though the main beneficial effect of tamoxifen is to delay relapse and thus reduce mortality from breast cancer (20 (23%) deaths from breast cancer in the group given adjuvant treatment compared with 35 (32%) in the group given tamoxifen after relapse), it also has a striking cardioprotective effect (one fatal myocardial infarction (no radiotherapy given) without relapse in those given adjuvant treatment compared with 12 (five with radiotherapy) in those given the drug after relapse). Together these benefits have produced, after a maximum follow up of 12 years, a significant prolongation of survival, which was apparent only after three years from randomisation (hazard ratio 0.614 (95% confidence interval 0.41 to 0.92), $p=0.017$ with the likelihood ratio test fitting Cox's proportional hazard model). This overall effect on total survival is seen regardless of oestrogen receptor status, although the number of patients who were oestrogen receptor poor is too small (total=31) for statistical evaluation.

These results reinforce Dixon's comments regarding the potential benefits of adjuvant tamoxifen for breast cancer in elderly patients and highlight the additional protective effect against fatal myocardial infarction before relapse.¹

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- 1 Dixon JM. Treatment of elderly patients with breast cancer. *BMJ* 1992;304:996-7. (18 April.)
- 2 Breast Cancer Trials Committee, Scottish Cancer Trials Office (MRC). Adjuvant tamoxifen in the management of operable breast cancer: the Scottish trial. *Lancet* 1987;ii:171-5.
- 3 McDonald CC, Stewart HJ. Fatal myocardial infarction in the Scottish adjuvant tamoxifen trial. *BMJ* 1991;303:435-7.

Recommendations for use of hepatitis A vaccine

EDITOR,—As a microbiologist at a district general hospital I have received a number of inquiries during recent weeks from general practitioner colleagues about the recently licensed hepatitis A vaccine. I felt limited by the shortage of available trial results. In that respect I very much welcome the publication of the clinical trial by Anthea J Tilzey and colleagues.¹

The structure of the article causes me concern. The authors come from St Thomas's Campus, SmithKline Beecham, and the Central Public Health Laboratory. That is as one would expect with regard to the product evaluation. However, the article, in its title and text, also addresses the issue of recommendations for its use. Should this be included in an article of which the manufacturer is coauthor? This concern is compounded further by the absence of guidelines, at present, from the Department of Health.

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- 1 Tilzey AJ, Palmer SJ, Barrow S, Perry KR, Tyrrell H, Safary A, et al. Clinical trial with inactivated hepatitis A vaccine and recommendations for its use. *BMJ* 1992;304:1272-6. (16 May.)

AUTHORS' REPLY,—We are glad that M A Hegarty welcomes the publication of our paper as he felt limited by shortage of available trial results. As Hegarty states, the paper is multiauthored. We believe it is important to acknowledge the roles of all those who made a major contribution to our study.

We thought it important that the results of our trials should not be considered in isolation, as some readers might themselves wish to make use of the vaccine; we knew that the vaccine would be

available by the time our paper was published. The views we have expressed are shared by a number of leading experts in hepatitis A infections. Furthermore, our recommendations for the use of the vaccine were essentially in keeping with the Department of Health's recommendations for the use of human normal immunoglobulin for travellers,¹ which would include such groups as members of the armed forces and medical students on electives. Although we suggested that consideration should also be given to people who may be occupationally exposed to hepatitis A virus, such as sewage workers, and certain patient groups, such as homosexual men² and injecting drug misusers,³ we took care to provide appropriate references for readers to make their own assessment.

The Department of Health has yet to provide guidelines but medical practitioners with an understanding of infectious disease and epidemiology should have little difficulty in identifying appropriate people for vaccination.

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- 1 Department of Health, Welsh Office, Scottish Home and Health Department. *Immunisation against infectious disease*. London: HMSO, 1990.
- 2 Kani JIA, Handwani RAK, Gilson RJC, Johnson AM, Maguire HC, Tedder RS. Hepatitis A virus infection among homosexual men. *BMJ* 1991;302:1399.
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Deaths from haemolytic disease of the newborn

EDITOR,—I Z MacKenzie and colleagues suggest that the Office of Population Censuses and Surveys (OPCS) data on death associated with haemolytic disease account for only 15% of the fetal loss attributable to the disease.¹ Although we agree that some cases are missed owing to fetal loss before 28 weeks' gestation, our records indicate that the magnitude of the discrepancy is far less.

In Yorkshire, from 1977 to 1990 inclusive, 114 pregnancies with detectable anti-D antibodies resulted in either spontaneous or therapeutic abortion (before the 28th week). In 44 of these pregnancies fetal loss seemed to be anti-D related, being due either directly to haemolytic disease or, where therapeutic termination occurred, to high anti-D levels, when the likelihood of a successful pregnancy was low. Over the same period 35 deaths were registered with OPCS (after the 28th week).

It seems that at most 55% of anti-D related fetal loss within Yorkshire will not have been registered, though this figure is the worst estimate as it includes the therapeutic abortions. Only 47% of deaths that were directly anti-D related were unregistered if therapeutic abortions are excluded. This implies that OPCS data underestimate fetal loss by about a half.

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- 1 MacKenzie IZ, Bowell PJ, Selinger M. Deaths from haemolytic disease of the newborn. *BMJ* 1992;304:1175-6. (2 May.)

Delayed diagnosis in NIDDM

EDITOR,—The paper by B M Singh and colleagues¹ reported findings similar to those from our department.² We questioned 150 newly diagnosed diabetic patients, 133 (89%) of whom had symptoms attributable to diabetes. Only 23 (17%)

symptomatic patients attributed their symptoms to diabetes. Twenty two (17%) had had symptoms for less than one month, 65 (49%) for between one and six months, and 36 (27%) for more than six months. The remainder could not be specific about the duration of symptoms.

We also inquired about a family history of diabetes to see whether this might influence the recognition of symptoms and speed of diagnosis. Sixty five (43%) patients had a relative with diabetes, and 51 (34%) had an affected first degree relative. Remarkably few of those with a family history realised the cause of their symptoms or appreciated their higher risk of developing the condition. This applied even when several members of the family were affected.

I agree with Singh *et al* that there is a need to educate the general public about the symptoms of diabetes but, with limited resources, it seems particularly important to concentrate on relatives of patients with non-insulin dependent diabetes who also have the means for screening with readily available blood or urine tests.

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- 1 Singh BM, Jackson DMA, Wills R, Davies J, Wise PH. Delayed diagnosis in non-insulin dependent diabetes mellitus. *BMJ* 1992;304:1154-5. (2 May.)
- 2 Lloyd-Mostyn RH, Tan M. The influence of diabetic relatives on the diagnosis of diabetes. *Practical Diabetes* 1986;3:212-3.

Elderly people placed in wrong homes

EDITOR,—Fiona Godlee comments on the misplacement of elderly people in nursing and residential homes and on inadequate resources.¹ At a time of increasing demographic pressure the absolute reduction in the provision of both statutory residential homes and long stay NHS care is dictating the flow towards nursing homes. Valuable though nursing homes are, the soaring costs of support from the Department of Social Security do not necessarily reflect value for money, and some of the care procured is of inferior quality.

A continuing analysis (audit funded) of discharges from non-psychiatric hospitals in Aberdeen to continuing care, whether in a nursing home or a hospital, shows that those moving to nursing homes are much less dependent than those remaining in NHS continuing care wards. Among the first 25 residents admitted to each sector the mean modified Barthel index for those entering nursing homes was 33.0 (SD 5.1) compared with 23.8 (5.4) for those entering continuing care wards ($p<0.001$). (The modified Barthel index used in Aberdeen scores between 13 and 40, with the lowest score indicating maximum dependency.)

Although the dependency in many nursing homes is presently less than that in NHS continuing care wards,² this is changing rapidly. Those admitted relatively fit will age and become more dependent, and when the long overdue community care needs assessment is in place next year fitter people are likely to be offered more appropriate and cheaper care (whether at home or in residential settings that cost less).

Recent clinical experience suggests that nursing homes, relatives, and general practitioners are increasingly asking geriatric departments for advice and, at times, for problematic dependent patients to be removed from these homes and placed in NHS care. Such problems occur largely as a consequence of inadequate staffing, due partly to the insufficient funding available to nursing homes, many of which rely almost entirely on revenue from residents supported by the Department of Social Security.