with distal colitis such attacks are usually associated with extension of the inflammation.

Will the inflammation spread?—In patients with proctitis and colitis of intermediate extent, the inflammation may extend. In proctitis the chance of spread to the sigmoid colon is about 30% and to the whole colon between 5% and 10% in 10 years.[13]

Will I need an operation?—About 1 in 50 patients with proctitis, 1 in 20 with intermediate colitis, and 1 in 3 with extensive colitis are at present advised to undergo surgical treatment within 5 years of onset.

Will I develop cancer?—No carcinoma was observed in this series or in the study from Copenhagen.[4] Carcinoma complicating colitis tends to occur among patients with extensive inflammation of the colon shown on X-ray and a history of symptoms for many years. In this series, four-fifths of the patients had proctitis or colitis of intermediate extent; such patients can be reassured that the risk of cancer is little, if at all, greater than that in the normal population.[14] The risk of carcinoma developing within 10 years of onset among patients with extensive colitis is very small.[15] There are relatively few patients with extensive colitis and a history of 10 years or more. However, the risk of cancer in this small group of patients is appreciable and steps should be taken to avoid this complication.[15]

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NATIONAL SURVEY OF HÆMOPHILIA AND CHRISTMAS DISEASE PATIENTS IN THE UNITED KINGDOM

Report on Behalf of the Hæmophilia Reference Centre Directors of the U.K.

ROSEMARY BIGGS ROSEMARY J. D. SPOONER

Oxford Hæmophilia Centre, Churchill Hospital, Oxford OX3 7LJ

INTRODUCTION

IN 1954 the Medical Research Council, collaborating with the Ministry of Health and the Department of Health for Scotland, introduced a scheme under which a number of clinics and hospitals were designated as hæmophilia centres to provide specialist diagnostic, registration, and treatment services for hæmophilic patients. Since then many advances in medical science—such as the introduction of cryoprecipitate,[1] lyophilised factor VIII and factor IX concentrates,[2,3] and the means for some patients to treat themselves at home with factor VIII or factor IX concentrates[4]—have improved the treatment available to hæmophilic patients. The availability of these new forms of treatment has not altered the need for specialist care of hæmophilic patients and the Department of Health and Social Security has published several documents outlining their recommendations, the most recent of which was the February, 1976, circular to regional health authorities and family practitioners (HC(76)4).

During the 6-year period ending Dec. 31, 1974, 2600 hæmophilia A patients and 388 hæmophilia B (Christmas disease) patients attended centres for treatment.[5] It was realised that some patients with hæmophilia A or B attended hospitals not recognised as hæmophilia treatment centres and in 1975 the directors of hæmophilia centres decided that an attempt should be made to identify patients treated at other hospitals, so that provision for these patients would be made in the long-term plans of the D.H.S.S. and the fractionation centres for the production of factor VIII and factor IX concentrates. Accordingly a survey was done by the directors of six hæmophilia reference centres in Northern Ireland, England, and Wales to establish how many patients with hæmophilia A and B were treated at other hospitals during 1975, the reasons for their treatment, and the types of therapeutic materials which were used.

SURVEY RESULTS

Analysis of the information received showed that 228 hæmophilia A and 26 hæmophilia B patients were treated in 1975 at 97 hospitals not recognised at that time as hæmophilia treatment centres (16 of the hospitals were subsequently given this status). 108 (48%) of the hæmophilia A patients and 13 (50%) of the hæmophilia B patients treated at the hospitals received no treatment at a designated hæmophilia centre during 1975, and 97 of the hæmophilia A patients and 8 of the hæmophilia B patients had not previously been included by a hæmophilia centre in the hæmophilia centre directors' national register of patients, which was set up in 1969. In addition, the hospitals identified 73 other

DEGREE OF SEVERITY OF HÆMOPHILIA A OR B IN PATIENTS IN U.K. IN 1975

Level of clotting factor (% of average normal)	Hæmophilia A		Hæmophilia B	
	No.	(%)	No.	(%)
<2% (severe)	1707	(55·6)	205	(39·0)
2–10% (moderate)	685	(22·3)	173	(32·9)
>10% (mild)	462	(15·1)	66	(12·5)
Unknown	214	(7·0)	82	(15·6)
Total	3068		526	

hæmophilia A and 11 hæmophilia B patients who were known to them but not treated; 46 of these patients (40 hæmophilia A and 6 hæmophilia B) were not known at a hæmophilia centre.

When inquiries were made, only 48 of the 97 hospitals provided information about the reasons why hæmophilia patients were treated and only 53 gave details of the therapeutic materials used. Hæmarthroses and hæmatomata were the commonest reasons for treatment (21 hospitals); others were dental extractions (12 hospitals), epistaxes (3), hæmaturia (2), accidents (6) and other incidents (8), and minor surgery (4) and major surgery (1). Cryoprecipitate was used most frequently in treatment (31 hospitals) but 5 hospitals used plasma, 3 used commercial factor VIII concentrate, 6 used N.H.S. factor VIII concentrate, 1 used commercial factor IX concentrate, and 6 used N.H.S. factor IX concentrate. In 10 hospitals no therapeutic material was given.

DISCUSSION

During 1975, 1670 hæmophilia A patients and 275 hæmophilia B patients were treated at hæmophilia centres in the U.K.[6] The survey of patients treated at other hospitals revealed that 108 additional hæmophilia A and 13 additional hæmophilia B patients required treatment during 1975, which indicates that a minimum of 1778 hæmophilia A and 288 hæmophilia B patients were treated in the U.K. during that year (these are minimum numbers because a few hospitals were unable to assist with the survey).

Information provided by hæmophilia centres and other hospitals in the U.K. identified 3068 patients with hæmophilia A and 526 patients with hæmophilia B in 1975. The severity of the defect in these patients is analysed in the table. It is expected that all the severely affected patients will require frequent antihæmophilic treatment annually, most of the moderately affected patients will require treatment two or three times in a year, and many of the mildly affected patients will require treatment at least once a year. The 1975 national survey indicates that only 58% of the hæmophilia A patients and 55% of the hæmophilia B patients received treatment during the year.

After considering the results of their national survey, the hæmophilia reference centre directors are concerned that so many patients with hæmophilia A or B were not seen at a hæmophilia centre, even for confirmation of the diagnosis or for advice. In their opinion any patient who has a coagulation defect should be seen at a hæmophilia centre to establish a diagnosis. To ensure a suitable supply of therapeutic material and the highest standard of treatment available, the care of these patients should also be coordinated by a hæmophilia centre.

Requests for reprints should be addressed to R.J.D.S., Oxford Hæmophilia Centre, Churchill Hospital, Oxford OX3 7LJ.

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Round the World

Australia

FINDING THE DRUG TRAFFICKERS

The New South Wales Royal Commission, originally appointed for 6 months to investigate drug trafficking within the State,[1] is to continue its inquiries well beyond this period. The Commission is not charged with a general inquiry into drug trafficking; its purpose is to discover the names and addresses of people suspected of being involved. Accordingly, following his appointment as sole commissioner, Mr Justice Woodward asked for and received the assistance of a panel of accountants in order to have a thorough investigation made of the financial affairs of people in the Griffith area suspected of producing, supplying, and distributing cannabis. The recent acquisition of an expensive home or other manifestation of sudden affluence was considered to be a ground for suspicion, necessitating much time-consuming investigation. As the judge has pointed out, it seems that in this locality "prosperity fell out of the heavens after 1962".

The common practice is for individuals to explain that ill-gotten gains were won at the races. Unfortunately for the law-breakers, bets are now being recorded, and big brother in the form of the computer is with us in N.S.W. It is now possible to discover that a sum claimed as a win on a particular horse in a specified race in fact exceeds the total day's payout on that horse. People found out in this way may face charges of perjury and will certainly arouse the interest of the Commissioner of Taxation. In consequence, suspects using gambling as an alibi are now suffering from bouts of amnesia concerning the names of clubs, bookies, and horses, and the times and whereabouts of races. And others are telling "preposterous stories" which, according to the commissioner, "you wouldn't even tell as a child's fairy tale". For the remainder of the year, the Commission will concentrate on the metropolitan heroin market. It is hoped that the identification of the persons involved in the "hard" drug rings will result.

Japan

COURT DECISION ON S.M.O.N.

On March 1 the Kanazawa District Court ruled in favour of the plaintiffs in the first court decision on subacute myelo-optic neuropathy (S.M.O.N.) in Japan. The State, Ciba-Geogy (Japan) Ltd., Takeda Chemical Industries Ltd., and Tanabe Seiyaku Co. were ordered to pay compensation ranging from 6.45 million yen to 27.95 million yen (415 yen=£1) to 16 S.M.O.N. patients and relatives of those who died after contracting the disease. The compensation totals 181.64 million yen, or 249.56 million yen when interest is added. These amounts are about 70% of those suggested by the Tokyo District Court in formulating last October its out-of-court settlement.[2-4]

Presiding Judge Koichi Inoue found the four defendants guilty of negligence and said that the toxicity of clioquinol could have been foreseen even on the basis of data that were available as early as April, 1953. In the particular suit before the court the judges held that all the plaintiffs had suffered from S.M.O.N. caused by the use of clioquinol, but among other possible causes, a virus "could not be ruled out". The lawyers and officials of Tanabe welcomed the decision because the court showed interest in the theory that S.M.O.N. was caused by a virus; and Tanabe Seiaku Co. immediately lodged an appeal to the Nagoya High Court against the ruling. Tanabe categorically denies a causal relationship between cliquinol and S.M.O.N.[2] Ciba-Geigy (Japan) Ltd. expressed regret at the ruling, which it said, did not take its claims into consideration. Prof. Reisaku Kono, the former chairman of the Govern-

1. See *Lancet*, 1977, ii, 552.
2. *Lancet*, 1977, i, 534.
3. *ibid.* 1977, ii, 992
4. *ibid* p. 1219.