the final choice of treatment. In a recent survey on the management of laryngeal cancer in the United Kingdom and Ontario, Canada, Gaze *et al* found that 84% of otolaryngologists and 96% of clinical oncologists would recommend primary radiotherapy for T₃,N₀,M₀ laryngeal cancer.¹

The recent advances in stomal valves and speech buttons are excellent news for patients in whom laryngectomy is inevitable, but we should still strive to allow as many patients as possible to retain their larynges with good speech function.

MARGARET DALY
PERRIC CRELLIN
MARK GAZE
HUGH MACDOUGALL

Department of Clinical Oncology,
Western General Hospital,
Edinburgh EH4 2XU

- 1 Gleeson M. Voice after laryngectomy. *BMJ* 1992;304:2-3. (4 January.)
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SIR,—As a speech and language therapist working primarily with patients with head and neck cancer, and particularly patients who have had a laryngectomy, I wish to respond to Michael Gleeson's editorial on voice after laryngectomy.¹ I work in one of the British centres for surgical voice restoration (the technical term for voice valving). We offer this as the first option for communication after laryngectomy, except in rare cases in which the prognosis is particularly poor. It is important to note that the voice valve merely allows lung air to produce the sound for speech. As with normal speakers, this sound is modified by the oropharyngeal tract and the articulators. Voice is a small but fundamental part of speech. The editorial does not distinguish clearly between voice and speech.

Voice valves can also be offered to patients who have had a laryngectomy who have undergone more extensive resection with, for example, gastric pull up repair. Valves have been especially successful in those with jejunum grafts, where the quality of voice afforded is more acceptable than that with gastric pull up. These are patients who, as Gleeson says, would have had little chance of attaining satisfactory voice with traditional methods.

With regard to cost, maintenance may not be too expensive, but, especially in the early stages, the call on the time of medical staff and speech therapists is great.

No one can overestimate the far reaching effects that loss of voice has on lifestyle and personality. The availability of voice valves goes some way towards minimising these and providing successful rehabilitation.

J M DAWSON

Marie Curie Rehabilitation Centre,
Royal Marsden Hospital,
London SW3 6JJ

- 1 Gleeson M. Voice after laryngectomy. *BMJ* 1992;304:2-3. (4 January.)

SIR,—In his editorial on the quality of speech after laryngectomy Michael Gleeson is less than fair when reviewing the evidence for the effectiveness of non-surgical treatments.¹

At least two substantial British prospective randomised studies of radiotherapy with or without chemotherapy have shown that many patients with advanced laryngeal cancer (T₃,N₀,M₀ and

upwards, by Gleeson's chosen classification of stage) can be cured.² Not only is this clearly contrary to his statement that "Others present with advanced disease, and for these unlucky patients total laryngectomy provides the only hope of long term survival" but analysis of "salvage" surgery—that is, total laryngectomy after failure of non-surgical treatment—has confirmed that avoiding early surgery does not seem to prejudice overall survival (H R Grant *et al*, 5th European conference on clinical oncology, London, September 1989). This study showed conclusively that over half of the patients, particularly those with T₃ rather than T₄ laryngeal cancers, never required surgical treatment and were therefore cured, particularly if the tumour had not spread to lymph nodes in the neck, without laryngectomy and consequent loss of voice.

It should be emphasised again that loss of voice is a majority penalty of laryngectomy, however effective the rehabilitation, follow up, and supportive care. Every effort should be made to avoid this tragedy by offering the most powerful form of non-surgical treatment as the primary treatment. Fortunately, this message seems to have filtered through to most British specialist centres, although it is apparently not yet widespread in the United States, even though a recent American based randomised study again showed that only about one third of patients with advanced laryngeal cancer required laryngectomy for relapse after maximum non-surgical treatment.³

J S TOBIAS

University College Hospital,
London WC1E 6AU

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Appropriate chemotherapy for palliating advanced cancer

SIR,—R D Rubens and colleagues' suggestion that a consensus view on good clinical practice for the management of a particular cancer should be published¹ is to be applauded, provided the consensus view includes the best available treatments validated by research and is not just a restatement of traditional treatments, which will do little to improve the treatment of cancer.

Although the treatment of multiple myeloma remains palliative, considerable prolongation of good quality life is possible, and the Medical Research Council's fifth myeloma trial, which compared melphalan with combination chemotherapy, showed a clear survival advantage for combination chemotherapy. This large randomised trial is the first Medical Research Council myeloma trial to show a significant improvement in survival with the new regimen of adriamycin, carmustine, cyclophosphamide, and melphalan over the well established melphalan regimen. At four years 31% of patients treated with the combination were alive as opposed to 16% in the melphalan group.²

A second important advance has been the prolonged duration of the plateau phase in patients treated with interferon alfa as shown in a smaller randomised study³; this is the subject of a larger Medical Research Council study of interferon alfa-2b given during the plateau phase, which was started in April 1989.

These two well documented advances surely

deserved a mention in Rubens and colleagues' brief discussion of the treatment of myeloma, in preference to trials of high dose chemotherapy with bone marrow transplantation, which are at present too small or in which long term follow up is insufficient to determine outcome. Multiple myeloma is perhaps an example of a cancer for which achieving an accurate consensus view of optimal management from published reports required more detailed and wider consultation than was undertaken.

MALCOLM S HAMILTON

North London Blood Transfusion Centre,
London NW9 5BG

- 1 Rubens RD, Towson KE, Ramirez AJ, Coltart S, Slevin ML, Terrell C, *et al*. Appropriate chemotherapy for palliating advanced cancer. *BMJ* 1991;304:35-40. (4 January.)
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SIR,—As a director of public health, I welcome efforts by the *BMJ* to provide practical help to health authorities and general practitioners in their new purchasing role. Given the breadth of health authorities' remit, the advice given in R D Rubens and colleagues' review of appropriate chemotherapy for palliating advanced cancer is most useful.¹

What this and similar articles do not do is help authorities to make decisions when resources are scarce. Though Rubens and colleagues acknowledge that the costs of such services need to be weighed against potential benefits, no evidence is presented to support this aspect of decision making. As well as considering the utility of any treatment or intervention, as the authors suggest, it is important to assess its cost effectiveness. How else will public health directors and their health authorities be able to make informed choices about whether to spend money prolonging the quality of life of patients with lung cancer or to shift more resources into preventing smoking related disease?

BOBBIE JACOBSON

Department of Public Health,
City and Hackney Health Authority,
London N1 5LZ

- 1 Rubens RD, Towson KE, Ramirez AJ, Coltart S, Slevin ML, Terrell C. Appropriate chemotherapy for palliating advanced cancer. *BMJ* 1992;304:35-40. (4 January.)

Overheads for clinical research

SIR,—University departments are encouraged by the Committee of Vice Chancellors and Principals to charge realistic overheads when engaging in contract research with the pharmaceutical industry. Practices still vary widely, but non-itemised proposals for overheads of as much as 100% on research contracts are now being made in Britain.

The practice in continental Europe, according to a survey performed by the Association of the British Pharmaceutical Industry, is different. In Belgium, Switzerland, Finland, and Sweden overhead charges have never been incurred. In Norway, Germany, Ireland, the Netherlands, and Spain less than a quarter of institutions request such overheads, and invariably at a rate of less than 25%. In the United States overhead charges are not always added to research grants, but the practice is more variable than in Europe. The highest rate encountered in the survey was 70%, and in most cases the rate was less than 25%.

There can be no objection to itemised expenses, which can be debated directly by the institution and the company concerned. High demands that