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<th><strong>Title</strong></th>
<th>The tobacco industry and scientific publications. Challenges on grounds of self evident potential bias are not unfair.</th>
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value than measurement of the IgG anti- 
carboxylioprotein antibody and lupus anticoagu-
lagant status, both of which were negative.1 In 
this setting we question the decision to 
maintain the patient on lifelong warfarin, 
especially with the increased haemorrhage 
risk of maintaining the international nor-
malised ratio in the range 3.0-4.5 in this 
system.3

Elizabeth M McDermott Clinical research fellow 
M Judkin Senior registrar 
Richard J Powell Senior lecturer 
Clinical Immunology Unit, Queen's Medical 
Centre, University Hospital, Nottingham NG7 2UH

1 Cockwell P, Savage COS, Owen JTT, Thompson RA, 
1997;314:995-9 (29 January)

2 Austin HA, Khipple JH, Balow JR, Le Riche NGH, 
Controlled trial of prednisone and cytotoxic drugs. 

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4 Gerver R, Font J, Lopez-Soro A, Canals F, Gallardo L, Bose 
A, et al. Isotype distribution of anti cardiolipin antibodies in 
systemic lupus erythematosus: prospective analysis of a 

5 Khanna D, Chinnock MJ, Magi M, Thak NA, Huie R, 
335:565-9

Authors' reply

Editor—There is no evidence to support 
treatment of patients with antiphospholipid 
antibodies who have a history of deep vein 
thrombosis, or other features of the 
antiphospholipid syndrome.3 Two pre-
scriptive studies have addressed the treatment of 
antiphospholipid antibodies in pregnancy for 
women who have two or more fetal losses. 
Both indicate that low dose aspirin and 
prophylactic heparin is the treatment of 
choice.4,5 There is no good evidence for 
using steroids in pregnant patients with the 
antiphospholipid syndrome. Indeed, 
the inappropriate use of steroids in pregnancy in 
this disorder further worsens outcome.6 
We agree with Robert Llewellyn 
about the importance of adequate contraception 
and prenatal counselling in patients with 
systemic lupus erythematosus with or 
without an antiphospholipid syndrome. We 
posit routine contraceptive advice along 
with our obstetric colleagues, hold a joint 
prenatal clinic for all patients with systemic 
lupus erythematosus.

This patient underwent an urgent renal biopsy 
on referral to this centre, and we agree 
with Elizabeth McDermott and colle-
agues about the usefulness of an early 
renal biopsy in the management of sus-
ppected lupus nephritis. There is no evidence 
that prednisolone plus intravenous pulse 
cyclophosphamide is superior to oral cyclo-
phosphamide: the only controlled study 
showed no significant difference in renal 
survival.7 We believe that two to three 
months of daily oral cyclophosphamide at 
a dose of 1.5-2 mg/kg followed by daily oral 
azathioprine causes less gonadal toxicity and 
is as efficacious as intermittent pulse 
cyclophosphamide for two years. We are 
planning a multicentre randomised con-
trolled study to compare the efficacy and 
toxicity of these regimens.

Despite having proteinuria the patient had a 
normal serum albumin concentration. 
We recognise that venous thrombosis is a 
complication of the nephrotic syndrome. 
The duration of anticoagulation treatment 
is determined by the underlying disease 
and risk of recurrent thromboembolism. In 
a patient with a prothrombotic tendency 
(probable antiphospholipid syndrome) with 
a potentially fatal ileoceleal thrombosis (her 
third), five months after warfarin 
treatment was stopped, we believe that most 
doctors would accept the risk-benefit ratio 
of long term anticoagulation.

P Cockwell (Clinical research fellow in medicine 
(nephrology)

D Adams Consultant nephrologist

C Gordon Senior lecturer in rheumatology

C O S Savage Senior lecturer in medicine (nephrology) 
Queen Elizabeth Hospital, Birmingham B15 2TH

1 Lynch A, Silver R, Enslow W. Antiphospholipid antibodies 
1997;23:55-77

2 Rethel WH. Antiphospholipid antibody-associated recur-
rent pregnancy loss. Rheum Dis Clin North Am 
1997;23:117-20 (1 February)

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MC, Raghu A. Comparative trial of prednisone plus aspirin 
versus aspirin alone in the treatment of antiphospholipid 
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1995;172:1411-7

5 Austin HA, Khipple JH, Balow JR, Le Riche NGH, 
Steinberg AD, Fitz MA, et al. Therapy of lupus nephritis: 
controlled trial of prednisone and cytotoxic drugs. 

The tobacco industry and 
scientific publications

Challenges on grounds of self evidence 
potential bias are not unfair

Editor—Peter NLee complains about the 
concern, expressed by George Davey Smith 
and Andrew N Phillips, that Lee's vested 
interest in tobacco industry revenue to P N 
Lee Statistics and Computing Ltd might 
influence his interpretation of epidemiologi-

cal evidence.2 But what is unfair about 
challenges on the grounds of self evident 
potential bias? BMJ journals now require a 
clear statement from authors on conflict of 
interest.

Nevertheless Lee has been given the 
privilege of reply, but he asserts only that he 
is widely consulted on many issues. Granted, 
but may we now see an audited statement on 
the proportion of P N Lee Ltd's gross 
income from the tobacco industry during 
the past five years? 

Lee is the author of Environmental 
Tobacco Smoke and Mortality.3 
In his conclusion 

to the preface of this book he states that 
"There is no convincing evidence that expo-

sure to ETS [environmental tobacco smoke] 
results in an increased risk of death from 
cancer, heart disease or any other disease in 
non-smokers." Would Lee now clarify in 
what way the tobacco industry supported 
the publication of his monograph and how 
much he received?

The problem for Lee and others who 
depend on revenue from the tobacco indu-
stry for a large proportion of their consul-
tancy income is that the industry is clearly 
determined to corrupt the medical and 
scientific literature on tobacco and health 
through funneling academics, conferences, 
publications, and delegates' attendance at 
events supported by the industry in attrac-
tive venues. New initiatives include the 
establishment of academic posts in prestig-
iouls institutions world wide, and especially 
in regions that are now prime targets for 
market expansion. The industry's apparently 
limitless largesse is particularly noticeable in 
the Asia Pacific, where it is now trying to 
recruit health professionals as its advocates. 
P N Lee Ltd and others that take the indu-
try's commissions will have to find 

more novel reasons why we should not 

regard them as its servants and treat their 
outputs with circumspection.

A J Medley Professor 
Department of Community Medicine, University of Hong Kong, Hong Kong

1 Lee PN. Many claims about passive smoking are 
unjustifiably biased. BMJ 1995;311:1177-8

2 Davey Smith G, Phillips AN. Passive smoking and 
health: should we believe Philip Morris's "experts"? 
BMJ 1996;313:928-33 (12 October)

3 Lee PN. Environmental tobacco smoke and mortality. Basic 

Findings of scientists who were and were 
not funded by tobacco industry were 
strikingly different

Editor—It is hard to decide which part 

of Peter N Lee's letter is the most objet-
ctionable, but it is worth commenting on 
three points for the sake of truth. 
Firstly, Lee whines that George Davey Smith 
and Andrew Phillips mention that he receives 
tobacco industry funding. He implies that 
they insinuate that this financial support dis-

orts his scientific veracity. But what is 
wrong with noting the truth about the 

sources of his funding? I suspect that the 
real problem is that Lee's longs time associa-
tion with the industry, which for decades has 
done everything it can to obfuscate the 
truth, may have had its effect—perhaps subconsciously—on 

him.

Secondly, to support one of his argu-
ments he cites as prime evidence a report 

funded by Philip Morris USA. He fails to 
mention this financial link, incestuous as it is 
in the context of his letter, despite his 

previously search for truth. Furthermore, he 

does no state how the authors of that 
report, LeVois and Layard, obtained the data 

they used. For this information we need 
to turn to scientists who do not receive 
tobacco industry funding. They say several 
years ago the tobacco industry's lawyers 

obtained the American Cancer Society's CPS 
cancer prevention study) data set, ostensibly to help 

in preparation of the defence of a wrongful 
death suit against a tobacco company. The 
industry's lawyers subsequently provided 
this data set to two consultants, LeVois and 
Layard, who conducted an analysis of these 
data, which concluded that passive smoking 
did not affect the rise of heart disease.

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