Abortion doctor suffers second attack in six years

David Spurgeon *Quebec*

A Vancouver gynaecologist, Dr Garson Romalis, who performs abortions and who was shot six years ago as he ate breakfast in his home (*BMJ* 1994;309:1322), has been stabbed by a young man in the lobby of his office at a medical clinic.

Since this latest attack, Dr Ellen Wiebe, another Vancouver gynaecologist who had during the previous week announced she had begun clinical trials with the abortion pill mifepristone (RU-486), has received what police called "a threatening message through her answering service."

Dr Romalis, who was put under armed guard while in hospital after the attack, is reported to be doing well. Dr Wiebe said that the stabbing would not deter her.

Vancouver police urged all abortion providers to be on high alert, and British Columbia's premier, Ujjal Dosanjh, called for tougher penalties for those attacking doctors doing their jobs. The federal justice minister said that she was willing to look at tougher sanctions but that the Criminal Code already dealt with such actions.

Police are trying to determine whether the latest attack on Dr Romalis and the threat against Dr Wiebe are linked to the previous shooting of Dr Romalis and perhaps several other similar incidents. The weapon was different and the attack occurred in summer, whereas the other incidents happened during the autumn.

A warrant was issued earlier this year for American antiabortionist James Kopp, who is a suspect in the shooting of Dr Romalis in 1994 and of two other abortion providers in Canada. Mr Kopp, believed to be in hiding in Mexico, has also been indicted for the 1998 murder of Dr Barnett Slepian of Amherst, New York.

Several people who were in the Seymour Medical Clinic, where Dr Romalis has his office, said that the assailant, a white man in his 20s or 30s dressed in a hooded dark grey or black tracksuit, waited for some time for Dr Romalis to appear. He watched as the doctor left his car with a valet for parking, then returned outside for his forgotten briefcase, and when Dr Romalis re-entered he stabbed him in the left rib cage from behind and escaped. □

ANDY CLARK/REUTERS

Dr Henry Morgentaler, an abortion provider who overturned Canada's anti-abortion legislation in 1988, talks to reporters after the stabbing of Dr Garson Romalis

NICE issues guidance for heartburn and indigestion

Annabel Ferriman *BMJ*

The NHS could save £50m ($75m) a year if GPs were more circumspect in their use of proton pump inhibitors, the National Institute for Clinical Excellence said in its guidance to doctors last week.

The institute asked doctors to review their use of these drugs with the aim of reducing the dose or even stopping the medicine when appropriate. The NHS in England and Wales spent £314m on proton pump inhibitors in 1998. If the guidance were implemented it could reduce use by 15%, the institute said.

It recommends that patients diagnosed with non-ulcer dyspepsia should not be routinely prescribed proton pump inhibitors. If the symptoms seem to be acid related, an antacid or the lowest dose of an acid suppressor to control symptoms should be prescribed.

If the symptoms do not seem to be acid related, an alternative therapeutic strategy should be prescribed, the guidance says.

Patients with documented duodenal or gastric ulcers should be tested for infection with *Helicobacter pylori,* and, when positive, they should be treated with eradication therapy. They should not be treated with long term, acid suppressing therapy.

For patients with ulcers induced by non-steroidal anti-inflammatory drugs who have to continue taking these drugs, an acid suppressor (usually a proton pump inhibitor) should be prescribed. After the ulcer has healed, however, treatment should be reduced gradually to a maintenance dose.

Patients with severe symptoms of gastro-oesophageal reflux disorder should be treated with a healing dose until the symptoms have been controlled. After that the dose should be reduced gradually to the lowest dose that maintains symptom control. □

Copies of the full guidance and information for patients are available on the NICE website (www.nice.org.uk).

Ireland's measles outbreak kills two

Doug Payne *Dublin*

The Republic of Ireland is suffering its worst measles outbreak for seven years as a result of the low uptake of the measles, mumps, and rubella (MMR) vaccine. Uptake of the vaccine is less than 80%.

The Irish National Disease Surveillance Centre said that more than 1220 cases of measles have been reported this year, compared with just 148 cases for the whole of last year; two children in north Dublin have died. The bulletin can be accessed at www.ndsc.ie/.

The centre also said that the disease is starting to spread from Dublin to other parts of the country. Health boards are planning to launch a vaccination campaign in the autumn.

Reported cases are now at their highest level since 1993, when 4328 cases were notified. None of the country's regional health boards has reported vaccination reaching the recommended level of 95%. The average uptake of the vaccine is about 76%, with rates ranging between 68% and 86%. Uptake in the United Kingdom is 88%.

The disease surveillance centre's latest bulletin suggests that the low numbers of MMR vaccinations are the result of parental forgetfulness, apathy, and concerns about side effects. The centre cannot say, however, whether the uptake rate has been influenced by the *Lancet* article published in 1998, which suggested that the MMR vaccine was linked to autism (1998;351:637-41). It only recently started collecting national figures of the vaccination uptake and has no figures before 1999.

The article in the *Lancet* has been blamed for reducing the uptake in the United Kingdom from 90.4% to 87.6%.

Parents in Ireland have been influenced by the Best case. The Supreme Court found in 1992 that Kenneth Best, now a severely brain damaged adult, was affected by being given a dose from a toxic batch of pertussis vaccine. □