

applauded for his balanced presentation on hormonal replacement therapy (HRT) and the menopause.¹

General practitioners like myself need such reassurance so we can pass it on to our patients — HRT is an important issue we are required to consider often on a daily basis.

Each case must be considered on its own merits and one issue which Professor MacLennan failed to raise concerns women who present with a strong family history of carcinoma of the breast but (as yet) have no such problems. I feel these women must be tested, gynaecologically and mammographically, twice as often as menopausal patients with no family history of carcinoma of the breast. Also I would ask how many of the 38 deaths per 100 000 women using oestrogen would have a strong family history of breast cancer. Could this number be reduced by more appropriate caution? Nevertheless, it is a significant finding that women with breast cancer have a poorer prognosis if they are not on HRT, compared with those who develop breast cancer while taking HRT.¹ We as medical practitioners can take heart from this finding and be somewhat relieved.

Dr Prince, a lecturer at the University of Western Australia, recently responded in the media to Professor MacLennan's article and made some negative comments about HRT.² It concerns me that when such press statements are made, very often "frighteners" are put on women who are already anxious about HRT. Professor MacLennan does not advocate that HRT should be prescribed "willy nilly", but implies that too many women who are eligible for HRT are not receiving it at all and in fact may be experiencing a poorer quality of life as a result. Dr Prince also fails to address the issue of a family history of breast cancer despite his comment about studies which indicated a link between HRT and a 30% increased risk of breast cancer.

HRT is such a sensitive, topical and necessary issue that we must tread very carefully when making comments which will ultimately reach our patients.

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In reply: I thank Dr Pervan¹ for his kind comments about the consensus statement on hormone replacement therapy (HRT) and the menopause.² The statement was issued on behalf of the Australian Menopause Society and followed our 1991 conference. It was only a summary of the main conclusions.

However, the prescription of HRT to women with a strong family history of breast cancer was discussed at the conference. There is no published evidence that HRT increases the incidence of breast cancer in these patients. Thus, such a history is not a contraindication to HRT. Increased surveillance for breast cancer is appropriate whether they receive HRT or not.

The current message about HRT is very reassuring and doctors may wish to offer a copy of the consensus statement to women asking for up-to-date information.

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Necrotising arachnidism in Australia

To the Editor: Dr Harvey and Dr Raven have suggested that *Mycobacterium ulcerans* infection may be responsible for some lesions diagnosed as spider bites.¹ Dr Sutherland has written describing the marked clinical differences between spider bites and *M. ulcerans*

infection.² Spider bites characteristically are acute painful lesions which may result in skin ulceration within hours; *M. ulcerans* infection in its usual form produces indolent, painless or only slightly tender lesions which progress to form skin ulcers over a period of weeks or months. In Australia most cases of *M. ulcerans* infection are on an extremity but not on the hands or feet,^{3,4} where spider bites are most frequent.⁵

Despite these clinical differences between the two diseases patients with *M. ulcerans* infection may initially be diagnosed as suffering from arachnidism. In four of 48 known cases of *M. ulcerans* infection in East Gippsland this was the initial diagnosis made by the clinician; in one further case this diagnosis was suggested by the patient; in no instance was a spider seen. *M. ulcerans* infection may follow a variety of trivial injuries; in the Gippsland series these included laceration by barbed wire, abrasion by bracken fern and spiky Grevillea (*Grevillea acanthifolia*), falling down stairs, and a blow from a hockey stick. In Queensland the infection followed an encounter with a pineapple³ and in Africa infection has followed shrapnel injury and therapeutic injections.⁶ This variety of agents indicates that no one agent is the vector of the disease: rather it shows that minor trauma may serve to inoculate the organism through contaminated skin. It is possible that the bite of a spider or other insect may act as an inoculating vector in the same way. In Zaire mycobacterial ulceration in the foot of a physiotherapist treating a patient with the disease has been described after an insect bite;⁷ the insect was not identified.

Symptoms, clinical history and examination should distinguish *M. ulcerans* infection from necrotising arachnidism. *M. ulcerans* infection only occurs in defined areas; the history should include enquiry as to whether the patient has visited one of these endemic areas. Despite these differences it is conceivable that the two diseases may occur together when the bite of the spider inoculates the mycobacterium through intact skin.

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Global warming, ecological disruption and human health

To the Editor: Professor McMichael's leading article¹ warning of public health consequences of ecological disaster is welcome, two years after a similar editorial in the *Lancet*.² Ironically, although global warming is mostly the responsibility of developed nations the greatest future global environmental and public health threats emanate from the Third World.

Developing countries with rapidly growing populations are keen to attain further industrial development. Immense reserves of coal and understandable public and government demand for technology rather than concerns with pollution bode ill for the West.

Optimism regarding demographic transition (the trend for smaller families once infant mortality is reduced) to stabilise global population and technolog-

ical progress to fix pollution overlooks two key problems.

The first is the demographic trap.^{3,4} This refers to failure to attain demographic transition, so that population stability is achievable only by repeated catastrophe. This may occur if population growth is not matched by sufficient infrastructure growth, especially in the areas of education of women, family planning and sustainable economic policies.

The second is the technology trap. This refers to runaway global pollution through rapidly expanding industrial development using conventional processes in the Third World. One of the few areas of consensus in the contentious global warming debate is that there are many unpredictable feedback loops. Though still low on a per capita basis, greenhouse emissions from the Third World will overtake those from the West. Industrialising nations are likely to perceive national growth to be of higher value than any global cost. The technology trap may thus occur: uncontrollable greenhouse straws from the Third World breaking the camel's back in an increasingly warmed and alarmed Western world.

It is likely we will fall into both traps. Even if demographic transition occurs in countries such as China and India there may soon be more than four billion Asians demanding refrigerators and electricity. Where demographic transition fails the outlook is even more bleak. In both scenarios we in the West will inevitably be affected.

Apart from the moral responsibility we bear there are therefore fundamental selfish reasons for tackling these problems. Self-interested aid must concentrate on providing ways to "leap-frog" these twin traps.⁵ Means will include technology transfer, such as occurred at the recent meeting about the Montreal Protocol. Medical aid must target communities struggling to break free from the demographic trap.

That these problems are not better understood suggests to me some kind of mass denial. If so, this taboo subject must be faced. Confronting these problems requires global rethinking. Economic assumptions need to be challenged, as proposed by Schumaker⁶ and Henderson.⁷ Gross national product needs to account environmental and public health costs. Medical professionals, especially those in public health, need to do far more to raise public concern. First, however, we have to educate ourselves. To do nothing is to risk catastrophic global disease for us all.

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Clinical disagreement

To the Editor: We would like to thank Dr Meyers¹ for his comments on our paper. We did not wish to imply that there is one right or best line of action for every clinical situation. Rather we sought to identify sources of disagreement about the medical history, findings on physical examination, and interpretation of diagnostic investigations.

For many, if not most conditions, there are several equally acceptable methods of management. The strongest study design for determining the form of treatment which does the most good and least harm is the randomised controlled trial. Consensus conferences can develop workable guidelines for clinicians in the management of common conditions. An example is the asthma management plan developed by the Thoracic Society of Australia and New Zealand.² The questions