

# Conquering chemotherapy

*J. S. Dowden, Editor*

*(Aust Prescr 2000;23:5)*

Few reading this journal in 2000 will live to see the next century; death for all is inevitable. There should be an increased focus on how we die. As great advances have been made in reducing cardiovascular mortality, the relative importance of cancer will increase.

Chemotherapy can cure certain cancers. Unfortunately, in advanced cancers chemotherapy often merely delays the inevitable, sometimes only for a few weeks. In that short time the patient may have to endure unpleasant adverse effects. Chemotherapy aims to destroy all dividing cells, in the hope that normal cells will recover faster than cancer cells.

Patients are poisoned to the edge of their existence and products such as G-CSF allow us to push them even closer to the precipice. Some patients will fall because of their treatment rather than the disease.

The ability to destroy abnormal cells while sparing normal tissues has a strong appeal. Although it is still in its infancy, immunotherapy could be the way forward. There have been attempts to put the theory into practice, but there is a need to find antigens which are more specific for tumour cells.

I hope that by the end of the next century, we will be able to use the body's own immune system to fight cancer. This would allow us to consign aggressive chemotherapy to the list of twentieth century treatments, which already seem medieval.

## Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

### St. John's wort

Editor, – I enjoyed reading Professor Mitchell's article on *Hypericum perforatum*, 'St. John's wort – quack medicine or novel antidepressant treatment?' (Aust Prescr 1999;23: 112–3). It is nice to see some openness about herbal medicine in the medical profession. I would like to comment on hyperforin, one of the active ingredients in hypericum. It is true that studies have confirmed the antidepressant activity of hyperforin, however, this compound is very unstable, especially during the drying process of the herb, hence it is unlikely that the extracts which have been shown to be effective in many different clinical trials contained any hyperforin. Yet they worked. The hypericums may not have antidepressant activity in their isolated form, however one study has shown that oligomeric procyanidins (OPCs) are necessary for the bioavailability of hypericum. Hypericum extracts are now being marketed which are standardised to both hypericum and hyperforin, however these are only marker compounds for quality control. When the whole herb extract is used, St. John's wort is a safe and effective medicine for depression, anxiety and tension.

Michael Thomsen  
Medical Herbalist  
South Hobart, Tas.

### Antidepressants

Editor, – I refer to the articles on the new antidepressants (Aust Prescr 1999;22:106–8, 108–11). I have read elsewhere that antidepressants have not been shown to work better than an active placebo such as bextropine mesylate. Active means a placebo that makes you feel as though you are taking something by producing adverse effects such as a dry mouth.

Could one of the authors of your recent antidepressant articles comment?

Kevin O'Dempsey  
General Practitioner  
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*Associate Professor T.R. Norman, the author of 'The new antidepressants – mechanisms of action', comments:*

'Active placebos' have been employed occasionally in controlled evaluations of antidepressant drugs. Most often these have been used in tricyclic antidepressant trials to maintain the 'blind' as these drugs are well known for their anticholinergic effects and can often be distinguished from placebo on this basis. Over the course of evaluation of new antidepressants some trials will show no significant difference from placebo, but the weight of clinical evidence is that the new antidepressants are clearly more effective than placebo. Several reasons for the failure to distinguish a psychotropic medication from placebo can be recognised, such as inclusion of incorrect diagnostic groups, mild forms of depressive illness, failure to include a placebo washout period prior to commencing trial medication, and non-compliance with the study drug. Non-specific factors in treatment are also important and the psychotherapeutic aspect of a patient regularly consulting with someone willing to listen to their problems cannot be ignored. Furthermore, it should be recognised that the natural history of depression is for recovery to eventually take place, without treatment. (Medications can considerably shorten the period to recovery.) Clearly, if patients are at the point of recovery then any treatment, active drug or placebo, will apparently be 'successful'.