ophthalmic opticians should be used for such screening.

Though some diabetics requiring treatment were detected in their study, the false negative rate is uncertain. Their detection rate was half that of a major screening programme described by Mr Anthony J Bron in the same issue. An attempt was made for an ophthalmologist to recheck some patients screened by the opticians but the very high failure to attend (45%) made this inadequate. It is possible that diabetics requiring treatment have been overlooked, yet they consider themselves to have been screened. It is uncertain whether they are the responsibility of the ophthalmologist or of the optician.

Screening by opticians presently reaches only those who need and can afford spectacles, and recent legislation will further reduce this number. If all diabetics attended regularly, irrespective of the need for spectacles, the opticians would charge the NHS for a sight test and this would be very costly. Opticians were asked to record the appearance of diabetic retinopathy, necessitating a subjective assessment on their part. This is different from the numerical value obtained in screening for glaucoma and is a medical assessment for which they are not qualified and may make them liable to litigation. There is increasing medical unemployment, which will be aggravated by this proposed delegation of medical duties.

Those engaged in ophthalmology must train medical practitioners and students to perform ophthalmoscopy and to regard screening of the diabetic fundus through dilated pupils as routine.

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Reconstruction of general practice

SIR,—Two articles published recently have served to highlight the pressing need for general practitioners to assess the type and quality of the services that they provide. In particular, the paper by Dr C J Burns-Cox and Mr J C Dean Hart (6 April, p 1052) on the screening of diabetics for retinopathy by ophthalmic opticians gives an example of how channels of care may emerge that bypass general practice, in spite of the fact that GPs are in an ideal position to coordinate that care. In the same issue Dr M Kljakovic and colleagues (p 1043), reporting on referral of patients with glaucoma, suggest a way in which outside agencies can sensibly be linked into the existing medical referral system.

Diabetic screening presents a different problem, for here it could be argued that with a multisystem condition, fragmentation of care might ensue from involvement of other professional groups. There is ample evidence that improvements in services for diabetics require not large amounts of skill or money but relatively simple organisational changes which allow doctors to carry out the tasks for which they are trained.^{1,2} Where organised care in practice exists skills such as fundoscopy are well maintained. Examining the eyes of a diabetic should be carried out by the physician looking after the particular patient, though if we cannot organise ourselves to examine fundi then it will (and should) be done by others.

In two earlier issues of this journal Dr F Honigsbaum (16 March, p 823; 23 March,

p 904) touched on what may be at the core of this problem in general practice. A population of increasingly highly trained doctors is being asked to provide "traditional" general practitioner services while being faced with the inherent criticism that emerging general practice research brings: the health of our patients does not seem to be improved by our determination to work harder. Should we now be shifting the emphasis away from expensive doctor orientated immediate care to more flexible combinations of nurse and doctor consultation? It will certainly require a shift in the consulting role, not merely reduced list sizes, before the time needed for evolution of services within general practice is created.

For diabetes, as for other chronic diseases, comprehensive care could be most effectively organised within general practice; if we cannot carry out this task our only point of contact with our diabetic patients may well be intercurrent illness and the repeat prescription.

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- 1 Hill RD. Community care services for diabetics in the Poole area. *Br Med J* 1976;i:1137-9.
- 2 Singh BM, Holland MR, Thorn PA. Metabolic control of diabetes in general practice clinics: comparison with a hospital clinic. *Br Med J* 1984; 289:726-8.

SIR,—It was heartening to read Dr F Honigsbaum's recommendations for the reconstruction of general practice (16 March, p 823; 23 March, p 904): as a nurse practitioner I may yet avoid redundancy. However, there are dangers inherent in the system of care which he recommends, with nurse practitioners as the patient's first contact and doctors as the generalist specialists developing their own particular clinical interests and skills.

The art and science of nursing are difficult to define, but the aim is to enable patients to cope with whatever disease is affecting them, be it a disabling physical, social, or emotional problem. Nursing must take into account the possibilities of cure, but has to function too when cure is not possible. Many of the day to day problems presented to general practitioners (and nurse practitioners) are those for which there is no real cure; self limiting and uncomfortable coughs and colds, or the worried newly redundant man who cannot sleep. Chemotherapy may alleviate symptoms, but the patient has to learn to cope with his or her affliction until a health equilibrium is found. Because so many patients seek help from their general practitioner (or one of his staff) for ailments which fall into this "incurable" category offering nursing rather than medical care is often appropriate and helpful. The practice of nursing therefore should not replace the practice of medicine: the two are complementary and should be available as appropriate.

If nurse practitioners are seen as performing triage, handling the daily round of general practice, their nursing assessments will be impossible to undertake (because of the pressure of work) and they, too, will resort to six minutes for the patient. Nothing will be gained but a step up, and away, from the patient by everybody, and the real potential of nursing's contribution to primary health care will be lost, for it is in preventive medicine, health education, and health maintenance that nurses might significantly

affect the morbidity and mortality rates of a practice population.

There is plenty of room in primary health care for both nurse practitioners and general practitioners, and great benefits for the public in their collaboration.

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Blood pressure measurement: current practice and future trends

SIR,—The regular review by Dr Eoin O'Brien and his colleagues (9 March, p 729) draws attention to changes of blood pressure in different circumstances and the resulting difficulty in arriving at a diagnosis of hypertension in an individual patient. This problem has serious consequences in other branches of medicine.

Joint replacement surgery in middle aged and elderly patients accounts for an important part of elective orthopaedic operating time. Last minute cancellations of these operations may waste resources as well as inconveniencing the patient. In Gartnavel General Hospital 110 patients aged over 45 were admitted for elective hip or knee replacement over four months. All patients were asked briefly about their general health at the orthopaedic clinic and further assessment was delayed until shortly before surgery. The usual inpatient examination was carried out by the orthopaedic house officer and anaesthetist, and I also studied each patient prospectively, gathering standard data including a history, examination, and results of special tests on each patient. Seven patients (6%) had their operations cancelled because they were "unfit" for their anaesthetic. Four of these operations were postponed to allow treatment of hypertension in patients with blood pressures of 150/110, 245/140, 185/105, and, in one patient taking methyl dopa, 190/110 mm Hg. Two of these patients had had a myocardial infarction or characteristic electrocardiographic changes, one of whom had angina and symptoms and signs of ischaemic heart disease. A third patient had evidence of left ventricular failure.

Twelve patients in this series (11%) had a diastolic blood pressure of 110 mm Hg or more on admission and still had their operations without any subsequent cardiovascular complications. Most of these patients had evidence of myocardial ischaemia or hypertrophy similar to that which was present in the patients whose operations were cancelled.

Prys-Roberts *et al* recommended preoperative treatment of hypertension in elective surgery.² Raftery was more specific and said that a preoperative diastolic pressure of 110 mm Hg is an indication for treatment and postponement of elective surgery.³ Neither of these authors comment on how to obtain the representative blood pressure. Burn argued that serial recordings should be made if the blood pressure is high on admission but again did not state how to calculate the representative level.⁴

Hypertension was an important reason for last minute postponement of elective joint replacement in this series. Lack of clarity in published reports on the preoperative management of hypertension and even its definition has created difficulties for orthopaedic surgeons who do not have the service of an anaesthetic assessment clinic. In practice,

the preoperative management of hypertension varies in our hospital, the variation being at least partially explained by the number of anaesthetic opinions represented.

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High dose cisplatin compared with high dose cyclophosphamide in the management of advanced epithelial ovarian cancer

SIR,—In their randomised prospective study of 86 patients with epithelial ovarian cancer Dr Hannah E Lambert and Professor Roger Berry (23 March, p 889) concluded that cisplatin (120 mg given intravenously monthly for six months then 30 g intravenously monthly for a further six months) was superior to cyclophosphamide (2 g intravenously monthly for six months followed by 1 g intravenously monthly for six months). This superiority was seen with respect to both survival and time to relapse after complete clinical response.

When one looks at the patient characteristics in the two treatment groups age and stage are comparable, but analysis of tumour type shows a bias toward the cisplatin treated groups for mucinous tumours (18% v 5%) and toward the cyclophosphamide treated group for undifferentiated tumours (27% v 12%). With respect to grade generally 22.5% of the cisplatin treated patients had grade I tumours compared with 3% of the cyclophosphamide group; 54% of the cyclophosphamide group had grade III tumours compared with 35% of the cisplatin group. Thus any effect of the increase in grade I tumours in the cisplatin group was maximised by a comparable increase in grade III tumours in the cyclophosphamide group. There was also a preponderance of patients who had had optimal surgery in the cisplatin treated group (53% v 43%).

After standardisation for the differences in surgical debulking between the two groups the statistical significance of the survival difference between the two arms decreased and that of duration of complete response disappeared. At three years the curves depicting duration of complete response had come together whether considered with respect to chemotherapy received or to adequacy of initial debulking surgery.

The question which this paper seems not to answer is this: Do these results reflect any difference in effect of chemotherapeutic regimen or simply a difference in biological behaviour of different ovarian tumours? When stage of tumour is standardised grade of tumour remains prognostically important.¹ This importance has previously been shown to be independent of treatment protocol.² Other aspects of ovarian cancer biology may be implicated—for example, there appears to be a relationship between DNA ploidy and grade, borderline tumours being almost exclusively diploid whereas undifferentiated tumours are mainly aneuploid.^{3,4} Analysis of another prognostically important variable—adequacy of tumour debulking—with respect to tumour biology also suggests that well differentiated and diploid tumours are more often surgically removable.⁴

The preponderance of biologically favourable

characteristics in the cisplatin arm of this study raises the possibility that the difference in survival may be due to inherent prognostic differences between the two groups of patients.

The recommendation that "cisplatin is a more effective chemotherapeutic agent than cyclophosphamide for advanced ovarian cancer and should be the agent of choice in future trials" cannot be made on the basis of these data. The question of cisplatin versus other less toxic cytotoxic drugs either as single agents or as part of combination chemotherapy requires prospective randomised trials large enough to standardise for the many prognostically important variables. We appreciate the difficulty in conducting such a study.

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- 1 Malkasian GD Jr, Decker DG, Webb MJ. Histology of epithelial tumours of the ovary: clinical usefulness and prognostic significance of the histologic classification and grading. *Semin Oncol* 1975;2:191.
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SIR,—Drs Hannah E Lambert and Roger J Berry conclude from their study comparing cisplatin with cyclophosphamide that cisplatin "should be the agent of choice in future trials comparing combination chemotherapy with a single agent." Examination of the study, however, reveals major imbalances that make such a conclusion difficult to substantiate. Because randomisation was performed immediately after surgery 21% of those randomised had to be withdrawn after histological review. This left a major imbalance in patient numbers (cisplatin 49 v cyclophosphamide 37). When these patients were further examined according to the known major prognostic factors there was a much higher proportion of patients with favourable factors in the cisplatin arm.

The findings of this study contradict those of four major studies comparing a single alkylating agent with a cisplatin based combination (Vogl SE, *et al*, 13th International Congress in Chemotherapy 1983 and refs¹⁻³). Each of these studies showed a significantly higher surgically documented response rate for the cisplatin based combination, though in none was there any difference in overall survival. An additional, unpublished, Australian study of 369 patients has shown similar results (Tattersall M, unpublished data). This study of 86 evaluable patients from 51 participating clinicians has major methodological flaws and its conclusion must remain unproved.

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- 1 Sturgeon JF, Fine S, Gospodarowicz MK, *et al*. A randomised trial of melphalan alone versus combination chemotherapy in advanced ovarian carcinoma. *Proceedings of the American Society of Clinical Oncology* 1982;1:108.
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* * *The authors reply below.—Ed, *BMJ*.

SIR,—Drs Ward and Slevin and Dr Williams and Professor Whitehouse raise the possibility that the superiority of cisplatin over cyclophosphamide found in our study may have been due to an imbalance of prognostic factors between the two treatment groups, perhaps as a result of the different numbers in the two groups. As far as grade and histology are concerned, we can reassure them that these factors in no way explain the observed superiority. Since 10 of the 12 grade I tumours were debulked, grade provided little extra discrimination after allowance for debulking, and the histological subtypes did not appear to be correlated with survival at all. These results were confirmed using a stepwise linear regression based on Cox's proportional hazards model,¹ which allows for the imbalance in numbers.

Responses longer than three years remain in the minority in late stage ovarian cancer, our trial being no exception, but this does not invalidate the benefits seen for the majority of responders receiving cisplatin in our study.

We understand the writers' concern, however, since ovarian cancer is a disease where many factors affect the outcome, and such factors may always confound observed effects. DNA ploidy might indeed be influencing our results in such a fashion. However, the greater the p value observed for the difference the more unlikely this possibility becomes. With the smallish numbers in our study and significance levels of the order of 0.05 the observed superiority may, of course, have been a chance finding. Indeed we allowed for this possibility by suggesting rather than recommending cisplatin as the agent of choice in future trials. The results from the trials using combinations containing cisplatin quoted by Dr Williams and Professor Whitehouse confirm our improved response with cisplatin. However, published reports now show a diversity of results as far as survival is concerned.²

A final point is that the present management of advanced carcinoma of the ovary requires a multidisciplinary approach. This is reflected by the fact that the North Thames Cooperative Group includes, as well as the 10 radiotherapists who administered the chemotherapy, gynaecologists, pathologists, and medical statisticians.

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- 1 Cox DR. Regression models and life tables. *Journal of the Royal Statistical Society* 1972;34:187-220.
- 2 Neijt JP, Van Der Burg MEL, Vriesendorp R, *et al*. Randomised trial comparing two combination chemotherapy regimens (hexa-CAF vs CHAP 5) in advanced carcinoma. *Lancet* 1984;ii:594-600.

Management of delayed puberty

SIR,—Dr Charles G D Brook's leading article (2 March, p 657) was correct to highlight the paramount importance of early treatment of