



Lack of adherence to scientific principles of objectivity

In response to the paper by Haines and Lowenthal,¹ I declare my conflict of interest; I am 'the famous patient's' wife but I do write with his permission. Also, I am a general practitioner (GP) who has worked with tuberculosis (TB) patients in Africa.

The hypothesis proposed by Haines and Lowenthal is highly contaminated by several factors that misrepresent the facts and make the hypothesis untenable.

The authors have failed to declare fully the extent of their conflicts of interest

- Haines was the treating physician for the 'famous patient's' father who died of bowel cancer.
- Lowenthal has been a critic of 'the famous patient' in the medical literature and the media for many years.²⁻⁴

An example of what might have helped them to draw a more accurate conclusion comes from the radiologist's report from the initial diagnosis of the secondaries:⁵

Mottled calcified areas of varying size from 1.5 to 3 cms in diameter are demonstrated overlying the right sacroiliac region, the appearances of which are those of glandular metastases.

If Haines and Lowenthal had spoken to the patient's doctors, they would have clarified the basis for their initial diagnosis and how, years later, they stand firmly by it.

ii) The available histology

The authors discount the histology of a large boney mass removed from the patient's left lung following pneumonectomy in 2004. That report⁶ cited the following:

... foci of coarse sclerotic and heavily calcified bone which are devoid of viable osteocytes. The latter appearance in particular

- The authors have gathered their version of the history and timelines involved, not directly from the treating doctors, or the patient's actual medical records, but from drawing heavily on the patient's ex-wife who has pursued many avenues to discredit the 'famous patient' since their separation in 1997.

The authors have failed to take account of three crucial pieces of evidence

i) The clinical experience and the medical records of the treating physicians

The authors did not consult the treating doctors: Mr John Doyle (surgeon in Melbourne), Dr Ivon Burns (oncologist in Melbourne), Dr Alistair Robertson (oncologist in Adelaide) and Dr John Piesse (GP in Melbourne). They did not access their medical records, including their clinical histories and the extensive diagnostic investigations that were carried out.

is recognised as a change which may occur in osteosarcoma after chemotherapy.

iii) The effects of cancer-related chemotherapy on active TB

The authors have overlooked the significance of the patient receiving chemotherapy in 1976 with adriamycin, vincristine, cyclophosphamide and D.T.I.C. (dacarbazine). This treatment was administered because his condition at the time was actively advancing. It is well known that this combination of chemotherapy is powerfully immunosuppressive. To give strong chemotherapy to a patient with widespread, active TB would almost certainly result in miliary TB and a rapid death. By contrast, this patient experienced no significant side effects.

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