

Injectable contraceptives

Injectable contraceptives (ICs) have been on the pharmaceutical map of the world since the early 'sixties'. Ever since then they have been at the storm centre of a controversy that may well be the longest ever on a medical issue. Two countries, USA and UK have appointed public enquiry committees on the matter.

In India, the ICs controversy was of largely academic debate until about six months ago when the Govt. issued a directive permitting the import of NET-EN, one of the ICs. Around the same time it was also decided to introduce the IC as one of the cafeteria methods offered in the Govt Family Planning Clinics.

The ICs controversy has raised some fundamental issues – the manner in which decisions which affect thousands of people are taken; the ethics of medical research and control and the more fundamental problem of appropriate animal models for the testing of drugs. It also bring into focus once again, the role of the multinational drug companies in pushing potentially harmful drugs in the third world with the active participation of the concerned Govt's.

ICs are hormonal contraceptives which may be administered in the form of once in 60 or 84 day injections. They are synthetic progestogens. The two currently available ICs are Depot medroxy-progestogen acetate (brand name Depo-Provera) and Norethisterone enanthate or NET-EN (brand) name Norigest. While they are both synthetic progestogens they belong to different groups of steroids. These synthetic progestogens inhibit the production of gonadotropin which in turn prevents ovulation. The endometrium and fallopian tubes are also perhaps affected contributing to as reduction in fertility.

Depo Provera has currently been approved for use in 84 countries whilst NET-EN is 'registered' for use in 25 countries but approved for use in 40. It is neither registered nor used in UK and the US (War on Want, 1984).

The Depo Provera Board of Inquiry in the US has strongly recommended to the FDA that the drug should not be licensed as a contraceptive. In UK however, the Board of Inquiry has cautiously permitted the use of ICs in cases where other methods are unsuitable. In India Depo Provera is not allowed to be imported. However, it is not banned either.

Since Depo Provera has been in use much longer, much more research material is available on this than on NET-EN. Although they are different

steroids, it is possible to examine some of these findings with reference to NET-EN. Toxicological studies have been carried out in accordance with the requirements of the US FDA. These results have been monitored by the WHO Toxicological Review Panel periodically. The drugs have been tested on rodents, beagle dogs and rhesus monkeys. The Depo Provera animal studies have come in for a lot of criticism. Stephen Minkin a former Nutrition Chief of the UNICEF project in Bangladesh first revealed that Upjohn, Depo Provera's manufacturer had not in fact reported all the findings of their trial on beagle dogs. The 7-year studies on beagle dogs had shown that mammary gland nodules developed in all those animals which survived beyond the first few years and some of these were malignant. Another finding was acromegaly or an abnormal growth process. Ten-year monkey studies have also been conducted using DP. Again mammary nodules developed in the low-dose groups. Endometrial carcinoma was also observed in some of the monkeys, (WHO, 1982). Minkin further reports that curvature of the spine was also found in experimental animals, which is a possible indicator that Depo Provera inhibits growth hormones.

The NET-EN studies have not however shown the same results. The beagle dog studies have shown that the drug may be inhibiting or affecting carbohydrate metabolism. One case of endometrial cancer was reported in the monkey studies. The WHO Toxicology Review Panel, after a thorough examination of the results came to the following conclusions – (i) that beagle dogs were considered an unsuitable toxicological model for the study of progestogens; (ii) that the tumours in DP administered monkey arose from a cell type not found in women and so could not be considered to indicate increased risk for cancer. (WHO, 1984).

Late last year the USFDA's Board of Inquiry has categorically countered both these contentions of the WHO Panel. It has stated that "Data from the studies on the rhesus monkey and beagle dogs cannot be dismissed as irrelevant to the human without conclusive evidence to the contrary. Such evidence is not available at this time. Therefore, the same is not available at this time. Therefore the fact that malignant neoplasias developed in two species in target organs of sex steroids must be considered as an indication of the potential of progestogens, including DMPA, to promote the development of malignancies in target organs," (Report of Public Board of Inquiry, 1984).

If one were to accept the WHO conclusions on the unsuitability of beagle dogs as toxicological models for progestogens, then obviously the animal studies data becomes invalid. If this is so, on what basis are human trials, which can only follow upon animal trials, being conducted?

Human Trials

There are volumes of literature on the Depo Provera human trials. One of the 'pioneers' in the use of Depo Provera was E. MacDaniel who tried out the drug on thousands of Thai women. These studies have come in for a lot of criticism. The US Board of Inquiry has stated that the data on humans is insufficient and inadequate to either confirm or refute the animal study results (Report of Board of Inquiry, 1984). It has pointed out that in a majority of the sufficient background information on which one may decide on the possible carcinogenic risk. Moreover the Thai trials have also been criticised on ethical grounds—'informed consent' was nowhere practiced.

Depo Provera has been tried out in India, by the ICMR, but reports have never been available. There are two major NET-EN studies – both coordinated by the WHO. The first was a two-year multinational comparative trial of three regimens of DP given at 90 days interval, NET-EN at 60 day intervals, and 84 days interval. Over 3000 women participated in the trials which began with recruitments in 1977 and the final follow-up in 1982 (WHO, 1983). The other multi centre trial was conducted in India by the ICMR in 16 Human Reproduction Research Centres. This study compared two regimens of NET-EN of one 200 mg injection at 60 days and 90 days. Over 2000 women participated in this study which ended its first phase in October 1983. (ICMR, undated)

A common feature of both the studies is the very high drop out rates, most of which were due to menstrual irregularities. In the 1977 WHO trial the drop out rate per 100 women ranges from 59 to 89 and in the Indian study about 50 per 100. Menstrual irregularities included amenorrhea, excessive bleeding, and spotting. In the WHO study 40 % of the women suffered from amenorrhoea of more than 90 days.

The 1982 WHO document has specifically noted that menstrual irregularities are not likely to be a major health problem. There is really no known about the mechanism of bleeding disturbances especially those related to steroid contraceptives (WHO 1982). This being so, it is rather curious that the Indian decision to introduce the IC into the family planning programme should have come after the study results were known. One apparently facetious argument that is being used is that since Indian women are in any case anaemic, amenorrhoea would in fact help them in the long run. A similar argument is forwarded for another of the similar argument is forwarded for another of the side effects, weight gain. In the light of how little is known about menstrual irregularities, such arguments coming from 'experts' in the field must be roundly condemned as being thoroughly unscientific.

MFC Anthologies

We are sorry to inform our readers about the unavoidable delay in the Printing of the IIIrd anthology and the reprinting of the I and II anthology. Those who have sent us pre-publication payment are requested to bear with us. The pre-publication offer of Rs. 35/- for the set of three anthologies is also being extended till 30th of May 1985

It is also rather disturbing to note that a 24 months study should be deemed sufficient to prove the drug's safety when it is known to be a possible carcinogen. Another area which has been ignored is the possible teratogenic effects of ICs. The child may be exposed to the drug if the mother's pregnancy is undiagnosed when the contraceptive is administered.

Experts have stated that there is a positive and significant association between progestin's and birth defects (War on Want, 1984). There have been hardly any well-designed follow-up of children who might have been exposed to the drug. Contraception failure may also lead to exposure of the foetus to progestogens. In the two studies cited contraception failure occurred in 0.4 to 1.4 women per 100 women (WHO, 1983). While this seems like a small proportion, the total numbers are likely to be large when ICs are being given to be the family planning clinics. Another factor to be considered here is the effect of progestogens on breast fed infants. According to the WHO report a breast fed infant of a mother on NET-EN would receive about 0.05 % of the maternal dose over a two-month interval. (WHO, 1982). It has been reported that even this small amount may prove harmful because (i) the brain is not fully developed and is sensitive to hormones and (ii) the immature liver and the consequent slower elimination may lead to high accumulation of the hormone in the blood. (War on Want, 1984). When so little is known in this area, is it ethical to introduce this contraceptive in the national family doctor being able to devote to the potential IC user?

As reported earlier the Govt has now allowed the import of NET-EN by private practitioners, nursing homes etc. And yet there is no mechanism to ensure that the guidelines are followed. Moreover, ICs have a great potential for misuse. For instance, in UK, women in some hospitals were refused rubella vaccine unless they accepted DP (Campaign against Depo Provera). Closer home in Bhopal, women are not being allowed to have MTPs unless they accept copper T's. This perhaps is the most frightening aspect of the whole situation. Women will lose whatever little control they had over contraception. There is plenty of evidence that even during the trial is plenty of evidence that even during the trial phase, 'informed consent' was only a myth. When IC's become part of the 'cafeteria' approach, information will be at a greater premium because then there will be no need to 'persuade' the subject so as to get a adequate sample for research. The manner in which ICs have been introduced smacks of indecent haste. For one things, although the ICMR study was

completed by October '83, no report was forthcoming until recently. In fact the first published article seems to have appeared not in an ICMR publication but as an article in a specialised journal to which few non-research oriented institutions have access—**Contraception**. It may of course be argued that since there has never been a tradition of debate on scientific and medical issues in the country, why ICMR should have acted any differently. And that is in fact the major issue here. – That people have a right to decide whether or not they would like to take the risks that are today being thrust upon them.

Padma Prakash
Bombay

Reference:

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Bhopal – Citizens Responses

(a) A National Convention on "Lessons from Bhopal:

Environment, Science and Democratic Rights in the context of the Role of Foreign Capital and the Indian, State" was held on Feb 17-18 at Gandhi Bhavan, Bhopal. It was attended by more than 150 delegates belonging to about 65 organisations form 13 different states of the country and also by delegates form Afghanistan and Nepal. Copies of the declaration made by the Convention are available from: Rashtriya Abhiyan Samiti, Zahreeli Gas Land Sangharsh Morcha C/o Vibhuti Jha, Advocate 49 Shyamala Road, Bhopal 462002.

(b) A National Campaign Committee (Rashtriya Abhiyan Samiti) was formed at the above convention and had its first meeting on April 6-7, 1985 at Bhopal. It decided to organize a mass rally (hold a public meeting and present a memorandum to the Prime Minister with

signatures—target being the ten Lakhs) at Delhi on June 5, 1985 which is observed as world Environment Day. For a copy of the memorandum, and further details of the national committees, plan and suggestion for action, write to the above address. (a)

(c) (C) Bharat Vignan Kala Morcha

The Kerala Sastra Sahitya Parishad has organized an All India Science through Art Campaign, covering 8000 kilometers in the month of May through 100 places spread over Karnataka, Andhra Pradesh, Madhya Pradesh, Maharashtra; Rajasthan, Uttar Pradesh and Delhi. This Morcha is dedicated to the memory of the brothers and sisters who lost their life in the Bhopal genocide with a promise to avenge their death the route/dates in May 1985 of the Yatra are as follows: Bangalore (1-3); Harihar (4); Hubli (5-6); Sholapur (7); Pune (8-10); Secunderabad (11-14). Bhopal (14-18); Indore (18-19); Ajmer (20-21); Jaipur (21-22); Delhi (22-29).

(d) Eklavya has brought out a Bhopal—The State of the Environment report on the 100th day of the gas tragedy (March 12, 1985), in English and Bhopal Gas Tragedy—Jan Vigayan Ka Saval – a brochure in Hindi on their exhibition held in the bastis. For further details/copies write to: **Eklavya, E1/208, Arera Colony; Bhopal 462016**

(e) “No More Bhopals” – an exhibition

The Centre for Education and Documentation, Bombay, along with a few friends has put together a large exhibition to highlight the world’s worst ‘industrial accident in Bhopal. Two sets of 35 posters mounted on flat hard board are available: one in Hindi and one in English. These two sets are now circulating in India. All groups interested in showing it may contact: **CED 3 Suleman Chamber**, 4 Battery Street, Behind Regal Cinema Bombay 400039 (telephone 2020019).

The MFC Bhopal intervention

(a) the mfc study report:

The report of the study undertaken by the mfc team from 17-26 March 1985 has just been consolidated at Baroda on 27-28 March 1985 has just been ready for circulation by the end of May. The report which probably will be among the first community based epidemiological and socio-medical surveys to be released to the scientific community, press and public will highlight the grave findings of the state of health of the Bhopal gas victims three months after the disaster. It will also contain a report on people’s perception of health services, case studies and bibliography. For further information, write to mfc office, Bangalore.

(b) Communication strategy on Health Issues

A note on the need to evolve a communication strategy on health issues following the Bhopal gas tragedy has been prepared and circulated to voluntary agencies and citizens groups working in Bhopal and the MP Govt. health authorities. This note is available on request from the mfc office, Bangalore. Thelma Narayan of mfc will be based in Bhopal from 12-28 May 1985 to help evolve such a communication strategy. Please send comments on the note, ideas suggestions, to her C/o Gandhi Bhavan, Shyamala Hills Near Polytechnic; Bhopal 462002.

(c) Study on Pregnancy outcome

A tentative plan for a study on "Pregnancy Outcome" to be undertaken in Bhopal in the second week of June has been drawn up and preparations are on the anvil. Volunteers interested in participating and readers/members interested in supporting this study with ideas, suggestions and technical information, please write to: Satyamala, C-152, MIG Flats Saket, New Delhi-110017.

The J N U Study

An epidemiological and sociological study of the Bhopal tragedy focusing on the size, distribution and causes of the various health conditions produced by the tragedy, and social and economic profile of the victims was undertaken by the Centre for Social Medicine and Community Health of JNU in December – January 1984-85 and has been reported in JNU News in April 1985

For further details and copies of the report, write to: D Banerji, Professor of the above Centre, JNU New Delhi –110067.

Dear Friends.....

Annual Meet 1985 - Some reflections

1. This was the first MFC moot I attended, I am very happy to have come. I am impressed and encouraged to meet such a variety of people who are committed to people 'especially the oppressed and who are concerned about a change in values - a change of society.

The meet was interesting, but a little too pocked; there was not enough time to meet people individually (But in only 2 days it is almost impossible)

— Hilda Sina, Vagamom,
Kerala.

2. First let us say that the qualities, backgrounds, achievements, activities, and aspirations of the group in general were varied and exciting. It is good that such different people can come together' with same hopes and interests in common, and share and' develop their ideas. The 'old' group did not dominate the 'new' nor did they show impatience nor intolerance with the 'new'. Even the long term

MFC members did not criticise each other in harsh terms and showed mutual respect even in disagreement. This is amazing and highly commendable.

Everyone seemed welcome to attend and participate. The attitude seemed to be that we could all learn from each other.

Small group discussions followed by plenary sessions were very good. A little more time for informal meetings would have been nice;

It would have been nice to have all the background papers before the meet because reading time was short once we arrived...

The meet served its main purpose for US in meeting like minded medicos and non-medicos alike from various parts of India.

— Penny Dawson, Jamie Uhrig,

Mitraniketan, Kerala.

3. I got to know quite a number of people with whom I would never have come in contact otherwise. It was quite informative except where people were getting into unavoidable technicalities, which of course were difficult to follow.

The time limitation was an inhibiting factor. We had to skip quite a lot of things.

I was in the group discussing how to raise /public awareness about TB. The ways that were discussed were the ones that we had already discussed in OUT SPACE meetings. Participants were trying to express with their experiences why they came to such conclusions. They were not allowed to tell their experiences but what they had inferred from it— course due to lack of time.

Then some participants had a set of opinions formed and they refused to come out their circle. This led to heated arguments onward then.

On the whole it was nice.

Malarvizhi, Mamas.

Drug Action Focus

4. Instead of choosing new topics each time can we have a meet where we reanalyze some past issues and topics. There is a general feeling amongst people that after discussion we do not follow up on the topics anymore. Drugs topic for example.

I think although the Drug Action Network is working full time some of us in MFC feel sidelined now and find little or nothing to contribute. Raising the issue in an annual meet may turn out newer aspects of the problem. I think that DAN is directing its efforts in the wrong direction. Instead of pressing the drug controller of India for action all of us should conscientise undergraduates and upcoming doctors. Our fight should be at a lower level rather than at the level of government policy. This is my disillusionment with the DAN and I hope we can correct its course by another discussion on the topic of drugs.

Vineet Nayar, Vellore

Whither Company Doctor?

5. The purpose of this Letter is to motivate a social scientist or a researcher to conduct a study on the interaction between a worm and the so called "company Doctor" I am sure that the findings of such a study will be revealing. Both public and private sector Industries employ doctors on part-time or full time basis to man their first aid centres, ambulance rooms, dispensaries and hospitals, and these doctors are called "company Doctors".

An observation made by me (over a period of three decades) is that the workers look at the company doctor with askance. He is considered as a "management Agent" having no sympathy for the workers. The workers attribute the following

characteristics to the company doctor.

- 1) He lacks human touch. He thinks that workers FEIGN sickness.
- 2) His medical opinion and diagnosis are dependant on the instruction of the company /management.
- 3) At the behest of the management, he goes to the extent of certifying as "medically unfit" even physically fit persons.
- 4) He asserts that working environment and sanitation are the best available any where. In most cases where his opinion is contested and referred to outside doctors and specialists, he is proved wrong. In most of the court oases, he is disbelieved and held to be biased. I wish that there is a healthy debate and any company doctor comes forward to assuage these feelings of workers. It is observed that public sector employees-have better opinion about their company doctors.

Yours

U. S. Venkatraman, Bangalore

GARIBI HATAO!

A more is on in India's Planning Commission to determine a new the parameters for defining poverty.

The action was undertaken, reportedly, after Prime Minister Indira Gandhi observed that she found a lot of bright faces in rural India, which was not reflected in current official statistics showing that poverty in India is actually increasing.

The controversy actually started last year after a cross-country walk-athon by Janata Party President Chandra Shekar, who said that he was appalled to find the dehumanizing poverty in which India's masses were living 36 yrs after independence.

Drinking Water Data

Half of the country's 576,000 villages still did not have any drinking water facilities, Shekar said after hi 2,500-mile trek that took him through six of India's 22 states in six months.

According to official statistics, 339 million of the total populations of about 700 million were below the poverty line defined as a daily minimum calorie intake of 2,400 pre person in the rural areas and 2,100 in the urban areas, or a \$6.50 per capita income a month in the rural areas and \$7.50 per capita income a month in the urban areas.

This means that 45 % of the people still live on a less than subsistence level. Of them, 272 million were in the rural areas and 67 million in the urban areas, showing that large-scale poverty continued in the villages.

Officials Are Upset

These statistics and comments by Shekar were not appreciated by the powers that be. They felt, and some economists backed them that the extent of poverty in the country was being exaggerated and that undue publicity might hamper foreign investment.

So a group in the Planning Commission advocated a lowering of the cut-off point, thereby lifting a large segment of the people above the poverty line.

According to views expressed by some members of this group, the actual calorie intake of Survival was actually much lower. One of them Prof. P. V. Sukhatme, contended that the present cutoff point was the average requirement of a healthy and active population and not the minimum below which a person should be considered undernourished. He suggested that a defined lower end of the range of the energy intake of a healthy individual be used as the cutoff point for determining undernutrition and the poverty line.

Targets of Sixth Plan

The Sixth five year development plan (1980-85) target is to reduce those below the poverty line from 339 million to 215 million and the midterm appraisal contends that the number has already been cut to 282 million in the first two year of the plan.

If these claims are indicative, all 339 million can be expected to be lifted above the poverty line by 1990 some economists said. And if the line itself was amended, poverty itself could be expected to be eradicated in India very soon.

Prof. C. Gopalan Director General of the Council of Medical Research, has disputed Prof. Sukhatme's claim and said that mean calorie intake of community should continue to be the dividing line of poverty. He hoped that the commission would not undertake such a deceptive short cut to national prosperity considering the magnitude of the problems of poverty.

Source: INDIA ABROAD
April 6th, 1984.

Rational Drug Policy cell mfc

PRESS RELEASE

Irrational Pain-Killers

Only 14 out of 59 analgesic preparations found scientifically justified!
Dr. Jamie Uhrig and Dr. Penny Dawson of Medico Friend Circle have analysed 59 preparations listed as analgesics and antipyretics in the July' 84 issues of MIMS, India and found 45 of these 50 preparations to be irrational on some ground or the other.

Basing themselves on the latest authentic text-books, Dr. Uhrig and Dr. Dawson rigorously studied each of these preparations and graded them into the following categories:

A: Use of the product is justified – 14 preparations for example: plain Paracetamol, Aspirin etc.

B: The combination is not proven to be superior to single ingredient preparation and hence not recommended..... 17 preparations. For example – Equagesic, Malidens, Micropyrin, Optalindon.....etc.

C: The combination has been proven to be inferior to single ingredient preparations. For example – Apidin, Carbutly, Dolopar Plus, Norgesic, Parvon—N, Parvon—P, Proxivon, Spasmo—proxivoan, Sudhinol—N C.....etc.

D: The preparation contains Analgin and should be banned17 preparations. For example—Codosic, Dolopar, Novalgin, Ultragin, Sedyne—A forte, Spasmizol.....etc.

We congratulate Dr. Uhrig/Dr. Dawson for their spontaneous initiative in conducting this study. This study is available with the Rational Drug Policy Cell of M. F. C. at a cost-price of Rs. 3/-. Please write to:—Anant Phadke, 50, LIC Quarters, university Road, Pune—411016 also available with mfc office, Bangalore.

Book Review

BEHIND POVERTY, Djurfeldt and Lindberg, Oxford & IBH Publishing Co., 1976 - Books 22 & 23 in Scandinavian Institute of Asian Studies Monograph Series.

Health Care in India seems to have row hard cut opinions: this makes it easier to digest (but far more boring) than Rakku's Story, The latter is a hard hitting (i.e. unpleasant) view of the medical system. It rejects the alternative approaches usually suggested and so rejects their creators (after all it is these people who might have profited from reading Rakku's Story).

Further, Rakku's Story is too local in place as well as in time; it does not explore the broader Tamil Nadu or Indian situation at all; no effort is made to refer to the history of the area.

I agree that the people represented in the book do not know history or geography - political, economic or social. But changing the world begins at this point, at this question: How, do we in' this historical and graphical situation relate to other situations? For this is the beginning of the next question: How can we change the present situation?

Here one point to Djurfeldt & Lindberg's book Behind Poverty. The first section of this study is devoted to filling in such background material and it is both specific to the area discussed (Chialgteput in, 1969-70) and also related to relevant parts of the broader situation unlike Health Care in India which has a vague "wide" background or Rakku's Story, which has a super "narrow" outlook.

Studies like Behind Poverty (the Social formation of a Tamil village) might be done far other areas - North Arcot, Larkana, anywhere. This study is useful to its immediate neighbours and as a model for other areas to imitate. But readymade analysis of all India (without specifying how different various areas are) like Health Care in India are prone to become "Bibles".

Why don't more people read their State Gazettes, State Histories and study local languages as a background to ,NGO W01" in communities?

A pill against Poverty — companion volume to Behind Poverty — is a book by two Scandinavian University Sociologists on the introduction of Western Medicine in a Tamil village.

The name gives away the authors views but one hopes doctors will read Behind Poverty first, however tempting the medical topic is.

—Prabir, CMC, Vellore

Keeping Track

(MFC sources)

1. **When the Search Began** – Ulhas Jajoo

The story of a team of friends and their experiences in organising a Novel Health Insurance Scheme among villagers in Maharashtra – the lessons learnt, the failures, the perspectives gained.

Mahatma Gandhi Institute of Medical Sciences Sevagram – 442 102, Maharashtra (Rs. 5/-)

2. **Health Education Posters on Malnutrition** – Ulhas Jajoo

A set of Xeroxed posters developed from the experiences gained in the above project (1) Mahatma Gandhi Institute of Medical Sciences Sevagram – 442 102, Maharashtra (Rs 35/-)

3. **Minimum Wages** – need for fair reward to labour in Agriculture and Employment Guarantee Scheme – Abhay Bang.

– An examination of the cost of production of labour and new recommendation of what should be appropriate minimum wages based on Calorie and Protein requirements.

– Academy of Gandhian Studies, 2-2-1 1334/5, New Nallakunta, Hyderabad – 500004 (Rs. 2/-)

4. **Diarrhoea and ORT** – Lalit Khanra

A discussion of the issues involved in the management of diarrhoea and the rationale of oral-rehydration therapy for professional and community education (in Bengali)

Chandabrati, Tamluk Dist, Midnapore; West Bengal – (Rs. 1/-)

5. **Diseases of Children** (in Marathi)

A book for educating para-medical staff and for child health education with 64 pages of line drawings from a total of 175 pages.

Mamata, Mamledar Malegoan – 423203 Dist Nasik. (Rs. 20/-)

Drugs in Diarrhoea—A Question of Life & Death

Clioquinol & Antimotility Drugs—are they safe?

CLIOQUINOL

1. In the thirties, when Ciba-Geigy introduced Clioquinol, the animal experiments has shown the occurrence of the same disorder of the nervous system as was found later on in human begins. The company, in fact had warned the veterinarians not to use the drug in animals. But this information was not passed to others.
2.Even Cases of SMON studied by doctors on behalf of Ciba-Giegy have shown that the disease is found all over the world and was not confined to Japan. Seven cases were reported from Bombay.
3. Clioquinol can also produce Optic atrophy. The Indian Ophthalmogists do see cases of Optic atropy for which they fail to assign any cause. When asked, if they took the history of prolonged or repeated courses of Clioquinol taken by these subjects, the answer was in negative.
4. Now that Clioquinol is shown to be harmful to animals as well as human begins, why should this drug be used when we have comparatively safer alternatives like Metronidazole? Dr. Andrew Herxheimer, editor of the reputed 'Drug and Therapeutics Bulletin' told me that considering all the factors like efficacy, safety and price; Metronidazole was definitely to

- be preferred and with the present available evidence, Clioquinol should not be marketed. (Incidentally he is aware of the suspected carcinogenicity of Metronidazole in mice)
5. After all the scientific evidence was presented in the Japanese Courts, Ciba-Geigy Rendered an unqualified apology for the suffering that Clioquinol caused and then decided to withdraw the drug world-wide.
 6. When Clioquinol is readily available, even cases of watery diarrhoeas (which are mostly due to viruses) are treated by Clioquinol group of drugs. So it is better not to have such a drug for which a safer alternative was available.
 7. Myself, a pediatric Colleague and two very busy general practitioners of Bombay have not used Clioquinol for years and we are all quite happy, about it.

With my most sincere regards,

Yours sincerely,
Sd/--

Chairman, Medical Committee,
Consumer Guidance Society of India,

Ciba—Geigy Withdraws Tanderil

The multinational pharmaceutical firm Ciba-Geigy Pharma has announced the withdrawal of the drug Tanderil world-wide and restricted use of the drug Butazolidin, the Voluntary Health Association of India said here today.

Tanderil was commonly prescribed for joint pains. While its sales will be discontinued by the firm, it has announced that Butazolidin will be restricted to the treatment of only four classical forms of rheumatic diseases: active ankylosing spondylitis, acute gouty arthritis, active rheumatoid arthritis and acute attacks of osteo arthritis. It is to be recommended only for cases where other therapeutic measures have been tried and found unsatisfactory.

Dr. Mira Shiva, Coordinator, Low Cost Drugs and Rational Therapeutics attached to the Volun-Health Association, said the demand for screening all the drug in the market, with immediate withdrawal of the hazardous drugs cannot be emphasised more. The basic expectations from the national Drug Policy in the offing were: (A) The withdrawal of Hazardous and irrational drugs; (B) Adequate production, distribution, and availability of essential and life-saving drugs; (C) Availability of unbiased drug information for health personnel and public and (D) Effective quality control and drug control.

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