multicentre studies, and clinical trials, appropriate referencing systems need to be developed. I propose that use of a study's name instead of named authors, with details of the writing committee and collaborators clearly stated in a footnote on the title page, is self explanatory and the most elegant solution. This would avoid confusion, facilitate the identification of papers from a particular group, and benefit the individual contributors.

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Campaign to eradicate polio is funded by charity

EDITOR,—Margaret Dooley's report on the campaign to eradicate polio does not mention that in the late 1980s the World Health Organisation was reluctant to tackle the project partly because of the cost and partly because of the problem of refrigerated transport and distribution. Rotary International spurred on the WHO by paying $250 million for the purchase of the vaccine over five years and then providing a "cold line" through its volunteer organisation in thousands of clubs in 180 countries across the world. Only recently has Rotary been allowed to have clubs in the former Soviet Union, which is why these states are only now catching up with universal immunisation.

Rotary International planned to ensure that the world would be free of polio by its centenary year, 2005. The present rate of progress may see the goal achieved by 2000.

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1 Dooley M. Campaign targets polio "hot spots." *BMJ* 1995;**310**: 894. (8 April.)

Poor response to erythropoietin

EDITOR,—Iain C MacDougall's editorial on poor response to treatment with erythropoietin outlines a rational approach to this problem.[1] We agree with his scheme of how to investigate and manage patients who apparently show resistance to erythropoietin but would strongly advocate one further investigation—namely, assay of plasma erythropoietin concentrations in such patients.

We routinely assay erythropoietin concentrations in all patients receiving this treatment from our dialysis centre, including the few patients who start the treatment before starting renal replacement therapy. We use a competitive binding, disequilibrium radioimmunoassay which uses recombinant human erythropoietin for both tracer and standards and a goat polyclonal antibody to erythropoietin (EPO-Trac, INCSTAR, Stillwater, MN, USA). The assay requires overnight incubation. The primary aim of this approach is to optimise erythropoietin treatment rather than to screen for non-responders. We believe that this approach enables us to tailor the treatment to patients; in view of the cost of erythropoietin, the saving in unnecessary treatment easily covers the costs of the assay.

While using this approach we have investigated a number of non-responders. Many have had a deficiency in their erythropoeitic axis, principally of iron. Importantly, we have also detected patients in whom erythropoietin concentrations have been subtherapeutic. Subsequent investigation of this group has shown either poor subcutaneous absorption or non-compliance. Use of the erythropoietin assay enabled us to avoid extensive and unnecessary investigations in this last group.

Assays of plasma concentrations of erythropoietin are a useful adjunct to the investigation of poor response to erythropoietin treatment and in selected cases will obviate more expensive and invasive investigations.

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Safety of complementary medicines should be monitored

EDITOR,—As Western medicine accepts the role of complementary treatments, should not these alternatives be expected to conform to the stringent safety standards expected of orthodox drugs? We ask this in the light of three cases illustrating the toxic effects of Chinese herbal remedies.

Firstly, Kane *et al* recently reported two cases of hepatotoxicity associated with the use of herbal and plant extract remedies.[1] Secondly, we wish to report a case of fulminant hepatic failure in a 32 year old man. Four weeks before presentation he had taken a locally dispensed Chinese herbal remedy, labelled "eternal life," as treatment for simple lipomas. By five weeks he was deeply jaundiced and became encephalopathic. Despite urgent liver transplantation he died. No viral, immunological, or metabolic cause for his liver failure was identified.

Analysis of the herbal remedy that this man had taken confirmed the presence of *Dictamnus dasycarpus*; this was also identified in previous cases of herbal hepatotoxicity.[1,2] This plant contains a wide range of potential toxins, including xanthotoxin and psoralens, along with steroid-like compounds, vasoactive substances, coumarins, and flavinoids.

We are not blind to the possible benefits of herbal remedies. But these remedies are not innocuous placebos, and we agree with the issues raised by P A G M de Smet.[3] If such adverse events happened with a conventional drug, at the very least one would expect the Committee on the Safety of Medicines to be notified. In addition, the prescribing clinician and pharmaceutical company could potentially be held liable for damages. Who monitors the safety of alternative medicines? Is there any liability for their prescribing? What action can be taken when side effects occur? Are people profiting from this business without accepting responsibility for their work?

This is an important public health issue for which there seems to be no responsible representative body. Licensing is merely the first step; much more ought to be done.

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AIDS is less of a health threat than other diseases in Africa

EDITOR,—In November 1986 the *Sunday Express* predicted that "the deadly disease AIDS is now so out of control in black Africa that whole nations of people are doomed, leaving vast areas of now populated land devoid of a single person within the next ten years." Richard Rigby's personal view about the condition of Africa in the wake of AIDS[1] is reminiscent of the newspaper's doomladen sentiment and follows another apocalyptic vision of post-AIDS Africa, in which people eke out a "hand to mouth existence in dusty, forgotten rural homes, while in the towns, industry falls silent, businesses and stores lie closed and derelict while the wind blows rubbish and old leaves down deserted dead streets."[2] I do not wish to underestimate the tragedy that AIDS represents for Africa, but there is something deeply disturbing about the discussion of a disease creating continental collapse when in reality it has made only a minor contribution to the enormous human suffering in Africa.

The World Health Organisation estimates that AIDS has claimed 2 million lives since the early 1980s.[3] During that same period, the organisation estimates, 3·5 million people in Africa died of tuberculosis[4] and 16·8 million people of malaria.[5] Despite these figures, one would scour the press and scientific journals looking for predictions of continental collapse in the face of malaria or tuberculosis in vain. As a health threat AIDS is not even close to malaria and is not yet as important as tuberculosis or, indeed, measles, tetanus, pertussis, or diphtheria, which combined claim around 500 000 lives every year. I suggest that the high profile given to AIDS is more a consequence of the assumption that Africa is a continent sitting on several time bombs than a consequence of a rational assessment of the real situation.

While this is deplorable in itself, the hyperbole about AIDS is having perverse effects on the understanding and treatment of health problems in Africa. Far from AIDS being hidden among tuberculosis and other illness, as Rigby suggests, the clinical definition used to diagnose AIDS in Africa is an encouragement for established illness to be interpreted as AIDS. This helps to obscure the relation between poverty, disease, and early death and associates the cause of disease with the African propensity for fecklessness and immorality. As Larson coldly spelt it out, "African attitudes towards sexuality and marriage have undoubtedly accelerated the spread of HIV."[6] The wringing of hands and condemnation are a familiar refrain, but the frightening consequence of millions being condemned to die of curable diseases is new.

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