Tuberculosis in the third world

We cannot agree with the view expressed by our good friend Stefan Gryzbowskii in his editorial (August 1992; 47: 689-91) that what is now needed is a unit or units, like the Medical Research Council tuberculosis unit, "capable of organising therapeutic trials in the developing countries." Such a limited approach would, in our view, be disastrous.

The two MRC tuberculosis units, with the MRC statistics unit, established a team that covered basic laboratory research, the principles and mechanisms of drug action, pharmacology, sociological interests, and epidemiological investigations, often under service programme conditions, into, for example, drug resistance, case finding and national surveys of the characteristics of patients presenting, their treatment and response, the trends at intervals (as in Kenya, Tanzania, and Britain), and controlled chemotheraphy trials.

The multidisciplinary approach, necessary even for chemotherapy studies, as in the 1985 proposal for research on new drugs supported by the World Health Organisation, was also emphasised in the report of a workshop with wide international agency representation from WHO and 31 nations. This stated, "The Group sees a great need for an interdisciplin- ary approach in an approach that would link basic scientists with clinicians, microbiologists and epidemiologists. One approach to achieving this aim might be to create an international interdisciplin- ary centre for studying TB."

We are also surprised at the statements (1) that "casefinding is relatively easy and on the whole functions reasonably well in many developing countries," which is not the case; and (2) that Styblo has been successfully with "the problem of poor compliance" by hospitalising patients for an initial two months. This is not the official policy of the International Union Against Tuberculosis and Lung Disease (IUATLD) or the TB programme of the World Health Organisation, and it is unsupported by a broad evidence of success. Finally, the failure to distinguish between primary and initial drug resistance, totally different problems, is confounding.

K MOGHISSI
Consultant Cardiothoracic Surgeon, Humberside Cardiathoracic Surgical Centre, Castle Hill Hospital, Cottingham, North Humberside HU16 5JQ

AUTHORS REPLY
Professor Fox's MRC unit achieved international fame for its chemotherapy trials, conducted mainly in the developing countries. The conduct of such trials requires an interdisciplinary approach with strong statistical, bacteriological, pharmacological, clinical and other components; these were either developed within this unit or obtained from Professor Mitchison's unit, other MRC units, and other experts and institutions. I thought, obviously erroneously, that in advocating the creation of a unit or units similar to Professor Fox's MRC unit "capable of organising therapeutic trials in the developing countries" I did not need to list these individual components.

Styblo's method in dealing with poor compliance with an initial two months' hospitalisation is used in most if not in all of the dozen or so of the countries assisted by IUATLD. Admittedly, its success could be better documented in accessible medical publications. Competing health priorities for the hospital beds should be assessed. Primary resistance is resistance of the bacilli with which new patients are infected; initial resistance covers also patients who, for whatever reason, develop resistance during treatment, information about their previous treatment. The fact that in certain countries the distinction between the two is necessary constitutes a terrible indictment of the lack of interest of health authorities in treatment failures, and often of the absence of appropriate drug regimens for such patients.

It is regrettable that I have obviously upset two most eminent authorities on tuberculosis, particularly as one of them is a close personal friend; but I remain unrepentant.

STEFAN GRZYBOWSKI
Respiratory Division, University of St Andrews, 2775 Heather Street, Vancouver, Canada

Cystic fibrosis: current survival and population estimates to the year 2000

Drs J S Elborn and others (December 1991; 46: 881-5) estimate that the median survival of babies born in 1990 with cystic fibrosis will be 40 years. They base that estimate on an extrapolation from current survival figures but state that their prediction contains "an element of error that is difficult to estimate." Nevertheless, they suggest using their estimate for counselling purposes and imply that it should be taken into account when formulating policy, such as population screening, are being considered.

They are mistaken on two counts. Firstly, the case for population screening for cystic fibrosis is currently poor because the available tests give too many false positives. An increase in median survival from 20 to 40 or even to 80 years would not affect the issue because the purpose of screening is early detection and treatment, which would presumably still be desirable even if in the projected survival. Secondly, improvements in survival must depend on improvements in the general health of the population from social and environmental factors and advances in medical treatment. Future colleagues refer to "improved medical care" and "increasing use of heart-lung transplantation." They cannot know what improvements in medical care will occur or what the effect of transplantation will be (currently it seems likely to be small). There is no guarantee that present trends of improvement in survival will continue; the fact that plateausing has not yet occurred cannot be used as evidence that it will not occur and in fact, in the absence of new modes of treatment, it seems likely that it will do so as maximum benefit is reached from present management strategies. On the other hand, if a cure is found—from gene therapy, for instance—then babies born now might have a survival equalising that of the rest of the population.

All we are entitled to say is that the median life expectancy of babies born now is likely to be somewhere between 40 and 80 years and the normal life expectancy of the population. Other than that we might be more credibly and profitably employed predicting the winner of the next Grand National.

D P ADDY
Department of Paediatrics, Dudley Road Hospital, Birmingham B18 7QH