that their use in whooping cough has been on such a scale as would have influenced these rates. Is the reduced case fatality due to better care? Have physicians been notifying a large outbreak of a respiratory virus disease running along at the same time as the expected whooping-cough epidemic? Any ideas?

GEORGE DICK
President,
Rowhook Medical Society

The Chequers Inn, Rowhook,
Horsham, Sussex

Drugs for myeloma

SIR,—While welcoming the optimism in your leading article "Progress in myeloma at last" (24 June, p 1653), we cannot as yet share your enthusiasm for the use of drugs other than melphalan, cyclophosphamide, and prednisolone in the routine treatment of myeloma patients.

The evidence that vincristine improves response rates and survival in multiple myeloma is not watertight. The Southwest Oncology Group¹ has shown an increase in response rate in the vincristine-containing regimen VMCP (vincristine, melphalan, cyclophosphamide, prednisolone) compared with MCP (melphalan, cyclophosphamide, prednisolone), but this could be attributed to the more frequent (three-weekly) cycle used with the former regimen as compared with the four-weekly cycle used in the latter. The improvement in response shown in their VCAP (vincristine, cyclophosphamide, adriamycin, prednisolone) regimen compared with their CAP regimen is not convincing when the very low response rate with the CAP regimen (14/51, 29%) is noted.

The data on survival in different Southwest Oncology Group regimens² could be interpreted as showing more favourable survival for the vincristine-containing regimens, but there are other possible explanations for their results. It will be noted that their MCBP (melphalan, cyclophosphamide, BCNU (carmustine), prednisolone) regimen, which contains no vincristine, is showing as good survival as some of the vincristine-containing regimens. Furthermore, improved survival in the VMCP/VCAP regimen could be due to the ingenious syncopation of the two combinations and their use in three-weekly cycles instead of the former four-weekly cycles.

The improvement in survival in the M2 Memorial Sloan-Kettering five-drug combination³ compared with the retrospective group of patients treated with melphalan and prednisolone may or may not be due to the inclusion of vincristine in their highly intensive M2 protocol. The improvement, which is now significant at the $P < 0.05$ level, could also be due to the inclusion of cyclophosphamide or BCNU or to the synergism between any of the drugs in the combination.

All these reports of improved survival with multiple drug combinations are preliminary and there appear to be no clinical trials in progress at present which will enable the improved survival to be attributed to the addition of a particular drug to melphalan and prednisolone. It is also too early to say whether very prolonged survival (approaching "cure") is occurring in any of the trials.

The staging system of Salmon and Durie⁴ appears to be validated as a prognostic guide in multiple myeloma, but a disadvantage of this system is that most patients fall into the

stage III (high cell mass) category and we need further ability to discriminate prognostic factors in this large group of patients. The major prognostic factor remains as whether or not the patient will respond to therapy, and we cannot, of course, state this at the time of diagnosis. The drug sensitivity tests recently described by Salmon *et al*⁵ may help with this problem.

It seems likely that clinical trials will eventually show an advantage for the multiple drug combinations, but their toxicity will have to be balanced against their therapeutic benefit. We feel that the balance at present lies against giving multiple drugs besides melphalan, cyclophosphamide, and prednisolone from the start of treatment but that second-line drugs should be tried in special centres in patients who relapse from or fail to respond to the first-line agents.

J S MALPAS
DENIS PARKER

Imperial Cancer Research Fund
Department of Medical Oncology,
St Bartholomew's Hospital,
London EC1

¹ Alexanian, R, *et al*, in *Recent Advances in Cancer Treatment*, ed H J Tagnon and M J Staquet, p 19. New York, Raven Press, 1977.

² Alexanian, R, *et al*, *Cancer*, 1977, **40**, 2765.

³ Case, D C, Lee, B J, and Clarkson, B D, *American Journal of Medicine*, 1977, **63**, 897.

⁴ Durie, B G M, and Salmon, S E, *Cancer*, 1975, **36**, 842.

⁵ Salmon, S E, *et al*, *New England Journal of Medicine*, 1978, **298**, 1321.

Confidential inquiry into gynaecological laparoscopy

SIR,—We are grateful to both you (leading article, 24 June, p 1650) and Dr D B Scott (p 1695) for the interest expressed in this inquiry.¹ We appreciate the complimentary remarks made, for this study reflects hard work done not just by this working party but by hundreds of gynaecologists, anaesthetists, and their assistants.

A few points were raised upon which the working party would like to comment briefly. The leading article expressed disappointment that only 79% of the patients from some hospitals had been entered in the study. Many might have felt this to be a commendably high response rate to a purely voluntary study, and while biased results cannot be discounted the available evidence does not suggest that this occurred widely. In fact 79% represented the response rate of totally complete forms; in 85% we had most of the information about the patient and the operation. A fixed entry into the study at the time a laparoscopy was arranged, as you suggested, would have meant either a two-part form, with all the problems of subsequent record linkage, or retention of the form until the laparoscopy had been performed, sometimes months later. Both systems might have led to an even greater rate of incomplete response. We do not consider the advice that the operation time for laparoscopies should be kept under 35 minutes to be bizarre; it was one of the recommendations in the final section of the report by a group of experienced laparoscopists based on experience and not on a failure to recognise the differences of cause and effect in the data.

Dr Scott's letter was of great interest; he is a most experienced anaesthetist and in his hands the techniques he uses are extremely safe. Nowhere in the report was it contended that spontaneous respiration and the use of a face mask would lead to inhalation of stomach

contents. Rather it was suggested that since the anaesthetic given for a laparoscopy can be a difficult one, for respiration may be embarrassed by the raised intra-abdominal pressure and the steep tilt, it would be safer to have an endotracheal tube in place; this would especially apply in case unexpected surgical complications followed needing rapid action.

The survey did not show any increased complication rate when sterilisation was done with termination of pregnancy over the rates of elective sterilisation (tables 3.2 a and b of the report). Dr Scott considers the numbers too small; there were 3348 women in this group. In making his point about the use of a face mask he called 4750 out of 50 247 ("nearly 10%") "a very considerable number." May not 3348 women out of 29 661 sterilised (11.3%) be also regarded as considerable? The job of the working party was to report findings and in this survey the complication rates for sterilisation at termination of pregnancy were not increased. This was a confidential inquiry and if a post-mortem was not reported on the form we could not go back to the centre reporting the death. While two of the deaths may have been due to gas embolism, they may also have been associated with hypercapnia and disturbance of cardiac rhythm. We agree that it is a pity that the extra data were not available, but if inquiries of this nature are to be confidential, we have to accept the ensuing disadvantages as well as the benefits.

GEOFFREY CHAMBERLAIN

Chairman,

Working Party of the

Confidential Enquiry into Laparoscopy

Royal College of Obstetricians
and Gynaecologists,
London NW1

¹ *Gynaecological Laparoscopy Report of the Working Party of the Confidential Enquiry into Gynaecological Laparoscopy*, ed G Chamberlain and J C Brown. London, Royal College of Obstetricians and Gynaecologists, 1978.

Computer confidentiality

SIR,—Drs Peter M Dunn and Colin H M Walker (22 July, p 276) may well be acting in good faith to achieve a "high standard" of confidentiality, but they seem to have been misled about some of the issues involved. We would all agree that the personal professional care provided by paediatricians to the child and the family depends on trust—trust that what may prove to be highly sensitive information to the individual is absolutely confidential. If this trust is betrayed essential information to the proper management of the child may be withheld. There are well-established reasons why in the overriding interest of the child this confidentiality may be broken, but those reasons should be seen as the exception that proves the rules rather than an excuse to break them.

Mr Moyle's announcement in Parliament that he had accepted the ethical safeguards demanded by the BMA's Central Ethical Committee is of value only if the computer system used is a secure one. The Department of Health and Social Security employs the centralised batch-orientated type, similar to the one used at the Vehicle Licensing Centre in Swansea. It is well recognised by computer experts that with the necessity for outside agents to execute the preparation or entry of data the number of stages at which confidentiality could be broken are legion. Also