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were born to mothers with AIDS (11%), at high risk by
features were protozoal and bacterial infections. 90% of
the Bronx, or Manhattan. Many more, born seropositive,
seem to have chosen to die quietly with pride, but the rest of
price for their government’s policies. These Iraqi patients
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What I saw in terms of suffering and deprivation will stay
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go to your alumnus Murphy and Mulcahy (April 15, p 988) generalise that AIDS is increasing faster in
women than in men. To imply that this is so in all women
denies to those few at uniquely high risk the special attention
that they need, while ringing alarm bells everywhere for
enormous numbers of women who are not and need never
be at risk.9

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A physicist’s eyewitness report in Iraq

Sir,—Recently I returned to visit my alma mater in Iraq—the University of Mosul’s Medical School. On the basis of what
I had heard about the dire need for medical supplies there, I
took with me a container with a balanced supply of
medicines sufficient for about 100 patients for one month.
The medicines were donated by pharmaceutical companies,
physicians such as myself, and Jordanians.

In all, I visited seven medical centres throughout Iraq. What I saw in terms of suffering and deprivation will stay
with me for a very long time. The worst thing that can
happen to an Iraqi nowadays is to become ill. Very basic
medical supplies including cotton, antiseptics, and
antibiotics are not available in most public clinics and
hospitals. Some items are available on the black market but
their prices are beyond the reach of most Iraqis and their
storage conditions leave much to be desired. The fortunate
might find enough insulin for a diabetic child to last for a
month. The price will be many times more than their salary.
Faced with a near total collapse of their country’s health
infrastructure, Iraqi physicians often resort to diagnosing
cases without the necessary laboratory tests. The medicines
they prescribe are often the very few that are available at the
time. By the time they get patients with chronic illnesses
stabilised on a drug it becomes unavailable through the
regular channels.

I find it difficult to decide who is most hard hit by
this widespread shortage—elderly people, children,
hypertensives, epileptics, diabetics, or the ones who suffer
from an acute surgical condition for which surgery cannot
be done because of the lack of anaesthetics and surgical
sutures. If available, an X-ray film is used for 3 patients at
one time.

The patients I encountered in Iraq were not consulted
when Iraq invaded Kuwait in 1990. They should not pay the
price for their government’s policies. These Iraqi patients
seem to have chosen to die quietly with pride, but the rest of
the world, especially the medical community, should not
stand idly by. I should like to invoke the principles of our
civilisation to stop this cruelty against a whole nation. Our
pledge to save human lives and to care for and love the sick
should motivate us to save human lives in Iraq. All medical
and humanitarian agencies and physicians around the world
should lend a hand to the patients of Iraq. They desperately
need such assistance now.

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Authorship inflation: a trend reversed

Sir,—With the growing pile of publications, several surveys
suggest a constant rise in the number of coauthors.1,2 This
continuing rise of contributors increases the chance of
authorship inflation. As shown by the Pearce/Chamberlain
case from St George’s Hospital, London, in which
authorship was awarded to one who had not contributed
intellectually, this might increase the likelihood of fraud.3
A paper investigating the number of authors for Lancet articles
suggested that the mean authorship escalated from 1-3
authors per major article in 1930 to 4-3 in 1975. Moreover,
there was a striking acceleration of this increase in the years
just before 1975. To see whether this trend is continuing,
the number of coauthors to Lancet articles was examined for

Articles were retrieved electronically via MEDLINE and
were selected by the keyword journal-article for publication
type. This selection criterion excludes all papers published as
letters to the editor and reports appearing in the news and
bookshelf section. The dataset was loaded onto a
wordprocessing programme and names were counted.
Anonymous reports were omitted from the study. Because
MEDLINE truncates the number of authors at 10, such
papers were examined individually. In the 19 years studied,
the mean number of authors showed a steady increase, from
3·18 in 1975 to 4·16 in 1990 but then a decrease to 3·99 in
1994. The number of papers with more than 10 authors
showed a steady increase from none in 1975 to 36 in 1994.

The difference between mean authorship in 1975, as
reported by Strub and Black1 (4·3) and in our study (3·18),
is probably attributable to different selection criteria. Strub
and Black looked exclusively at major articles (presumably
publications appearing in the articles section), but such
reports only reflect a small part of publications in The
Lancet. Thus, although the growth of mean authorship is
stable, the number of papers with more than 10 authors is
rising.

Complex clinical questions often need input from a wide
range of disciplines, resulting in a large number of potential
authors. In multicentre studies, which typically involve many
collaborators, agreement about authorship when individual
collaborators are not credited is difficult to achieve. But in
such reports participation solely in the acquisition of funding
or collection of the data does not justify authorship. In a
study of 12 articles in a general peer-reviewed journal, only
51 of 84 authors fulfilled possible and definite criteria for
authorship, suggesting that at least a third of authors did not
contribute substantially to the intellectual content of the
paper.5

This lax view on authorship is worrisome, but some
solutions can be offered. First, the contributions of separate
cooauthors to multiauthor papers should be assessed more
critically as to whether individuals’ efforts qualify for
authorship. The decrease in mean authorship nevertheless
suggests that investigators can adhere to the criteria for
authorship. Furthermore, reports of studies involving many
collaborators could be made on behalf of a joint group,
instead of listing each separate contributor as an author. This style of reporting is developing in recent issues of The Lancet.

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Viscous hearing loss

Sir—Acute sensorineural hearing loss is well recognised in renal failure. The causes include recurrent infection, underlying immune-mediated disease, or side-effects of drugs such as aminoglycosides and loop-diuretics, but usually the hearing loss remains unexplained.1 We report on a patient with acute sensorineural hearing loss associated with blood hyperviscosity due to polyclonal gammopathy. Despite progression of renal failure a return to normal blood viscosity was accompanied by recovery of hearing.

A 69-year-old woman with progressive renal failure secondary to glomerulonephritis was admitted for evaluation of acute unilateral hearing loss. Audiometry confirmed the hearing loss of 40 dB over frequencies of 0.5 to 4.0 kHz and an air-bone gap of 5 dB. Her serum creatinine (4.0 mg/dL) and blood urea (56 mg/dL) were raised. The haematocrit was 34.8% and she had a raised serum protein of 9.1 g/dL. Viscosimetry (dropping ball technique) showed her blood to be abnormally viscous (1178 ms [normal 850–975]). The viscous hearing loss.

Despite the worsening renal function audiometry on day 20 revealed an improvement of hearing function by 20 dB. At that time the blood viscosity measurement was 1102 ms. Serum total protein was 8.1 g/dL with 27.4% γ-globulins and an albumin/globulin ratio of 0.92. During the next 3 weeks her hearing returned to normal, as did viscosimetry (950 ms) and the serum protein (7.4 g/dL), γ-globulin (24.2%), and albumin/globulin ratio (1.24). Intermittent haemodialysis was continued.

The internal ear is supplied by an end-artery, so rheological abnormalities resulting in increased blood viscosity are likely to play an important part in the pathogenesis of hearing loss.2 Hearing impairment secondary to hyperviscosity may be underdiagnosed yet it carries a good prognosis if treated. Further studies of the relation between blood viscosity and hearing loss may help toward specific preventive strategies in patients at risk of viscous hearing loss.

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Hyponatraemia after rehydration with sports drink

Sir—A 44-year-old boy was admitted to our unit acutely ill with fever, vomiting, and, predominantly, diarrhoea. He was passing frequent, small, loose stools, and was thought likely to have an acute gastroenteritis. Examination suggested that he was about 3% dehydrated and an oral rehydration solution (Gastrolyte) was prescribed. Over the next 36 hours his diarrhoea remained severe (he was subsequently found to have both salmonella and cryptosporidium in his stool) and his oral intake was less than intended. Because the dehydration was thought clinically to have worsened, his urea and electrolytes were checked and his sodium was found to be 124 mmol/L. Inquiry on the ward revealed that because the child had not liked the taste of Gastrolyte he had been allowed to drink Powerade, a sports drink, in the belief that such drinks would contain enough electrolytes to replace his losses.

<table>
<thead>
<tr>
<th>Content</th>
<th>Liquid</th>
<th>WHO ORS</th>
<th>Gastrolyte</th>
<th>Powerade</th>
<th>Gatorade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na⁺ (mmol/L)</td>
<td>00</td>
<td>00</td>
<td>05</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>K⁺ (mmol/L)</td>
<td>20</td>
<td>20</td>
<td>07</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Glucose (g)</td>
<td>22</td>
<td>18</td>
<td>40</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Sucrose (g)</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

Table: Electrolyte and sugar content of two oral rehydration solutions (ORS) and two sports drinks

The table shows the electrolyte and sugar contents of Powerade, another sports drink (Gatorade), Gastrolyte, and the oral rehydration solution recommended by WHO. Although the electrolyte content of sports drinks may be suitable for replacing losses during sporting activity, it is entirely inadequate for the purpose of rehydration in the setting of the electrolyte losses associated with an acute gastrointestinal illness. The high sugar content of the sports drinks may also be too high for the damaged gut, resulting in a worsening of the diarrhoea due to an osmotic effect.

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Early diagnosis of Duchenne muscular dystrophy

Sir—Marshall and Galasko (March 4, p 590) have appropriately emphasised the persistent difficulty of delayed diagnosis in Duchenne muscular dystrophy (DMD). They do not tell us the mean age at which the diagnosis was made. The timing is especially relevant for genetic advice because the earlier the diagnosis is made the greater is the opportunity of providing accurate counselling and, importantly, the possibility of offering prenatal diagnosis in subsequent pregnancies.

In our regional paediatric neuromuscular clinic the average age of diagnosis of 51 boys with DMD was 4.5 years (range 3 months to 8.5 years); in four of these families, further affected siblings were born before the diagnosis was established in the older child. Early diagnosis and the identification of high-risk pregnancies to prevent subsequent affected children is the predominant (and some would argue only) justification of screening of newborn babies for DMD.1

In the absence of a universal neonatal screening policy it is, as Marshall and Galasko correctly point out, imperative that this invariably fatal disorder is considered as early as possible.2

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