Fatty acids for treating pancreatic cancer

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As I reported, the phase II trial showed that, depending on the subgroup, patients with inoperable pancreatic cancer have a threefold to sixfold dose-related increase 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 is of great interest not only because there are no effective treatments for pancreatic cancer and partly because of the lack of toxicity of lithium gammalinolate 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 gammalinolate 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 gammalinolate, 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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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. 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. Was smoking banned 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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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."