Volunteers (or families) might, however, have a role in maintaining benefit, and indeed the aim of all rehabilitation should be to involve families in longer term support. To this extent we failed, and further studies are needed to confirm our results and investigate ways of maintaining mobility.

DERICK T WADE

Rivermead Rehabilitation Centre,
Oxford OX1 4XD

Lipoprotein(a) in cirrhosis

SIR,—The primary site of synthesis of lipoprotein(a) has not been clearly identified. Like J Feely and colleagues,¹ we have measured lipoprotein(a) concentrations using an enzyme linked immunosorbent assay (Immuno, Heidelberg). We studied 18 patients with severe cirrhosis as assessed by the Child Turcotte classification. Cirrhosis was due to chronic active hepatitis in 12 patients and to primary biliary cirrhosis in four; in two others it was associated with hepatocellular carcinoma.

In 14 of the 18 patients lipoprotein(a) concentrations were almost not detectable (mean 23 mg/l, range 0-60 mg/l), which supports the hypothesis that lipoprotein(a) is synthesised primarily by the liver. In contrast, the four other patients had high normal or raised concentrations of lipoprotein(a) (ranging from 150 to 360 mg/l). The cirrhosis in these four patients was due to chronic active hepatitis in two and to primary biliary cirrhosis in one and was associated with hepatocellular carcinoma in one.

Therefore, we support the hypothesis that lipoprotein(a) is synthesised primarily in the liver; non-hepatic tissue may, however, contribute to the concentration of lipoprotein(a) in the serum.

H SCHMIDT S WAGNER
R KOLM M MANNS

Department of Gastroenterology
and Hepatology,
Medical University of Hannover,
3000 Hannover,
Germany

1 Feely J, Barry M, Keeling PWN, Weir DG, Cooke T. Lipoprotein(a) in cirrhosis. *BMJ* 1992;304:545-6. (29 February.)

Hospital admission and start of benzodiazepine use

SIR,—D Surendrakumar and colleagues present data from three general hospitals in which a total of 65 patients had been supplied benzodiazepines when discharged.¹ There is no indication as to what proportion of total discharges this represents and seven (11%) of the relevant records were not scrutinised and no reason was given for their omission. The mean age of patients scrutinised was 74 years, and 60% were male, an unusual population distribution about which no comment was made. Only 17 patients were found to have been first prescribed benzodiazepines during the index admission; five patients had been taking the drugs for up to two months, seven for up to a year, and 20 for over a year. That leaves only nine of the 58 unaccountable, although it had been said that for 12 of the cases details of when the drug had been started were not ascertained.

Discrepant or not, these are trivia. What is not trivial is to report finding evidence of dependence in eight out of 10 patients said to have taken the drugs for more than two years. What evidence is not stated, nor why attempts to stop the drug had been made in only five patients, nor what were the withdrawal symptoms which had occurred in only two patients. Such symptoms, the mainstay of a diagnosis of dependence, can be difficult to extricate both from symptoms for which the drugs were prescribed and from "pseudowithdrawal" symptoms.^{2,4} Nor is it trivial to accuse colleagues

both of unwarranted prescribing and prescribing without assessment of need: in effect, of negligence. The former is supported by minimal details of just three cases, the latter by no data at all.

It is true that some doctors have a righteous concern about the allegedly careless prescribing habits of other doctors, as referenced in the paper. It is also true that some doctors are equally concerned that prejudiced reporting has led to a situation where patients in need may be denied appropriate treatment.^{5,7} The promotion of medicines should reflect accurately and clearly an up to date evaluation of all the evidence. Might it not be appropriate for similar requirements to apply to publications in influential medical journals?

KEVIN WOODCOCK

Serenissima Medica,
Winchester,
Hampshire SO23 7ET

- 1 Surendrakumar D, Dunn M, Roberts CJC. Hospital admission and the start of benzodiazepine use. *BMJ* 1992;304:881. (4 April.)
- 2 Winokur A, Rickels K. Withdrawal and pseudowithdrawal reactions from diazepam therapy. *J Clin Psychiatry* 1981;42:442-4.
- 3 Roderigo EK, Williams P. Frequency of self-reported "anxiolytic withdrawal" symptoms in a group of female students experiencing anxiety. *Psychol Med* 1986;16:467-72.
- 4 Noyes A, Garvey MJ, Cook BL, Perry PJ. Benzodiazepine withdrawal: a review of the evidence. *J Clin Psychiatry* 1988;49:382-9.
- 5 Hollister LE. Recent media coverage inflates fear of using benzodiazepines. *Clinical Psychiatry News* 1980;8:1-38.
- 6 Nagy A. Long term treatment with benzodiazepines: theoretical, ideological, and practical aspects. *Acta Psychiatr Scand* 1987;76(suppl):47-55.
- 7 Uhlenhuth EH, De Wit H, Balter MB. Risks and benefits of long-term benzodiazepine use. *J Clin Psychopharmacol* 1988;8:161-7.

AUTHOR'S REPLY,—K Woodcock's attitude towards medical audit is unacceptable. Making accusations of inconsistency in data without carefully reading the article is inappropriate. The data are correct and consistent. As is evident from the paper, in 12 cases it was not possible to ascertain whether the patient had started benzodiazepines in hospital or in the community. This number is not applicable to the question of when they started.

It is surprising that Woodcock does not appreciate the brevity of the presentation of results and discussion required for a short report. However, I can now fill in the details he requests. The reasons for not scrutinising some notes were simple administrative difficulties and refusal by one consultant to give permission. Dependence was implied by the presence of statements in the notes to the effect that the patient could not manage without the tablets. A clear statement of increased insomnia or anxiety in the period immediately following a dose reduction was considered to be a withdrawal effect. Although I can be positive that the benzodiazepine medication had been reduced in five cases because of concern, that this was not attempted in the others cannot be ruled out.

It is only through examination of its prescribing habits that the medical profession can move towards rationalisation in therapeutics. Benzodiazepines have done enough harm. The publication of studies whose conclusions encourage doctors to keep within nationally agreed policies can only result in good.

CLIVE J C ROBERTS

Department of Medicine,
Bristol Royal Infirmary,
Bristol BS2 8HW

Side of origin of ovarian cancer

SIR,—D J Cruickshank recently suggested that ovarian cancer arises more frequently on the right than on the left ovary.¹ This finding was discussed in terms of the incessant ovulation hypothesis, on the basis of the observation that ovulation occurs

more frequently on the right.² Along this line, a paper by C B Johannes and colleagues based on about 300 ovarian cancer cases has shown that 53% of cancers were right sided in origin (compared with 59% in Cruickshank's study).³

To offer further data on the issue we have reviewed the pathological diagnosis in 556 cases of ovarian cancer consecutively observed for first line treatment between 1980 and 1991 at two obstetric and gynaecology clinics of the University of Milan. Information on the side of origin of the tumour, histological type, stage of the disease, age, and menopausal status at surgery were retrieved from clinical records. Of the 556 cases, 235 were at stage I, 35 at stage II, 237 at stage III, and 24 at stage IV; in 25 cases the stage was not reported in the clinical records.

The side of origin of the tumour was determined in 333 (unilateral) cases. Of those, 172 (52%) were of right sided origin and 161 (48%) of left ($z=0.55$, $p>0.05$). The tumour was bilateral in 212 cases, and in 11 the data on the side of tumour were missing. The proportion of right and left sided unilateral tumours was largely similar in strata of menopausal status, stage, and histological type of the disease.

Our analysis was based on pathological data reported in the clinical records, and the hypothesis of the study was not known to the pathologists who performed the histological analysis or to the clinicians who recorded the data. We had no information on right and left dominance in bilateral tumours. This is of some concern, since both in Cruickshank's and in Johannes *et al*'s series the greater proportion of right sided cancers was mainly accounted for by right dominance in bilateral tumours. It should be pointed out, however, that the assumption with bilateral tumours that the side with the larger tumour is the side of origin is merely speculative.

In conclusion, our analysis gives little support to the hypothesis that ovarian cancer is more common in the right ovary.

FABIO PARAZZINI
LAURA LUCHINI

Istituto di Ricerche Farmacologiche "Mario Negri,"
20157 Milan,
Italy

PAOLO VERCELLINI
GIORGIO BOLIS

II Clinica Ostetrico Ginecologica,
University of Milan

MORENO DINDELLI

Cattedra di Oncologia Ginecologica,
University of Milan

- 1 Cruickshank DJ. Aetiological importance of ovulation in epithelial ovarian cancer: a population based study. *BMJ* 1990;301:524-5.
- 2 Potashnik G, Insler V, Meizner I. Frequency, sequence, and side of ovulation in women menstruating normally. *BMJ* 1987;294:219.
- 3 Johannes CB, Kaufman DW, Rosenberg L, Palmer JR, Stolley PD, Lewis JL, *et al*. Side of origin of epithelial ovarian cancer. *BMJ* 1992;304:27-8. (4 January.)

Medicine in Europe

SIR,—The interesting series of articles on medicine in Europe will have struck a chord in many of those involved in this scene. Many of Tessa Richards's misgivings of the current structures¹ are widely shared.

One of the weakest links is that between the European Union of Medical Specialists (UEMS) and its monospecialist committees, and one can legitimately question both the value and the need for this relationship. The UEMS is constituted on the basis of national representation—which is incompatible with its role as a representative specialist body. One can have either national or specialist representation, but not both.

The figure shows a simplistic view of a medical advisory structure for a country (with the "matching" British organisations shown in brackets) and

National medical advisory structure (British organisations shown in brackets); (bottom) how this system might be applied in Europe

how this system might be applied in Europe. Both diagrams show the lines of communication and the three principal differences from the current European arrangement: a merging of the various directorates at European Commission level into a single medical directorate; separation of the monospecialist committees from the UEMS to form their own specialist organisations; and re-definition of the function of the UEMS and the European Union of General Practitioners (UEMO).

This would represent evolutionary rather than revolutionary change and would have several advantages. It would provide clearly defined channels of communication for the Department of Health, BMA, royal colleges, and specialist societies; allow specialties to develop on the lines of the proposed European Boards but without the constraints of working through the UEMS or UEMO; and allow the UEMS/UEMO to develop on a basis not dissimilar to the BMA. Indeed, its constitution—through nominations of national medical associations—would lend itself to this.

JOHN S M ZORAB

European Academy of Anaesthesiology,
Frenchay Hospital,
Bristol BS16 1LE

1 Richards T. Who speaks for whom? *BMJ* 1992;304:103-6. (11 January.)

Public opinion and purchasing

SIR,—Andrew Richardson and colleagues used a postal questionnaire to derive information about public priorities and perceptions of health care provision.¹ In the planning of a cardiovascular strategy for health in South Glamorgan we have embraced community participation.

Representative "focus groups" considered the question of how we could reduce illness and disability due to heart disease and stroke in South Glamorgan. Their discussions resulted in a questionnaire containing 26 answers to this question, randomly paired so that each answer was matched with three others at some point in the questionnaire. Respondents could indicate not only which of the matched answers was more important but approximately how much more important. The

overall priorities of respondents could be tabulated by computer analysis. In this way questionnaires were devised for the use of local residents, patients with cardiac disease, and patients with stroke.

The three groups surveyed responded with slightly different priorities. The cardiac patients were primarily concerned with speed of treatment for both emergency and planned admissions, and preventive measures did not figure highly. Stroke patients also wished to receive speedy attention but were concerned about support provided at home and integrating after care provided by hospital and general practitioners. The local residents advocated banning tobacco advertising and increasing the awareness of the effects of anxiety, poor eating patterns, and the importance of research into cardiovascular disease. Their main priorities, however, also related to speedy treatment.

The priorities identified by these consumers of health care have been merged with the views of health care professionals to form the local strategy for health. In this way the views of local people can help determine the nature of local health services.

CLIVE WESTON

Department of Epidemiology and Cardiology,
University Hospital of Wales,
Cardiff CF4 4XW

ROBIN ANDERSON

Community Health Unit,
South Glamorgan Health Authority,
Cardiff CF1 3NW

SUZANNE TREWAVAS

District Planning Department,
South Glamorgan Health Authority,
Cardiff CF1 3NW

1 Richardson A, Charny M, Hanmer-Lloyd S. Public opinion and purchasing. *BMJ* 1992;304:680-2. (14 March.)

Women in the NHS

SIR,—Elizabeth Shore's letter draws attention to the urgent need to make the best use of trained medical staff.¹ This is likely to mean fundamental changes in specialist training and patterns of work. She refers to the cooperation that now exists between the BMA and the Medical Women's Federation and to former problems. I wish to clarify the history of the relationship of these two organisations.

E Garrett—better known by her married name, Elizabeth Garrett Anderson—joined the BMA in 1874. Probably only her sponsors, a physician at the Middlesex Hospital and a physician at St Mary's Hospital, knew that the E stood for Elizabeth, and of course the rules of the BMA then admitted all British registered medical practitioners. She was the only woman member until 1892, when at the annual general meeting of the association in Nottingham a resolution to revoke a resolution of 1878 excluding women was passed by 297 votes for with four against.

In 1879 the Association of Registered Medical Women, based in London, was formed to give the few women then on the medical register an opportunity to meet to discuss clinical and other matters of professional concern. As more women became registered four other local associations were formed in other parts of the United Kingdom. In 1917, the date to which Shore refers, these five associations formed the Medical Women's Federation (hence the title). Women were not at that time excluded from the BMA. They believed that a national body was needed to study the implications for women patients and women doctors of the Lloyd George National Insurance Act and other medical matters of concern to women and to make recommendations to relevant bodies when necessary.

The Medical Women's Federation is now an educational charity concerned with medical education and medical and related sciences. It has

always been complementary to the BMA, and long may it be so.

JEAN LAWRIE

Eynsford, Kent DA4 0AA

1 Shore E. Women in the NHS. *BMJ* 1992;304:717. (14 March.)

Starting date of house officer posts

SIR,—Can I encourage A Kaiser to make the changes he suggests¹ without waiting for a master plan from the Department of Health or the General Medical Council?

In November 1975 I converted our six paediatric posts into 12 month posts, starting in February, May, August, and November instead of the traditional January and July. They had a three monthly rotation, and for the first time in the United Kingdom training included a three month period in community child health. At some point (certainly before 1979) we also made the appointments begin on a Monday.

Since 1990 (due to internal cover for holidays) the first week of the appointment has been a study leave week for orientation, training, and teaching procedures such as neonatal resuscitation. The new senior house officer is resident on call alongside the experienced senior house officers. Finally, in 1991 we changed to an 8 am to 4 pm working day to ease the problems of travelling and parking, since most senior house officers can afford their own residence.

There are two problems with a Monday start. Candidates are told the post starts on a Monday and they will have to take bank holidays owed to them in their current post to cover any overlap. If they are too frightened of their consultant to do this, they miss some of their training week but not all of it. Secondly, 365 days is more than 52 weeks. Consequently every so often a senior house officer works for 53 weeks. They have already been paid appropriately and so far nobody seems to have noticed.

I encourage my paediatric colleague to make changes if they seem sensible. Some of those we have made have been widely adopted. For some specialties, where consultants seem unable to work as part of a specialist unit and wish to maintain their own personal retinue, this approach will be more difficult.

RICHARD G WILSON

Kingston Hospital,
Kingston upon Thames,
Surrey KT2 7QB

1 Kaiser A. Starting date of house officer posts. *BMJ* 1992;304:917. (4 April.)

Communication between GPs and consultants

SIR,—The recent paper by John Newton and colleagues made a plea for more information from a wider spectrum of doctors regarding the content of discharge letters.¹ We recently conducted a survey of 400 general practitioners in Leeds, who were circulated with a questionnaire regarding the contents of discharge letters from the accident and emergency department, with specific reference to abdominal or chest pain. Accident and emergency departments present special problems of communication to general practitioners. Many patients are self referred without the knowledge of the general practitioner and have treatment provided without reference to primary health care. The volume of work often precludes detailed communication about every patient, and some degree of selectivity is of necessity adopted. It may thus be even more important in this clinical situation to