ations that should feature in the reckoning of a profession that regards itself as having a scientific basis. Perhaps we should remember that always and never are words that we contemplate at our peril in medical debate, even if explanation eludes us.

Incidentally, with reference to Loudon's article, the only person who offered a guess as to how long I might have difficulties was a retired general practitioner with a lifetime of community experience behind him.

SHARON IFE
Medical director

Mount Edgcumbe Hospice,
St Austell,
Cornwall PL26 6AT

1 Loudon M. Great expectations. *BMJ* 1994;**309**:676. (10 September.)

Controlled trials of dental amalgam are needed

EDITOR,—The response of almost every writer from the dental profession to the suggestion that dental amalgam is hazardous to health is that adopted by Ivar A Mjör: to sit back and challenge the opponents of amalgam to produce proof of harm.[1] Not only is this notoriously difficult to do, as in all cases of chronic low level toxicity, but it is fundamentally the wrong approach. The initial question is not a scientific one at all but a question of the burden of proof.

With any procedure that may be hazardous the onus of proof must shift. It is up to the advocates of that procedure to show its safety, not for its opponents to prove damage. The charge against the dental profession is that this has never satisfactorily been done. It is not enough to rely on comparisons with staff who handle mercury, but who absorb it in different ways from dental patients; on theoretical considerations of dose; or on a hundred or more years of use (what about smoking?). Contact hypersensitivity is not the issue here. Nothing less than long term population studies with proper controls, in the best traditions of rigorous research, will suffice in a case of such potential seriousness. These have not been done.

The dental profession should get its house in order with regard to research; above all, attention should be paid to the key question of the burden of proof in medical as well as environmental matters of this kind.

E A A BALDWIN*

1 Mjör IA. Side effects of dental materials. *BMJ* 1994;**309**:621-2. (10 September.)

*Lord Baldwin is joint chairman of the Parliamentary Group for Alternative and Complementary Medicine.

Use of complementary therapies

EDITOR,—Peter Fisher and Adam Ward report high use of complementary therapies throughout Europe.[1] The figures for the United Kingdom are based on surveys of public opinion carried out by organisations such as the Market and Opinion Research Institute and Gallup. As the authors admit, such data should be interpreted with caution. With a view to overcoming some of the shortfalls of these studies the Research Council for Complementary Medicine recently commissioned a methodological pilot study for a population based survey of the use of complementary medicine (unpublished report); this was conducted by Kate Thomas and colleagues at the University of Sheffield.

Postal questionnaires were sent to 921 adults sampled from electoral registers. Subjects were asked whether they had consulted a practitioner of six named therapies or any "other specialist in complementary medicine" in the past 12 months. The six named therapies were acupuncture, chiropractic, osteopathy, homoeopathy, herbal medicine, and hypnotherapy. A 78% response rate was obtained (718 subjects).

The crude estimate of use of the six named therapies in the previous 12 months was 8·5% (95% confidence interval 6·7% to 10·9%), with lifetime use estimated at 16·9% (14·3% to 19·9%). Use of other complementary therapies (for example, spiritual healing and aromatherapy) was estimated at 2% a year. A quarter of the sample had purchased over the counter homoeopathic or herbal remedies at least once. Roughly two thirds of these people had never visited a practitioner, giving an estimate for lifetime use of some form of complementary medicine of 33%. These preliminary data broadly support the figures given by Fisher and Ward. Use among certain groups of patients was higher. It has been reported that 46% of children with cancer,[2] 66% of patients with rheumatoid arthritis,[3] and 40% of patients with HIV infection and AIDS[4] have used complementary therapies.

Given this degree of use of complementary medicine and that such therapies may affect health status, doctors should routinely include questions about complementary therapies in history taking. There is strong evidence that patients do not readily volunteer this information, possibly for fear of admonishment.[2] In addition, use of complementary medicine may be a confounding factor in clinical trials, especially as many trials study the groups of patients most likely to use complementary medicine. Documentation of such use should therefore become a routine measure in assessments of outcome in clinical trials.

ANDREW VICKERS
Director, information services

Research Council for Complementary Medicine,
London WC1N 3JF

1 Fisher P, Ward A. Complementary medicine in Europe. *BMJ* 1994;**309**:107-11. (9 July.)
2 Sawyer MG, Gannoni AF, Toogood IR, Antoniou G, Rice M. The use of alternative therapies by children with cancer. *Med J Aus* 1994;**160**:320-2.
3 Boisset M, Fitzcharles MA. Alternative medicine use by rheumatology patients in a universal health care setting. *J Rheumatol* 1994;**21**:148-52.
4 Anderson W, O'Connor BB, MacGregor RR, Schwartz JS. Patient use and assessment of conventional and alternative therapies for HIV infection and AIDS. *AIDS* 1993;7:561-5.

Antibodies to phospholipid in alcoholic liver disease

EDITOR,—F Violi and colleagues report that a third of patients with cirrhosis of the liver had circulating antibodies to phospholipid (cardiolipin antibodies and lupus anticoagulant) and that the presence of antibodies to phospholipid is associated with an increased prevalence of splanchnic venous thrombosis.[1] Some of their patients had alcoholic cirrhosis, which is associated with a high frequency of non-organ specific autoantibodies.[2] The incidence of splanchnic venous thrombosis in chronic liver disease is less clear but is roughly 0·6-20%.[3,4] We have evaluated a series of patients with a range of alcoholic liver disease but without splanchnic venous thrombosis (as determined by Doppler ultrasound scanning) for the presence of antibodies to phospholipid.

Thirty patients admitted for investigation of liver disease during 1991-2 were tested for IgG and IgM antibodies to phospholipid with a commercial enzyme linked immunosorbent assay (ELISA; Cambridge Life Sciences, Cambridge, United Kingdom). All the patients had a history of alcohol misuse. Serological testing for hepatitis viruses yielded negative results, and liver biopsy specimens were characteristic of those seen in alcoholic liver disease. The table shows our findings. We conclude that antibodies to phospholipid are common in alcoholic liver disease and are not restricted to patients with cirrhosis; they also arise in patients with alcoholic hepatitis without an underlying cirrhosis.

Presence of antibodies to phospholipid, categorised by immunoglobulin type, in patients with alcoholic liver disease. Figures are numbers (percentages)

	IgG	IgM	All antibodies
Alcoholic hepatitis (n=14)	3	3	3 (21)
Alcoholic hepatitis with cirrhosis (n=10)	5	5	6 (60)
Inactive cirrhosis (n=6)	0	0	0

GEORGE BIRD
Senior registrar
PETER MILLS
Consultant physician

Gastroenterology Unit,
Gartnavel General Hospital,
Glasgow G12 0YN

DUNCAN SMITH
Chief medical laboratory scientific officer

Department of Haematology,
Stobhill General Hospital,
Glasgow G21 3UW

JOHN RUNCIE
Consultant physician

Broomhill Hospital,
Glasgow G66 1RR

1 Violi F, Ferro D, Basili S, D'Angelo A, Mazzola G, Quintarelli C, *et al.* Relation between lupus anticoagulant and splanchnic venous thrombosis in cirrhosis of the liver. *BMJ* 1994;**309**: 239-40. (23 July.)
2 Bailey RJ, Krasner N, Eddleson ALWF, Williams R, Tee DEH, Doniach D, *et al.* Histocompatibility antigens, autoantibodies, and immunoglobulins in alcoholic liver disease. *BMJ* 1976;ii: 727-9.
3 Okuda K, Ohnishi K, Kimura K, Matsutani S, Sumida M, Goto N, *et al.* Incidence of portal vein thrombosis in liver cirrhosis: an angiographic study in 708 patients. *Gastroenterology* 1985;**89**:279-86.
4 Oko K, Tanaka K. Intravascular coagulation in autopsy cases with liver diseases. *Thromb Haemost* 1979;**42**:564-70.

Measles and rubella immunisation campaign

Older children should be included

EDITOR,—Do others share my reservations about the national measles and rubella immunisation campaign?[1] It is based on a model dear to the hearts of some people who have influence in and around the Joint Committee on Vaccination and Immunisation and draws on campaigns for one off "catch ups" in the Caribbean and in Latin America,[2] Such campaigns are not necessarily transferable to Britain.

Previously the Joint Committee on Vaccination and Immunisation stated that there were cohorts of increasing age still susceptible to measles and recommended that they should be offered measles, mumps, and rubella vaccine if they had not had it before.[3] It is with these cohorts that the real problem for future years lies (figure). Measles is more severe in older teenagers and young adults, and the American experience of outbreaks in colleges and universities would inevitably be repeated in Britain.[4] Health authorities, such as Argyll and Clyde Health Board, that followed those recommendations, however, got no financial help and are now likely to be penalised through having to deal with parents' and health professionals' confusion and frustration over the recommendation that children should be immunised with the measles and rubella vaccine even if they have previously been immunised with measles, mumps, and rubella vaccine.