bullous lung disease in young people. Inflammatory lung changes, chronic cough, and chest infections are similar to those in cigarette smokers, but may also be commoner in younger people. Premalignant changes have been shown in the pulmonary epithelium, and there are reports of lung, tongue, and other cancers in cannabis smokers. Tetrahydrocannabinol has cardiovascular effects, and sudden deaths have been attributed to smoking cannabis. Myocardial infarction is 4.2 times more likely to occur within an hour of smoking cannabis. However, despite these alarming facts, there is no evidence at present on whether smoking cannabis contributes to the progression of coronary artery disease, as smoking cigarettes does. More studies of the cardiovascular and pulmonary effects of cannabis are essential.

It may be argued that the extrapolation from small numbers of individual studies to potential large-scale effects amounts to scaremongering. For example, one could calculate that if cigarettes cause an annual excess of 120 000 deaths among 13 million smokers, the corresponding figure for deaths among 3.2 million cannabis smokers would be 30 000, assuming equality of effect. Even if the number of deaths attributable to cannabis turned out to be a fraction of that figure, smoking cannabis would still be a major public health hazard. However, when the likely mental health burden is added to the potential for morbidity and premature death from cardiopulmonary disease, these signals cannot be ignored. A recent comment said that, however, there is no evidence at present on whether smoking cannabis contributes to the progression of coronary artery disease, as smoking cigarettes does. More studies of the cardiovascular and pulmonary effects of cannabis are essential.

People missing as a result of armed conflict

Standards and guidelines are needed for all, including health professionals

Mass graves from past or present conflicts, massacres in the Balkans, disappearances—South American style—and the missing in action are politically sensitive. One reason is that they usually entail violations of international humanitarian law (the wartime rules that protect people who are not in combat or no longer in combat) or human rights law. International criminal tribunals to try individuals (whether combatants or civilians in combat or no longer in combat) or human rights law (the wartime rules that protect people who are not combatants or combatants who no longer are) may be established by the United Nations, and non-governmental organisations. Military bodies, international organisations including the United Nations, and non-governmental organisations. Clearly it is time for standards and guidelines on best practice for all professionals.

The International Committee of the Red Cross has been forced into undertaking an initiative, “The Missing,” which has taken the form of a series of expert workshops and studies and a review of its own practice over time and by continent. The outcome has revealed ambiguity about the legal and ethical basis of any action involving forensic specialists, the lack of best practice guidelines to guide these specialists, the difficulty of accommodating local customs and culture in an investigation, and recognition of an inconsistency of the International Committee of the Red Cross’s own practice with regard to missing people. At centre stage, however,
Biventricular pacing for heart failure

Left bundle branch block in structurally normal hearts results in loss of synchrony of ventricular contraction and impairs both regional and global left ventricular systolic function. In hearts with good overall left ventricular systolic function this has very little clinical effect. But in patients with ischaemic or idiopathic dilated cardiomyopathy it further impairs already poor systolic function and may have a major clinical impact. The prevalence of conduction delay in these contexts; guidelines for psychological support of affected families; and recognition that working without taking the pertinent culture and context into account amounts to professional negligence.

Left bundle branch block results in loss of synchrony of ventricular contraction and impairs both regional and global left ventricular systolic function. In hearts with good overall left ventricular systolic function this has very little clinical effect. But in patients with ischaemic or idiopathic dilated cardiomyopathy it further impairs already poor systolic function and may have a major clinical impact. The prevalence of conduction delay in patients with heart failure is as high as 30%, and this has led to the development of biventricular pacing in an attempt to restore synchronous ventricular contraction and so improve left ventricular function. Biventricular pacing involves the transvenous placement of a third pacing lead via the right atrium and coronary sinus into a left ventricular cardiac vein; this is in addition to the standard pacing leads in the right atrium and right ventricle and permits simultaneous stimulation of the right and left ventricles.

What is the evidence that this works? Several studies have indicated that biventricular pacing improves symptoms in patients with heart failure and left bundle branch block. A recent multicentre randomised trial of resynchronisation has substantially enhanced the evidence supporting this treatment. This was a double-blind study of cardiac resynchronisation in 453 patients with chronic moderate to severe symptoms of heart failure (New York Heart Association class III-IV) due to ischaemic and non-ischaemic cardiomyopathy and dysynchronous ventricular contraction evidenced by a QRS duration of 130 milliseconds or more in left bundle branch block. Patients were randomised to either control (n = 225) or atrial synchronised biventricular pacing (n = 228), with follow-up for six months. In keeping with previous studies, notable improvements in the primary end points of New York Heart Association functional class, six minute walking distance, and quality of life were observed in the resynchronisation group over those in the control group. These benefits became apparent one month after randomisation and were maintained at six months.

In addition, cardiac resynchronisation seemed to reduce the risk of clinical deterioration during follow up, with the combined risk of a major clinical event (death or admission for worsening heart failure) being reduced by 40%. The number of patients requiring admission for heart failure (34 v 18 for control and resynchronisation groups, respectively) was reflected in a notably reduced number of total hospital days for management of heart failure (365 v 83). This finding has potentially major implications for cost effective use of healthcare resources.

One important limitation of this study is the relatively short period of follow up, and whether the longer term effects are as impressive remains to be seen. In addition, the prognostic implications of biventricular pacing are unknown, although they are being addressed by continuing mortality studies.

The clinical response to biventricular pacing has been shown to be heterogeneous, and an important limitation of this study is the relatively short period of follow up, and whether the longer term effects are as impressive remains to be seen. In addition, the prognostic implications of biventricular pacing are unknown, although they are being addressed by continuing mortality studies.

These and other recommendations were considered and adopted by consensus by government representatives, international organisations, and independent experts at an international conference on "The Missing" held in Geneva from 19 to 21 February 2003. However, whether people disappear in armed conflict or internal violence, whether their fate is ascertained, and whether the families receive the information and support they require depends ultimately on action taken by governments. Doctors and national medical associations can make a difference firstly, by ensuring that the statement "Forensic Investigations and the Missing" proposed in October 2002 and to be published by the British Medical Association is adopted by the medical ethics committee of the World Medical Association at its next meeting in May in Divonne, France and secondly, bringing its content to the notice of policy makers.

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