countries that can define their priorities convincingly (but do not have large populations of poor people), funding for corrupt and dictatorial governments that have little regard for their poorest citizens, and the enormous waste of the limited talents of many developing countries. Such haste has been spent on inventing new approaches to developing competitive proposals to satisfy yet another under-resourced aid bureaucracy with little chance of success.

That Périn and Attaran are urging a repeat of the failed design for the Global Fund that Attaran proposed in his and Sach’s 2001 Lancet article as the basis for allocating donor support for the health sector as a whole, is shameful. If there was ever a need for evidence-based thinking about international health policy to replace ideological befuddlement, Périn and Attaran have demonstrated it in their Viewpoint.

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Sir—Ines Périn and Amir Attaran want to replace ideology with dialogue in international medical aid. But by basing donor funding exclusively on a recipient country’s proposals they assume that governments of such countries always act in the best interests of the populations they represent. However, in many countries people suffer exactly because of the negligence, corruption, and unfair policies of their governments.

Périn and Attaran suggest that submitted proposals should be assessed only if they are technically sound and fiscally accountable. This way of thinking presents exactly the same problems as the World Bank’s conditional loans policies they criticise.

What I understand by dialogue is an engagement in practical work alongside local counterparts to see if different approaches can work in practice, to understand the needs of the people, and to ensure that those most in need benefit from essential services.

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Sir—Imatinib or transplant for chronic myeloid leukaemia?

In his account of the development of imatinib and its remarkable clinical efficacy in chronic myeloid leukaemia, Edward Sausville (April 26, p 1400) alludes to the dilemma that faces newly diagnosed patients who in the pre-imatinib era would have been obvious candidates for early allogeneic stem-cell transplantation. We agree with his view that the long-term benefit of imatinib cannot yet be reliably assessed, but feel he has perhaps underestimated the likelihood of cure in patients who, for long periods after transplant, have no evidence of residual disease even at the molecular level. Sausville draws attention to the fact that stem-cell transplants are hazardous, but omits mention of the fact that reduced intensity allografts are undoubtedly safer and could be as good as conventional transplants for treating the disease.

The decision not to offer selected newly diagnosed patients the option of an allograft as primary treatment is probably simplistic. A good case can be made for identifying transplant candidates by combining the use of the Sokal or Hasford risk criteria to define a patient with standard or poor prognosis with non-transplant therapy with the Graswold score to identify a patient with a good chance of survival after transplant and consequently a reasonably good chance of cure.

In the next few years, improved knowledge of overall survival data with imatinib, improved understanding of the effect on survival of complete cytogenetic responses to imatinib, and updated assessment of reduced intensity conditioning allografts should allow more definitive recommendations. In the meantime, we believe that the younger patient who is not low-risk and who has an HLA-identical sibling or a molecularly HLA-matched unrelated donor should still be offered the choice of an initial trial of imatinib or an upfront transplant.

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