well prove to be important in increasing our understanding of disease pathogenesis.

Although we acknowledge that distinguishing carefully between subgroups may not always be appropriate, we believe that it helps rather than hinders the interpretation of most studies. The *BMJ* has tried to increase the awareness of its readers to the lifestyles of ethnic minorities in the UK.[2] It would be helpful if journals could now ensure that, when appropriate, articles relating to groups derived from the ethnic minorities accurately define and evaluate them according to criteria that reflect their different geographic origins, religions, cultures, and, if relevant, dietary habits.

How accurately Asian study population was defined in BMJ papers and letters since January 1985

	Well defined and homogeneous*	Defined but not homogeneous†	Not defined
Papers	1	4	8
Letters	3	2	7
Total	4	6	15

*Groups defined during data collection were homogenous in demographic, cultural, and religious factors; analysis compared homogeneous subgroups with each other and white controls.
†Asian and non-Asian subgroups defined during data collection but were not homogeneous; analysis referred only to "Asians."

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1 Wharton PA, Eaton PM, Day KC. Sorrento Asian food tables: food tables, recipes, and customs of mothers attending Sorrento Maternity Hospital, Birmingham, England. *Hum Nutr Appl Nutr* 1983;**37A**:378-402.
2 Black J. *Child health in ethnic minorities*. London: BMJ, 1985.

Desensitising vaccines: an allergist's view

SIR,—The statement on desensitisation from the Committee on Safety of Medicines (11 October, p 948) was much needed and has at last drawn the attention of all doctors to the potential dangers of desensitisation therapy. While we agree with the statement in general, further points need to be made.

The present widespread and uncritical use of