nity, brings together community groups with purchasers and providers to implement change.[12]

Examples of community development interagency activity include the work of a safety group in Torquay which resulted in policy changes within the housing department, play areas, and other borough and police services. While health professionals prescribed drugs to patients in their hilly area in Lewisham, a community development solution was found through a new bus service.[13] By involving the local authority, it was possible, in a single intervention, to respond in a practical way to issues of loneliness, isolation, and problems of exercise tolerance.

Such initiatives need to be judged by the amount of change and public involvement generated—and by changes in health status. Primary care groups need to understand community development and be open to alternative methods of evaluation. Collecting baseline data is of limited use as measurable objectives cannot be set until needs have been identified. It takes a long time to establish a project and to show reductions in inequalities or improvements in health. However, by examining intermediate health and social indicators (uptake of health services, improved housing and social support) rather than health status, and by using appropriate, often qualitative, research methods, rigorous evidence can be produced.[3]

Community development techniques could help primary care groups develop decision making processes that truly involve users. The lay member on the group will become an isolated figure unless supported by a vigorous and effective infrastructure. A community development agency, with a representative co-opted on to the board, should be established in each primary care group, perhaps by expanding an existing organisation. By continuing existing locality community development and drawing together voluntary groups and local authority initiatives, an agency could support and challenge planning by the primary care group. Information and recommendations from local people could go directly to the primary care group while the group could also request representative lay views or action on particular issues. This structure may provide for some measure of accountability and help the primary care group focus on key social determinants of health. It would enable users' views to be given appropriate respect and weight in the planning process.

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Bone marrow transplantation for autoimmune diseases

An interesting approach—but only for patients with few alternatives

The cross fertilisation of ideas between different medical specialties means that traditional techniques from one field are beginning to find surprising roles in others. Bone marrow transplantation, for example, is becoming more sophisticated and safer, particularly since the advent of peripheral blood stem cell transplantation, and this is now being studied as a treatment for autoimmune diseases.[1–3]

Conventionally, long term immunosuppressive drugs are administered to control the autoimmune disease process, but these offer little in the way of a cure. Because autoimmunity is viewed as a failure of the immune system to protect against self reactivity, however, some have argued that by completely "resetting" the immune system, it might be possible to eradicate the autoimmune disease process altogether. People with both haematological malignancies and autoimmune diseases sometimes go into remission from both conditions after undergoing bone marrow transplantation. This incidental observation has prompted some haematologists to argue that such a reset of the immune system may be provoked by completely ablating the patient's lymphoid system and then rescuing the bone marrow with a haemopoietic stem cell transplant.

In recent years, in Europe and the United States, stem cell transplantation has been offered to selected

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patients suffering from severe autoimmune diseases such as rheumatoid arthritis, systemic sclerosis, and multiple sclerosis. The initial results have been encouraging, with some patients going into clear remission.[2 4] Allogeneic transplants (where the recipient receives haemopoietic stem cells from another person) have a procedural mortality rate of up to 20%, but in some cases have resulted in a two year remission of the autoimmune disease. Autologous transplants (harvesting and reinfusing the patient's own cells) have a much safer procedural record, but patients tend to relapse faster.

As yet there is no definitive explanation for these observations. Some haematologists argue that peripheral blood stem cell transplantation simply allows more intensive immunosuppression than is conventionally used by rheumatologists, with the stem cell transplant being used as a rescue vehicle. Another theory is that the stem cell transplantation "stirs up" the immune system enough to re-educate the way it works, so that even putting back the patient's own cells is likely to work. Early relapse with autologous transplantation may be explained by assuming that residual colonies of T lymphocytes (thought to play an important part in autoimmune diseases) are either left behind, or reinfused back, and that these are in some way responsible for triggering self reactivity again.

But perhaps more interesting are the patients with autoimmune disease who relapse after allogeneic transplantation. In such cases the disease appears to recur despite the new immune system. It is as if the same "mistakes" are being learnt by the new system, mediated perhaps by as yet unidentified antigens.

The rationale for the use of peripheral blood stem cell transplantation in autoimmune disease is questionable, and it is certainly too early to call it a curative procedure. Many rheumatologists argue that even with intensive immunosuppression and bone marrow rescue, this approach is unlikely completely to cure diseases such as systemic sclerosis, which is also mediated by fibroblast dysfunction. It is also unlikely to benefit patients who already have severe joint destruction from rheumatoid arthritis, for example. Thus peripheral blood stem cell transplantation may be able to tackle some of the important mechanisms of autoimmune disease, but it certainly cannot deal with them all. Several longer term risks also render the decision to undergo a stem cell transplant more difficult. Total body irradiation and high dose chemotherapy, for example, are associated with an increased risk of solid tumours and other haematological malignancies, and infertility in both men and women is also common.

At present the evidence for peripheral blood stem cell transplantation as a therapeutic option in autoimmune disease relies on a small number of transplantations performed at a few centres around the world. Since September 1996, when the first international meeting took place in Basel, work has started on producing consensus guidelines and European protocols for treating several autoimmune diseases, including systemic sclerosis and multiple sclerosis.[3] Most patients who are offered peripheral blood stem cell transplantation are those with highly progressive disease, where there is a significant threat to life but as yet no severe end organ damage and where there are few therapeutic options. For these people the high risks of the procedure must be weighed against the higher risk of dying from the disease itself. It is therefore highly unlikely that peripheral blood stem cell transplantation will ever become a routine treatment for people with stable rheumatoid arthritis, where adequate control is achieved with more moderate immunosuppressing drugs.

This year when the European group meet again in October, there may be enough collective experience to start a large prospective clinical trial. Over forty cases have already been registered in Europe since 1994. The chronicity of all autoimmune diseases, however, means that the true efficacy of this approach will take many years to assess.

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Aspirin for preventing and treating pre-eclampsia

Large trials continue to show no benefit

Pre-eclampsia is a multisystem disorder usually associated with raised blood pressure and proteinuria. A relatively common complication of the second half of pregnancy, it affects 2-8% of pregnancies.[1] Although outcome is often good, pre-eclampsia remains a major cause of morbidity and mortality for both woman and child. For example, the woman may develop renal or hepatic failure or disseminated intravascular coagulation or have a cerebrovascular haemorrhage. The baby may have intrauterine growth restriction, suffer the consequences of prematurity, or die in utero. The causes of pre-eclampsia remain obscure, but women with the condition produce excess thromboxane, and thus aspirin has long been tried for

BMJ 1999;318:751–2