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Editorial/Van die Redaksie

Peer reviewers

It is fitting at the beginning of a new year to pay tribute to all those unsung heroes who without any reward whatsoever help to maintain the standard of the *SAMJ* by assisting in the process known as peer review. It is possible in the offices of a large journal with a large staff to assemble a group of editors from various disciplines, who between them can review most of the papers submitted. This is clearly impossible when only one editor or at the most two are involved. We would like to thank all those who have helped us, but some commentary on the whole system of peer review is perhaps called for.

Recently, Stephen Lock, Editor of the *British Medical Journal,* wrote a critical leading article on the subject of peer review, which he employs for roughly half of the manuscripts submitted.[1] Various studies, some of which Lock quotes, have suggested that this sacred cow of scientific journalism may have serious faults. One highly controversial study concerned 12 papers on psychology which had been accepted and published by reputable journals. These were slightly doctored with false names of authors and institutions of origin and changed titles and resubmitted to the same journals some 18 - 32 months later. Only 3 of the 12 articles were spotted for what they were; 8 of the remaining 9 were rejected on the second submission. However, psychology is the sort of science in which many mediocre papers are published and the boundary between acceptance and rejection may be a thin one.

One reason for the change of heart by editors and referees seems to have been that the institutions from which the articles were alleged to have come had been altered from prestigious to lesser known or mythical institutions. It may be retorted, however, that there are good reasons for favouring authors from a prestigious institution, because the paper they submit has probably been torn to pieces already by colleagues and rewritten accordingly.

Meanwhile, in spite of suggestions that the system is imperfect, we continue to be grateful for specialist guidance, acknowledging, however, that the final responsibility for acceptance or rejection must remain with the editor. This may not be democratic, but until all this is done by computer, that's the way it is.

1. Lock S. Peer review weighed in the balance (Editorial). *Br Med J* 1982; **285:** 1224-1226.

Lukrake behandeling

Daar was in die afgelope tyd in Brittanje baie gissinge oor lukrake kliniese proewe, wat hoofsaaklik spruit uit die ontdekking dat een van diesulke proewe sonder die toestemming van die betrokke pasiënte uitgevoer is. Vanselfsprekend is dit verkeerd om mense sonder hulle verlof te behandel, en tog, is dit werklik so afkeurenswaardig om hulle lukraak te behandel (natuurlik op voorwaarde dat die terapeute verantwoordelike mense is)? Per slot van rekening, die ou gesegde dat elke voorskrif wat aan 'n pasiënt gegee word, 'n eksperiment is, geld nog steeds. Dat dit so is, word bewys deur die feit dat pasiënte skielik en heel onverwags vreemde newe-effekte ontwikkel terwyl ander 'n sogenaamde 'swak respons' het. (Laasgenoemde is 'n eienaardige frase wat op een of ander manier impliseer dat die pasiënt beter moes gereageer het en dat dit sy skuld is dat hy nie verbeter nie.)

Daarbenewens is daar baie min siektetoestande waarvoor daar een soort terapie bestaan wat onteenseglik as effektief bo alle ander bewys is. In hierdie lig gesien, moet 'n dokter wat 'n pasiënt behandel baiekeer 'n keuse tussen twee of meer erkende metodes maak. Hy onderwerp dus in der waarheid sy pasiënt aan lukrake behandeling.

Hierdie punt word baie duidelik deur Brewin[1] in *The Lancet* gestel wat voorstel dat 'n metode van behandeling nie skielik oneties kan word net omdat dit in 'n lukrake proefneming ingesluit word nie. Hy wys heel tereg daarop dat diesulke proefneminge nie noodwendig enigiets nuuts hoef in te sluit nie. Chirurge by verskillende hospitale mag jare lank twee verskillende operasies vir dieselfde siekte uitvoer en oortuig daarvan wees dat hulle s'n die mees gepaste tegniek is. Sou dit dus nie beter wees om 'n lukrake proefneming uit te voer om uit te vind watter van die twee operasies die suksesvolste is nie? 'n Mens het die ongemaklike gevoel dat sulke situasies al vir 'n lang tyd in sekere plekke bestaan sonder dat enigiemand die nederigheid het om die vraag op die proef te stel. Dit is natuurlik onwaarskynlik dat een van die twee tegnieke

merkwaardig nadeliger of effektiewer vir die pasiënt sal wees, maar daar is slegs één manier om uit te vind.

Brewin wys daarop dat baie van die kritiek wat die mediese professie uitlok, uit die onvermoë om hierdie konsep aan die publiek oor te dra, ontstaan het, en ook as gevolg van die misbruik van die term 'navorsing' wat vir die publiek iets gevaarliks of onrusbarends inhou. Lukrake behandeling (mét of sonder spesiale toestemming) is 'n etiese manier om uit te vind wat die beste behandeling vir 'n gegewe pasiënt is. Ons moet ook nie die kwessie verwar deur na kontrolegroepe te verwys nie.

'n Goeie voorbeeld van die kwessie onder bespreking is onlangs in die *New England Journal of Medicine*[2] gepubliseer. Daar word algemeen aanvaar dat ingrypende chirurgie met postoperatiewe bykomende chemoterapie of immunoterapie gekombineer moet word in die behandeling van huidmelanome. 'n Verskil in opinie het egter ontstaan as gevolg van 'n gebrek aan gegewens van goed-uitgevoerde proefneminge. Hierdie kwessie blyk nou sonder enige twyfel opgelos te wees deur die verslag van die WGO se internasionale melanoomgroep-proefneming waarin 761 pasiënte vanuit 'n wye reeks lande, met patologiese stadium II-melanome op enige plek van die liggaam of patologiese stadium I-melanome van die romp in 'n lukrake proefneming van bykomende chemoterapie, immunoterapie, of albei, bestudeer is. Wye lokale uitsnyding en uitsnyding van die limfknoopstreek was die enigste behandeling in 185 pasiënte en die resultate is vergelyk met dié van chirurgie plus chemoterapie in 192 pasiënte, chirurgie plus immunoterapie met BCG-vaksien in 203 pasiënte, en chirurgie plus albei die ander bykomstige metodes in 181 gevalle. Terloops, in dié verslag word geen melding van ingeligte toestemming gemaak nie.

Wat die proefneming duidelik getoon het, was dat nòg die siektevrye periode ná die operasie nòg die algemene oorlewingsyfer van pasiënte deur bykomstige behandeling (van watter aard ook al) verander is. Dus blyk bykomende behandeling nie 'n voordeel te gehad het nie, en die verslaggewers sluit af deur te sê dat, indien 'n verskil wél bestaan het, dit van beperkte kliniese waarde was. Sonder so 'n grootskaalse lukrake proefneming sal baie pasiënte in die toekoms aan die ongemak en ongerief van chemoterapie (dakarbasien, die middel wat gebruik is, het naarheid en braking in ongeveer 20% van pasiënte veroorsaak) blootgestel word, en dít vir geen doel.

1. Brewin TB. Consent to randomised treatment. *Lancet* 1982; **ii:** 919-921.
2. Veronesi U, Adamus J, Aubert C *et al.* A randomized trial of adjuvant chemotherapy and immunotherapy in cutaneous melanoma. *N Engl J Med* 1982; **307:** 913-916.

News and Comment/Nuus en Kommentaar

Consequences of maternal rubella at various stages of pregnancy

The risk to the fetus after maternal rubella at successive stages of pregnancy has never been adequately assessed, according to Miller *et al.* (*Lancet* 1982; **ii:** 781). Between January 1976 and September 1978, all pregnant women who had had rubella (as confirmed by the laboratory) in England and Wales were followed up respectively by Miller and her colleagues. Diagnosis was based on a fourfold rise in antibody titre or in the detection of specific IgM. Altogether 95% of the 1 016 women in this study had developed a rash while the remainder were symptom-free. Of the 966 women for whom the outcome of pregnancy was known, 523 (54%) had had a therapeutic abortion and a further 36 (4%) had spontaneously aborted. The proportion of women continuing with their pregnancy increased from 6% in the first 12 weeks to nearly a half at 13 - 16 weeks. Among the 407 pregnancies that continued there were 9 stillbirths and 4 of the stillborn infants had severe abnormalities.

The presence of IgM antibody soon after birth or persistence of IgG after the 1st year was taken as evidence of congenital infection, and in the series of infants tested, infection was diagnosed in 43%. The frequency of congenital infection varied at successive stages of pregnancy; with symptomatic rubella in the first 12 weeks only 3 out of 16 infants escaped infection, but the infection rate declined progressively to 25% at the end of the second trimester, only to rise again to a higher figure in the last month. Notably the chance of infection was negligible in infants whose mothers had symptomless rubella.

A total of 273 children were followed up after birth and defects consistent with congenital rubella were found in 20 children, all of whom were seropositive. The study confirmed that rubella defects occur in all fetuses infected before the 11th week of pregnancy (principally congenital heart disease and deafness) but in only 35% of those infected at 13 - 16 weeks (deafness alone). No defects attributable to the infection were discovered in 63 infants who had been infected after 16 weeks of pregnancy.

Bingo brain

Puzzled by the chest pain and mental confusion of an elderly patient who visited the local bingo hall 3 nights a week, a Canadian physician made a trip to the hall and found that 304 out of 310 bingo players were smoking in the worst polluted atmosphere he had ever encountered (*Can Med Ass J* 1982; **126**: 1266). He suggests that her chest pain and confusion were due to carbon monoxide poisoning inducing 'bingo brain'. Health education in Canada must be in its infancy.

'Wrongful birth'

The Supreme Court of Connecticut recently awarded a mother and her daughter over $100 000 damages against a gynaecologist for 'wrongful birth'. The mother became pregnant after a failed laparoscopic tubal ligation, performed because she had given birth to two children with orthopaedic defects. The damages included compensation for rearing a third child, also born with the same defect (*AMA News*, 18 June 1982).