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Treating Critically Ill Patients With Sugar Pills

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25 healthy individuals. This study was approved by the local ethics committee, and all patients gave written informed consent. As shown in Figure 1, none of these cytokines was elevated in patients with IPAH; patients with APAH, however, had significantly elevated serum levels of TNF- α but not of IL-1 and IL-6.

Thus, the role of inflammation in PH remains unclear. We need rigorous clinical studies with appropriate methodology and adequate sample sizes to obtain a level of scientific evidence that allows us to draw meaningful conclusions.

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Response

To the Editor:

We appreciate the thoughtful comments by Hoepfer and Welte on our article in *CHEST* (August 2006)¹ demonstrating that elevated pulmonary artery pressure in COPD is associated with increases in C-reactive protein (CRP) and tumor necrosis factor (TNF)- α levels. We fully agree that there are several limitations to our study that were discussed in depth in the original article.¹ Importantly, in view of the cross-sectional character of the data, our results should be considered as hypotheses generating. Indeed, Sin and Man² underline that it is a challenge for the COPD research community to determine, through well-designed clinical and animal studies, the validity of the hypothesis that systemic inflammation may be involved in the pathogenesis of pulmonary hypertension. Hoepfer and Welte provide us with interesting observations of no increases of interleukin (IL)-1, IL-6, or TNF- α in patients with idiopathic pulmonary arterial hypertension compared to healthy individuals. However, TNF- α but not IL-1 and IL-6 were increased in patients with pulmonary arterial hypertension associated with connective tissue disease. These data do not contradict our results in any way. First, we have studied a different population of patients; second, Hoepfer and Welte did not assess serum CRP in their study. Importantly, our main result was that PaO₂ and log-CRP levels were the only two significant predictors of systolic pulmonary artery pressure. This finding is meaningful especially in the light of recently published studies indicating that CRP levels correlate with 6-min walk distance³ and, in addition, relate to mortality in COPD

patients.⁴ Nevertheless, valuable data of Hoepfer and Welte emphasize the need to publish also negative results in scientific journals. Only by doing so can the scientific community gain a complex picture of the studied medical field.

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Treating Critically Ill Patients With Sugar Pills

To the Editor:

It surprises me that *CHEST* would publish an article (March 2005)¹ on the effect of a therapeutic agent when in fact the patients received none of the agent mentioned in the title of the article. It is not mentioned in the title, but reading the article reveals that the “potassium dichromate” was a homeopathic C30 dilution. That is a dilution by a factor of 10⁶⁰, and for those of us who believe in the Avogadro number, that means there would be one molecule in a sphere with a diameter of approximately 1.46 \times 10¹¹ m. That is close to the distance from the earth to the sun. To describe this as “diluted and well shaken,” as the authors do, is the understatement of the century. The fact of the matter is that the medicine contained no medicine.

The authors¹ will doubtless claim some magic effect of shaking that causes the water to remember for years that it once had some dichromate in it. The memory of water has been studied quite a lot. The estimate of the duration of this memory has been revised² downwards from a few picoseconds to approximately 50 femtoseconds (50 \times 10⁻¹⁵ s). That is not a very good shelf life.

It is one thing to tolerate homeopathy as a harmless 19th century eccentricity for its placebo effect in minor self-limiting conditions like colds. It is quite another to have it recommended for seriously ill patients. That is downright dangerous.

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- 2 Cowan ML, Bruner BD, Huse N, et al. Ultrafast memory loss and energy redistribution in the hydrogen bond network of liquid H₂O. *Nature* 2005; 434:199–202

Response

To the Editor:

We want to thank Dr. Colquhoun for his interest in our study.¹ First, the terms used should be defined precisely. Homeopathy is a science based on applied toxicology. Using digitalis either as a conventional or as a homeopathic physician makes no difference; both rely on observations (William Withering 1785) from pharmacology or on homeopathic proof. We are happy that toxicology as well as homeopathic proof have been shown to be reliable and consistent for centuries.

Before I refer to the dilutions beyond the Loschmidt number, it is important to state that homeopathy doses that are equivalent to those of conventional medicine can be administered without any dilution. However, toxic effects should be avoided. If one refuses to use potencies beyond this number, they should simply not be used. Since Dr. Colquhoun assumes that high potencies exhibit no effect at all, then we cannot understand why it should be dangerous to treat critically ill patients additively if there is “nothing” in it. We are also concerned that Dr. Colquhoun questions the value of randomized controlled trials. This opinion appears to be inconsistent with the current position of conventional science.

It is correct that “the medicine contains no medicine”; however, “ultrafast memory loss” in the hydrogen bond network of liquid H₂O implies that at least some sort of memory exists. However, contrary to the study cited,² potentized drugs are not stored in water, but in an alcohol-water mixture.

I invite Dr. Colquhoun to join our efforts in studying the effects of high potencies on physical properties. We are always open to tolerant, academic-driven scientific cooperation. Let us make a common effort to reveal the riddle for the sake of millions of patients by supporting the Institute for Homeopathic Research, at Interuniversity College. Financial help is appreciated: Account No. 92,178,414, bank code 60,000, IBAN: AT95 6000 0000 92178414, BIC: OPSKATWW.

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Chronic Idiopathic Cough

Self-Sustaining?

Cough: A convulsion of the lungs, vellicated by some sharp serosity. It is pronounced coff.

Samuel Johnson

To the Editor:

Unaided except by amanuenses, Johnson was justly famed for authoring the magisterial *Dictionary of the English Language* (1755), the source of this definition (vellicate = twitch or pluck; serosity = a serous surface). Until succeeded by the *Oxford English Dictionary*, it remained the acknowledged standard reference for more than a century. A nonsmoker, Johnson died a respiratory death; at autopsy, he was found to have emphysema and cor pulmonale.¹ The severity of his cough and its potential contribution to his malady is conveyed by his vivid description of it as a “convulsion.”

In noting that “. . . the act of coughing itself may be responsible for the denudation and other histopathologic findings. . .” in persons with chronic idiopathic cough, and that these findings were indistinguishable from bronchial biopsies in persons with defined intrapulmonary and extrapulmonary sources of cough, the authors² assert the likelihood that these findings were the consequence, not the cause, of the observed cough. Implicit, I think, in this conclusion is the possibility that some instances of idiopathic chronic cough represent the tracheobronchial counterpart of neurodermatitis, *ie*, that chronic cough is self-sustaining; that, mediated by respiratory trauma, it begets cough. If this interpretation is correct, it follows that a sustained trial of drug-induced cough suppression would be a valid diagnostic and therapeutic strategy.

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