"Worthless but Harmless" Drugs Can Be Deadly

The nationally syndicated columnist, James J. Kilpatrick, recently condemned "the arrogance of know-it-all doctors who long ago lost the humility good scientists should have engraved in their very souls." The subject that aroused Mr. Kilpatrick's ire is the medical profession's attitude toward the concoction, Laetrile. The columnist described Laetrile as a "controversial drug," but perhaps this phrase is too generous to describe a compound whose effectiveness has never been supported by a single reputable controlled study. This is the reason that the Food and Drug Administration has prohibited the sale or dispensation of the substance; thus, the efficacy or lack of efficacy of Laetrile is not the subject of the columnist's diatribe nor the basis for his wrath. Mr. Kilpatrick maintains that patients should have free access to drugs, even those which have no known therapeutic effectiveness against the disease for which they are used. He is angered that the government would use its powers against a drug "merely because experts regard it as worthless."

The villains in Mr. Kilpatrick's report are the Food and Drug Administration and the medical profession. The hero, Judge Bohanon of the United States District Court in Oklahoma City, ruled Laetrile could be administered to a patient with terminal carcinoma. Mr. Kilpatrick urges the other 49 states to obtain the "freedom" which Judge Bohanon would grant in Oklahoma. The legal decision was based in part upon this statement of the patient's physician, "I think the drug is essentially worthless, but it has become such an obsession with the patient that I think he will derive great psychological benefit from use of the drug."

An editorial in the New York Times decried the current law which denies "the help" of Laetrile to patients who believe that it is effective against cancer. Fortunately, these are isolated journalistic episodes, but the potential for mischief is enormous and the immediate and vigorous objections from the American Cancer Society were wise moves. Surely the espousal of worthless "anticancer drugs" because of a possible placebo effect is misguided support. Shall we, as clinicians, permit our therapeutic recommendations to be subservient to enthusiasm engendered by scientifically unsound publicity in lay magazines? How could we respect the Food and Drug Administration if it permitted the distribution of a drug when the proponents for that agent are unable to provide data identifying specific therapeutic efficacy? We must resist the naive advocacy of some laymen and two or three journalists because their proposals would lead to a complete breakdown in faith in the labeling of drugs.

There is an abundance of zealots who prey upon those suffering from painful chronic diseases or individuals with advanced incurable sicknesses. Inevitably, some of these "miracle cures" are afforded publicity in local or national lay releases. Families desperate for solace travel to distant lands, there to be beguiled by unjustified claims. Upon their return to this country, initiation of word-of-mouth campaigns sometimes results in hysterical pressure from those similarly afflicted. The reaction of the responsible clinician to such pressure dare not be the easy route of acquiescence. Scientific truth is not a negotiable item. The physician who begins by "closing his eyes" to the use of a drug which is worthless but harmless is on the individual and collective road to the erosion of patients' trust in their doctors' intellectual honesty.

Advocates of unbridled therapeutic accessibility would have us believe that physicians will allow hope to be extinguished from the critically ill simply because a much publicized and useless drug is not made available at the insistence of the poorly informed. There are varieties of placebo effects attendant to the administration of legitimate medications and nearly all of these effects are related to the intimate relationship between patient and physician. One can be compassionate and honest, sensitive and yet truthful. Scientifically valid therapeutic programs can bolster the patients' hope even if they do not always alter the course of the disease. Surely the health team of physician, nurse, and allied health
professional can combine emotional support with judicious use of therapeutic agents which are understood honestly and used honestly. The terminally ill patient needs most of all to know that those around him care. Pursuit of will-of-the-wisp wonder cures will not eliminate this need, for frivolous quests are an inadequate substitute for faith in the physician's judgment.

Have our crusading columnists thought of two other possible results of their proposal? If compounds of this type are distributed because of the importune requests of laymen, is there not the probability that correct therapy will be delayed dangerously and often irrevocably in many subjects? Widely advertised "remedies" will be eagerly used by individuals with early cancer and these patients will be denied (until too late) a cure by proved methods.

Secondly, can anyone deny that the use of a nostrum such as Laetrile is historically associated with gross financial abuse by the purveyors of quack medication? The chronicles of the twentieth century are replete with stories of worthless "cancer cures" which made fortunes for those who slyly berated the opposition of the "medical establishment"; easy accessibility to these nostrums would compound such financial piracy.

Kilpatrick exclaims that "the government is too much with us." However, the physician does not believe that unnecessary restrictions have been placed upon him by governmental agencies when worthless compounds are prohibited from distribution. One can imagine the scientific anarchy that would soon exist in the Food and Drug Administration, if this agency permitted, for example, sale of a host of worthless but harmless drugs for the treatment of cerebral arteriosclerosis, arthritis, or multiple sclerosis. The medical profession vigorously defends its privilege to use drugs in ways that the manufacturer's label does not specifically indicate. The clinician must retain the right to use a drug on the basis of his best medical judgment. Since reactions to drugs are often unpredictable, every clinician can be an investigator as he observes and records responses. Based upon his individual experiences, the physician will decide to withhold or administer drugs in the context of the clinical setting. Such professional therapeutic freedom is aided and not compromised by the current policies of the FDA, which prohibit the use of medications unless the claims made for them are buttressed by facts.

The outcome of a legal dispute in one state is only one aspect of the newspaper essay on Laetrile. An ominous element is the animosity which is expressed in accusations against "know-it-all doctors." This tone will appeal to the prejudices of some patients that "doctors do not care enough about their patients nowadays." Fortunately, other columnists have correctly identified the desire of most physicians to achieve candid communication with their patients and to provide them with a better understanding of disease processes. At a time when isolated charges fan the suspicions of the ill-informed, it is vital that we allay the disquietude of the perplexed. Physicians in a variety of disciplines can identify for their patients the dangers in legalizing substances such as Laetrile. To inform and to instruct the afflicted and their loved ones is our challenge and our responsibility.

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The Scintigraphic Detection of Acute Myocardial Infarction: How Specific Is It?

Scintigraphy for the detection of acute myocardial infarction became possible with the observation that a number of technetium-99m (99mTc)-labeled radiopharmaceuticals localize in acutely necrotic tissue. At the present time, 99mTc-pyrophosphate is the radiopharmaceutical of choice for scintigraphy in determination of acute infarction because it clears rapidly from the blood, permitting scintigraphy to be performed soon after intravenous injection, and because the concentration of the tracer in the infarct is high relative to surrounding structures. The sensitivity of this technique for the detection of acute infarction has been very high.

Abdulla and his coworkers (Chest 69:168-173, 1976) point out a troublesome observation with this technique. They have found increased focal uptake in patients with unstable angina and without clinical evidence of acute infarction. While it has been suggested that this increased activity may reflect the presence of a small degree of myocardial necrosis in a quantity insufficient to be measured by other clinical techniques, the evidence is accumulating that these bone-seeking radiopharmaceuticals accumulate in ischemic myocardium both with and without infarction. Thus, while this test is very sensitive for the detection of acute myocardial necrosis, it is quite likely not specific.

What does this mean in terms of the practical application of this test? Abdulla et al have correctly pointed out that the amorphous population of patients who fall under the heading of unstable angina do have a higher mortality than patients with stable