



MIXED BAG

THE START OF REASON

The past few decades have seen an unfortunate trend towards increasing acceptance of myth, superstition and, in medical terms, downright quackery. Doctors and other health professionals often seem to be bogged down in political correctness to such an extent that they find it impossible to tell their patients that a large amount of what passes for 'alternative medicine' is little more than rubbish. I certainly get extremely hostile reactions from friends who are convinced that their alternative remedy is the reason they did not get flu last year, or worse, were lucky enough not to contract malaria after using a homeopathic 'antimalarial'. So the recent paper in *The Lancet* was a breath of fresh air, and also comes hard on the heels of a highly controversial report by the WHO, which has been said to be nothing but pro-homeopathy propaganda.

Aijing Shang and colleagues ask if the clinical effects of homeopathy are simply placebo effects by analysing trials of homeopathy and conventional medicine and estimated treatment effects in trials likely to be affected by bias. As they point out, homeopathy is widely used, but controversial. The basic premise is that like cures like, in other words, diseases can be treated by substances that produce the same signs and symptoms in a healthy person. Homeopathic remedies are prepared using serial dilution, commonly to levels where no molecules of the original substance remain. Vigorous shaking between dilutions is thought to transfer information from the diluted substance to the solvent, called potentisation, and regarded by most as somewhat implausible in the light of modern knowledge. Most reasonable people assume that any effects of homeopathy must be through nonspecific placebo effects. It is also possible that bias in the conduct and reporting of trials is an explanation for positive findings of placebo-controlled trials of both homeopathy and conventional medicine.

Shang *et al.* analysed placebo-controlled trials of homeopathy using a comprehensive literature search, covering 19 electronic databases, reference lists of relevant papers and contacts with experts. Trials of conventional medicine were matched to homeopathy trials for disorder and type of outcome. These were randomly selected from the Cochrane Controlled Trials Register. The effects of bias were examined using specific statistical methods. The team matched 110 homeopathy trials to 110 conventional medicine trials. Most studies included around 65 participants. Twenty-one homeopathy trials and 9 conventional medicine trials were regarded as being of a higher quality because they were double-blinded with adequate randomisation. In both trials of homeopathic medicine and conventional medicine, those with fewer participants that were not double-blinded and randomised showed more beneficial treatment effects than larger and higher-quality trials.

Essentially, the team compared the effect of homeopathy and conventional medicine seen in placebo-controlled trials, they examined for the presence of bias resulting from inadequate research methods and selective publication and estimated results in trials least affected by these biases. They assumed that the effects seen in placebo-controlled trials could be explained by a combination of methodological flaws and biased reporting. They postulated that the same biases could not explain the effects observed in comparable placebo-controlled trials of conventional medicine. Their results confirmed these suppositions. When analyses were confined to large trials of higher quality there was no convincing evidence that homeopathy was superior to placebo, whereas for conventional medicine an important effect remained. This provides support for the supposition that the clinical effects of homeopathy are simply nonspecific placebo effects. Maybe a few more pieces of research such as this might start to convince people that science has some place in life and stop them spending good money on quackery.

Shang A, *et al.* *Lancet* 2005; **366**: 726-732.

WHY THE DELAY?

As someone who found clinical medicine difficult precisely because of demands that patients made on me, I was interested to see an article in *The Lancet* that looked at how patients' fears and concerns about symptoms related to delays in presentation of cancer. Lucy Smith, Catherine Pope and Johannes Botha point out that reduction in delay in cancer diagnosis has been targeted as a way to improve survival. Their research synthesised international evidence that provides insight into patients' experiences of recognising symptoms of cancer and seeking help.

In the UK there have been many initiatives that focus on the reduction of delays between the patient's first presentation with possible cancer symptoms to doctors and the subsequent diagnosis of cancer. There are several studies that have provided evidence that show that patients' failure to recognise symptoms as serious is a significant factor in delaying presentation and so the diagnosis of cancer. The team restricted their study to papers published in peer-reviewed journals, between 1 January 1985 and 31 July 2004, that reported qualitative research about cancer patients' help-seeking experiences, from first onset of symptoms to first medical consultation. They used 32 papers, based on focus groups, interviews with and testimonies of patients and their carers that provided information from more than 775 individuals, of whom at least 712 were patients with more than 20 different types of cancer.

There appeared to be a series of different reasons for delaying seeing a doctor. These were organised into reasons to do with recognition and interpretation of symptoms, fear, the patient's



gender and what the authors called sanctioning. In this context sanctioning covers aspects such as feeling that it is OK to seek help because of symptoms starting to interfere with life, or the patient's family encouraging the person to seek help. Under the recognition and interpretation of symptoms the delaying factors in recognising serious illness were the fact that the symptoms were vague and attributed to something common, to trauma or even to clothing that was too tight. The problem might have been seen as age-related or a simple disorder such as piles. The absence of pain or a lump was important, as was a belief that the symptoms would go away, particularly if they were intermittent. Some studies reported that patients were simply not aware of what constituted cancer symptoms or their possible risk of cancer. Many had also previously been told by a doctor that their symptoms were benign. Triggers to recognising illness were specific, well-known symptoms, symptoms that persisted and worsened, additional symptoms such as pain, severe symptoms that affected everyday life, knowledge of cancer and risks, and discussing symptoms with family and friends. Men were less likely to seek help and more likely to think that they would appear neurotic. Men thought that women would be more likely to seek help because they have more contact with health services for themselves and their family.

Fear was a particular factor that influenced presentation and not just fear of cancer, but fear of being seen as a time-waster or a neurotic, particularly by those patients whose symptoms were diverse or mild. Men appear to think that help-seeking is inappropriate and there was the obvious embarrassment about sensitive or sexual areas. Fear of cancer itself was what would be expected: fear of pain and incurable illness, previous negative experiences of cancer, fear of unpleasant treatment and loss of sexuality after treatment. A main theme throughout the study was how patients recognised abnormalities, attributed body changes to illness, and assessed the seriousness of their condition.

Patients with well-recognised specific symptoms, such as a lump, realised the seriousness of their symptoms fastest. Symptoms that were thought to have developed suddenly led to panic and earlier presentation. Patients with serious symptoms, such as a seizure, also recognised their illness faster. However, patients with vague or nonspecific initial symptoms often did not at first think that these symptoms were important. They recognised changes in their bodies but looked for alternative explanations such as trauma, skin problems, indigestion, menopause, childbearing, old age, or piles. They then did not take action because of fear, because they had very little awareness of cancer symptoms, or because of cancer not being something they initially considered because they were apparently fit, healthy, or too young. Health professionals also affected the process by suggesting patients' symptoms were benign. One woman had delayed because she previously had a benign breast lump and had been told she had lumpy breasts by her doctor. Others had attributed their symptoms to illness and delayed because of previous consultations with a doctor who suggested that the perceived abnormality was simply a typical part of ageing. Even after recognising symptoms, fear of being neurotic would then prevent many patients from seeking help. Those who often used health services would generally seek help earlier and be diagnosed faster.

It is tempting to simply see this study as a list of the reasons why patients don't recognise cancer symptoms. But there are also important lessons about how health professionals can make patients feel. It is apparent that a doctor making light of symptoms can make someone reluctant to go back again, either because those same symptoms are persistent or are getting worse. And it is important that those in clinical practice are aware that symptoms that may seem trivial may be more significant than at first realised.

Smith LK, *et al. Lancet* 2005; **366**: 825-831.

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