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SATURDAY 31 JULY 1993

BMJ

Received by: HSE
Indexing Branch
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HSE
JMDCCC



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More aspirin and more debate on resuscitation

A doctor's ability is often dismissed with the phrase "All she ever tells you to do is to take an aspirin." But that doctor may be showing remarkable wisdom—because every week that goes by seems to bring further evidence of benefit from aspirin. We know that it will relieve pain, reduce fever, treat arthritis, and prevent heart attacks, strokes, and other thromboembolic conditions, but now we learn that it may also reduce a person's chances of developing colorectal cancer (pp 278 and 285).

Aspirin inhibits the growth of chemically induced tumours of the colon in rats and mice, and the non-steroidal anti-inflammatory drug sulindac causes regression of rectal polyps in patients with familial adenomatous polyposis. In addition, three previous epidemiological studies have shown an association between aspirin and roughly a halving of the risk of colonic cancers. The paper we publish today shows a similar reduction in the risk of adenomas (p 285). The association might result from confounding because health conscious controls are more likely to take aspirin for other reasons, or it might be that aspirin has a genuinely protective effect—perhaps by inhibiting prostaglandin synthesis and so slowing tumour growth. The time may have come for the next step—a randomised trial

to see if aspirin will prevent colorectal cancer.

A man may naturally be shocked when his wife becomes pregnant after he has had a vasectomy, and he might wonder if she has been unfaithful. His suspicion may be confirmed when a sample of his semen shows small numbers of non-motile spermatozoa, a pattern usually thought to indicate infertility. But no man should jump to such conclusions. In a case like this reported on p 299, DNA profiling of the man, his wife, and the child showed a 99·999% probability that the man was the father. The normal criteria do not prove infertility.

Finally, we publish this week the letters resulting from our special resuscitation issue of 12 June; the largest number are in response to the proposed guidelines on withholding cardiopulmonary resuscitation. Several correspondents argue the cases for involving junior doctors (p 321), nurses (p 322), and relatives (p 322) more in the decisions, while one correspondent warns that resuscitation should not be used as a panacea for death (p 322); two others want doctors to remember that less than 4% of patients over 70 are discharged from hospital after cardiopulmonary resuscitation (p 322). This is exactly the sort of debate that the authors of the original guidelines wanted.

BMJ

Editor's Choice

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British Medical Journal.

US second class postage paid at
Rahway, NJ. Postmaster: send
address changes to: BMJ, c/o
Mercury Airfreight International
Ltd Inc, 2323 Randolph Avenue,
Avenel, NJ 07001, USA.
US (direct) subscription \$250.00.

Published by the proprietors,
the British Medical Association,
Tavistock Square, London WC1H
9JR. Printed by BPCC Magazines
(Milton Keynes) Ltd, Milton Keynes.
Typesetting by Bedford Typesetters
Ltd, Bedford. Registered as a
newspaper.