leads to a chronic onset of autistic symptoms.

Like you, I wish to see a full scientific description of O'Leary and colleagues' study as soon as possible. But, we must realise that the current epidemiological evidence does not refute MMR immunisation possibly triggering the onset of autism. In everyone's interest, we must keep an open mind.

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SIR—The title of your editorial1 is misconceived as there is no evidence linking MMR vaccine to autism. There is abundant evidence of the safety of MMR. Yet in England many autistic children have been granted legal aid to pursue claims alleging that their condition was caused by MMR. A case must satisfy the statutory requirement of reasonable grounds to receive legal aid. Last September, the High Court stated that “no positive link has ever been established”.

This litigation raises serious questions about the Legal Aid Board, which usually grants legal aid on the advice of the applicant’s lawyer. Such advice cannot be independent because the lawyer has a direct financial interest in advancing the case irrespective of its merit. There is a clear conflict of interest. Not surprisingly, the success rate of legally aided pharmaceutical litigation in the UK is negligible despite the expenditure of vast sums of public money in legal aid fees.

This high profile litigation provides popular support for the unsubstantiated health scare linking MMR to autism. The Board thus endangers the health of children by unnecessarily confusing a mere hypothesis concerning a possible role of MMR in the aetiology of autism as proper scientific evidence of causation.

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SIR—Your editorial, to use your own words, raises far more questions than it answers. Perhaps I can add a few more questions, plus some hard and disturbing facts, to the debate. I should first mention that I am the parent of a child who became autistic after monovalent measles and MMR vaccinations.

Do children such as my son have typical autism? I believe not. My son, and others like him, do not possess the isolationist-behavioural or self-injurious features. They also have acute multiple food allergies and hyperactivity, which they also acquired shortly after vaccination. So is this autism at all, or is it brain damage that only partially resembles autism? And is the damage to the brain directly linked to gut permeability, as seems to be the case in children such as my son and the children studied by Wakefield and colleagues? And what was it that damaged the gut in the first instance?

If there was a link with MMR, one might expect new-variant autism to start showing in official statistics. Why has autism among boys aged 3 years in part of east Surrey, UK, been running at one in 69 for the past 3 years? (C Clarke, Learning Disability Services, East Surrey Health Authority, personal communication, 1999).

Why did the education authority of Wakefield, West Yorkshire, UK, only have five autistic pupils in 1992, but had 111 by 1999? Can a 22-fold increase in just 7 years be credibly explained simply by better diagnosis of the condition?

Why is every autistic child in the Shetlands and the Western Isles of Scotland aged 12 years or under, with not a single case among children aged 13–19? Is this significant, given that MMR was introduced in 1988 (G Garson, Shetland Health Board, personal communication, 2000; and M Plant, Gilbert Brain Hospital, personal communication, 1999)?

Why is the USA also recording sharp increases in autism—eg, increases of 876% in 8 years (New Jersey), 627% in 6 years (Illinois), 13-fold in 6 years (Colorado), almost 1200% in 10 years (Broward, Miami), and so on (US state education data, published by the National Centre for Health Statistics)?

Many accounts given by parents are consistent. I watched my son descend from a perfectly normal toddler of 14 months to a mentally-handicapped toddler of 16 months, after measles vaccination. It was a powerful experience to observe this at very close hand. At 14 months he could post square bricks through square slots, today at 13 years, he still cannot.

In evidence presented to the UK Bovine Spongiform Encephalitis (BSE) Inquiry the then Medicines Division was reported to be in a disordered and very seriously understaffed state in 1988, the very year that MMR was licensed. Is this an irrelevant coincidence, or does it provide an illuminating insight into the background to MMR’s introduction into the UK?

MMR is said to be safe because there have been few reported adverse reactions. Yet degeneration into autism is not a recognised adverse reaction. The onset of autism after MMR has therefore not been monitored. Is it a new syndrome that has not been recognised, and then been missed, by most of the medical community?

All these pieces of the MMR-autism jigsaw fit together extremely well. They also fit well with the findings of Wakefield, O'Leary, and others. And there are no features among the children of parents like myself—none—that do not fit into the Wakefield–O'Leary explanation.

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Role of sleep apnoea in epilepsy in elderly people

Sir—Linda Stephen and Martin Brodie (April 22, p 1441) presented a comprehensive review of the aetiology and treatment of seizure disorders in elderly people. Although ischaemic brain injury was mentioned as a potential precipitating factor, the role of nocturnal hypoxaemia as a result of sleep apnoea (central or obstructive), was not addressed. The following case illustrates this.

A man aged 69 years with stable coronary artery disease presented after having three episodes of generalised tonic-clonic seizures that occurred at 0300 h or 0400 h during sleep. Brain computed tomography was normal; a cardiovascular assessment did not show myocardial ischaemia or cardiac arrhythmias. He was subsequently found to have nocturnal hypoxaemia as a result of obstructive sleep apnoea, which was ameliorated by treatment with continuous positive airway pressure during sleep.

Seizures have been reported as the presenting sign of sleep apnoea.1,2 Also, treatment of sleep apnoea has been shown to improve seizure control in children.3 Moreover, the development of obstructive sleep apnoea after pathological weight gain caused an increase in seizure frequency in one patient.4 Since hypoxaemia as a result of sleep apnoea can precipitate seizures or exacerbate an underlying seizure disorder, it may be worthwhile to consider this diagnosis in patients being assessed or treated for seizures.

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