RES MEDICA
Journal of the Royal Medical Society

Third Discussion

Chairman: Sir John McMichael, F.R.S.

Abstract

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ISSN: 2051-7580 (Online) ISSN: 0482-3206 (Print)
Res Medica is published by the Royal Medical Society, 5/5 Bristo Square, Edinburgh, EH8 9AL

Res Medica, April 1967, Special Issue – Lauder Brunton Centenary Symposium on Angina Pectoris: 49-50
doi: 10.2218/resmedica.v5i3-4.487

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Dr. Robertson: I wonder if Professor Morris or Dr. Oliver has correlated the number of miles driven in motor cars to the incidence of coronary heart disease, and particularly driving in traffic as opposed to driving on the open road; after all, the incidence of this modern epidemic roughly correlates to the rise of the motor car. I was very interested in a recent article which described a test in which a cardiotachometer was attached to the driver of a motor car and whilst waiting at the lights a pulse of 150–200 was recorded; this was quite usual.

Professor Hunter: I would like to ask Dr. Oliver if it is a reasonable risk to give Atromid-S for 5 years to otherwise healthy people?

Dr. Borchgrevinck (Oslo): Dr. Oliver, do you suggest that there may be a difference in response to what you call two different cultures, and do you think it might confuse the issue by bringing them into the study and possibly finding that the positive effects of the treatment in Britain, for instance, might differ from the results achieved effect in the other countries?

Dr. Turner: Would Professor Morris care to comment on the recent criticisms that have been made on the London Hospital pathological studies? I know most of you will be familiar with the work on the exceptionally good pathological material which apparently shows that the incidence of atherosclerosis has not changed very much and is certainly not commensurate with the apparent increase in coronary thrombosis. Dr. Robert Smith has recently published a book criticising this; he questioned whether there had in fact been this remarkable increase in clinical coronary artery disease on the grounds that insufficient attention had been paid to the changing age population in the London Hospital pathological material; this is obviously of very great importance.

Professor Morris: Recent studies have confirmed that the family history is important. In two main studies, one of whole populations and another based in London, findings suggest that the chance of a person developing a coronary is strikingly higher where there is a family history of the disease. They haven't taken it any further yet in terms of explaining the mechanism because insofar as we know blood pressure, cholesterol levels and obesity are all important mechanisms in disease; so the genetic components of these do not begin to explain the very striking family history. In answering the question which Dr. Robertson put, I would say that it is a question of whether it is the sitting and driving or whether it is the nervous strain. We don't know, but perhaps the answers will come from monitoring as you suggest. Professor Hunter asked whether we think it is a reasonable risk to give Atromid-S to people over a long period of time. Yes. We have looked at this very carefully, Atromid-S has been studied as you know for at least 6 years and some 5,000 men in this country have been receiving the drug for 2 years or more; one case of agranulocytosis has been reported in a patient who was also receiving three other drugs, one of which was known to produce agranulocytosis before, and which occurred at a stage when maturation arrest would not be expected, that is to say, three days after the administration of Atromid-S. It appears to be non-toxic and it has no side effects so far as we can see other than that which one would expect from oil. We are rather impressed by the effects of the drug. There is a system within our survey which will show difficulties as they rise; if toxicity or if serious side effects occur they

will become rapidly evident and will stop the trial.

Dr. Borchgrevinck: Might the application of the study in the two cultures confuse us? It could, but I think it is desirable that we should do it because it seems to me very important that if our study cannot be replicated in another culture then it is less meaningful and surely if we can reproduce the same results in other cultures they are likely to be more widely accepted.