value than measurement of the IgG anti-
cardiolipin antibody and lupus anticoagu-
ant status, both of which were negative. In
this setting we questioned 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
syndrome.1

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

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
D Ads Consultant nephrologist
C Gordon Senior lecturer in rheumatology
C S Savage Senior lecturer in medicine (nephrology)
Queen Elizabeth Hospital, Birmingham B15 2TH

Authors' reply

Editor—There is no evidence to support
treatment of patients with antiphospholipid
antibodies who do not have a history of fetal
loss, thrombosis, or other features of the
antiphospholipid syndrome.1 Two prospec-
tive 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.1,2 There is no good evidence for
using steroids in pregnant patients with the
antiphospholipid syndrome. Indeed, the
inappropriate use of steroids in pregnancy in
diseases with an adverse outcome is.
We agree with Robert Llewelyn about the
importance of adequate contraception and
prenatal counselling in patients with systemic lupus erythematosus with or
without an antiphospholipid syndrome. We
point out in our contraceptive advice and
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 M McDermott and col-
leagues 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.3 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 effective 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.

The tobacco industry and
scientific publications

Challenges on grounds of self evident
potential bias are not unfair

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

i ovid) evidence.4 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.5 In his conclu-
sion to the preface of this book he states that
"There is no convincing evidence that ex-
pose 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 funding academies, 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-
i ous 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
industry'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 Hedley Professor
Department of Community Medicine, University
of Hong Kong, Hong Kong

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 objection-
able, but it is worth commenting on three
points for the sake of truth. Firstly, he
whines that George Davey Smith and
Andrew N Phillips mention that he receives
revenue from the tobacco industry. He
implies that they insinuate that this financial support dis-
torts 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 long time association with the
industry, for decades has done every-
thing 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.6 He fails to
mention this financial link, incestuous as it is
in the context of his letter, despite his
previously mentioned for truth. Furthermore, he
does not note how the authors of that
report, LeVoi 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 that 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, LeVoi and
Layard, who conducted an analysis of these
data, which concluded that passive smoking
did not affect the rise of heart disease.