LETTERS

Size does matter and Homeopathic treatment of premenstrual symptoms

Madam

I am somewhat concerned that in the same issue of the Journal as the statistical paper entitled ‘Size does matter’ there was an Overview on ‘Homeopathy treatments for premenstrual symptoms’ which may be considered to have depended on evidence that contradicted the statistical paper. I would be grateful for your opinion as to the reliability of the one clinical trial by Yakir et al., which was cited as evidence in favour of homeopathy. I would like to make clear that my motivation is not to discredit homeopathy.

1. The Overview refers to the ‘recent’ trial by Yakir et al. It was actually carried out in 1992–1994 and not published until 2003.

2. The Overview refers to there being 20 women in the study but actually only 19 completed the study.

3. The Yakir et al. study claims 90% of the homeopathy group had improvement — actually it was 91%, i.e. even more favourable to homeopathy than was claimed.

4. Yakir et al. set an arbitrary improvement level of 30% of the menstrual distress questionnaire to determine effectiveness of therapy resulting in three of the placebo groups improving. However, Figure 2 shows that five of the placebo group had improved.

5. While claiming homeopathy effective they admit under Outcomes that, ‘the between group difference fell just short of statistical significance’.

6. The study certainly suggests that homeopathy is effective so why no larger placebo controlled trial 9 years later?

My main concern is that our Journal has given credibility to the effectiveness of homeopathy in the management of premenstrual syndrome on the basis of inadequate evidence. What do you think?

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Reply

Thank you for your letter regarding the above mentioned papers. I agree that the fourth key message point in the Jones article ‘A randomised, controlled double-blind trial published in 2001 has confirmed the positive outcome of the previous research experience’ is not substantiated. The findings of one, very small, randomised controlled trial set are not enough to substantiate the randomisation. One of the main conclusions stated is that the type of IUD and successful removal in 26/28 subjects. It implies that no scalpel is used to incise the skin, or, as in this case, electrocautery is used to breach the skin and subcutaneous tissues to gain access to the vas. Whichever method is used the incision in the skin has to be at least twice the diameter of the vas that is being exteriorised.

We use two Allis’ forceps or a single Allis forceps and a skin hook to deliver a loop of vas through an incision made by a Number 11 blade. We assessed some of the parameters described in the paper with the following results:

1. Using a visual analogue scale (0–10) to measure pain during the operation it was found that the average score for pain during surgery was 2.52 (range 0–9). The duration of analgesic use after vasectomy was for a mean of 3.6 days (range 0–1.4 days).

2. Patients returned to work on average 4.89 days after surgery (range 1.17) although, as in the Black and Francombe paper, not all the time off work was related to the operation.

3. On average 13.9% of patients visited the general practitioners after surgery; this was for infection in 2.8% and antibiotics were prescribed to 5.6% of patients.

In a survey of patient satisfaction 68% graded the service as excellent and 26% as good, while in a previous assessment these figures were 53% and 43%, respectively.

We have used this technique a few thousand times and believe that the single incision mini-vasectomy is as good as the ENSV procedure.

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References


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