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?

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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.

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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.

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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

when the output in the shape of reports has to be prepared there is a grave risk to confidentiality by intermediate agencies. Furthermore, the technical maintenance diagnostic requirements are an indication of how security can be bypassed and give potential access to collection of information (data bases). As Congressman Crane from Illinois has pointed out, "Had Dr Lewis Fielding's files on Daniel Ellsberg been collected into a computerised data bank to which federal officials had access, there would have been no need for the Watergate plumbers."

The BMA is not "against computers." The ethical safeguards could be brought into the alternative remote terminal system, like that used in the Exeter project. This would obviate the need for the number of civil servants handling the data and therefore resources could be concentrated on a narrower area of preventing unauthorised access to data held on magnetic media—for example, by personal codes, pass words, and uniquely identifiable terminals. This system, made available to individual doctors, may well be in a similar capital cost bracket to the DHSS batch system but would be much cheaper to run because few administrative staff would be required. More important, it would ensure that the doctor was responsible for the information that was stored and not the State.

Drs Dunn and Walker deplore the emotive way this subject has been discussed. They in turn seem to infer that doctors who are resisting the batch computer system are behaving like King Canute. In fact King Canute reigned wisely and the well-known tale of his rebuke to his sycophantic courtiers in the matter of the rising tide should warn Drs Dunn and Walker not to place too much faith in the almighty DHSS computer.

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Sexual pressures on children

SIR,—I read with interest the letter from the Responsible Society (29 July, p 353) which accused the Health Education Council and the Family Planning Information Service, among others, of promoting juvenile sex. Neither body is in fact involved with promoting sexual activity among young people. We accept the fact that sexual activity does occur among young people and our interest is in trying to prevent the ill consequences of this activity—unwanted teenage pregnancies, abortions, illegitimate births, or unhappy shotgun marriages.

In a society which treats sex indiscriminately, using sex unnecessarily for all forms of advertising and promotion and portraying irresponsible sexual behaviour in newspapers, films, and on television, it is impossible for young people not to hear about sex. As Gordon and Dickman¹ say in their pamphlet, "Sex Education: The Parents' Role," "The only way in which parents can be exclusive sex-educators for their young children would be to prevent them from having any friends, from talking on the telephone, looking at any but carefully censored books, newspapers or magazines; listening to the radio; playing records or watching TV; and never letting them into a public rest-room. The passage of years however might defeat such parental

efforts, because in adolescence the peer group appears just as influential as parents, if not more so."

The Health Education Council and the Family Planning Information Service aim to give young people accurate information. We cannot reach the group of young people who are least likely to act responsibly if we preface our message by a sermon.

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¹ Gordon, S, and Dickman, I R, *Sex Education: The Parents' Role*. Public Affairs Pamphlet No 549. New York, Public Affairs Committee, 1977.

SIR,—The Family Planning Association is deeply concerned by the hysterical, unfounded, and ill-informed criticism of the provision of accurate information on sex, personal relationships, and birth control—particularly for young people—made by members of the Responsible Society (29 July, p 353). The motives of organisations and individuals who seek to deny the provision of factual information and therefore to perpetuate the distress, the illegitimate births, and the abortions which result from ignorance of sexual matters must be challenged.

In a society which treats sex indiscriminately—using sex unnecessarily for all forms of advertising and promotion and portraying irresponsible sexual behaviour in films and television—it is irresponsible *not* to balance the scales by providing accurate information on sexuality. Those critics of charitable information services would better protect the young if their energies were directed at the media which exploit sex for commercial gain and which put pressure on young people to become sexually active at an early age. Indeed, if, as the Responsible Society itself admits, some areas of the media "have the most damaging influence," why does the Responsible Society not devote its efforts to urgently needed improvements in this field?

Both the FPA in its own work and the Health Education Council, which jointly with the FPA runs the Family Planning Information Service, are endeavouring to combat the damaging effects of irresponsible material by the provision of accurate information. The Responsible Society would be well advised to make a clear distinction between material produced by specialist, non-profit-making agencies which is accurate, informative, and designed to help and that which is produced solely for commercial gain, which has as its aim the intention to titillate and entertain and which constantly tarnishes sexuality as a human emotion.

True concern for the welfare of the young is shown by allowing them to grow up with an honest and sensitive understanding of their own sexuality and their responsibilities in personal relationships, not by ignoring these issues. Paramount in achieving this understanding is comprehensive and sensitive sex education, whether by parents or schools. More effort spent on encouraging good provision of sex education programmes in schools would be far more constructive and helpful in protecting young people from sexual pressures. This was made clear in a recent report from the Institute for Social Studies in Medical Care ("My Mother Said . . . The Way Young People Learned about Sex and Birth Control," researched by

Christine Farrell for the Department of Health and Social Security). It concludes that "there is no clear causal relationship between early information sources and teenage sexual behaviour. . . . Although a causal relationship is not established, we might speculate that inadequate information about sex could lead young people to experiment and 'find out for themselves'. . . . The dissatisfaction with friends as a first source of information and the greater satisfaction expressed if school or parents had been the first source emphasises the need for information to be provided by adults at an early enough stage so that young people can feel confident that they know the 'facts' and can use them as a basis for fuller discussions with friends and other adults."

Incidentally, it particularly behaves a "Responsible Society" to check facts. The Family Planning Information Service has never claimed to have sent out "millions of copies of a leaflet, 'Straight Facts about Sex and Birth Control.'" (If it had there might be fewer teenagers involved in sexual relationships, since the leaflet *does* inform young people that they should not be pressurised into having sex.) Distribution of this leaflet was, in fact, less than 250 000 in 1977. It seems that the Responsible Society is unaware that the majority of the literature which is produced and sent out by the FPIS—on request—to Health Service personnel and members of the public is factual information on topics ranging from methods of birth control to leaflets on cystitis, breast self-examination, and the change of life. In addition, members of the public are able to obtain practical help with problems and inquiries on family planning and related issues. Last year help on these matters was sought by over 55 000 members of the public.

There were other inaccuracies in the Responsible Society's letter. For example, the current "Straight Facts" leaflet does not refer to a contraceptive mail order service. The FPA does not run its own contraceptive business. The FPA receives covenanted funds from FP Sales Ltd, a separate, independent company, but the FPA is, of course, a non-profit-making charity.

Doubtless the 150 doctors who put their signatures to the Responsible Society's letter would be concerned about these inaccuracies.

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SIR,—From a conventional point of view, the letter from Dr S E Ellison and others (29 July, p 353) may, for this reason, appear reasonable. But those in family planning in general are in fact deeply concerned and responsible in their attitudes to those in their care. It is a difference in outlook. What is "sick," in my opinion, is society's attitude to sexuality.

Though man in his time has held other, saner attitudes to sexuality, Judeo-Christianity, in which our society is based and for which we have paid and are paying such an enormous price in guilt and compulsion, originated intolerance and persecution in religion and turned man against the well-spring of life, his own sexuality, as being the root of sin and evil.

Thus, metaphorically, we live in a society where it is the custom to break the limbs of