cycles of either mitomycin, ifosfamide, and cisplatin or mitomycin, vinblastine, and cisplatin.

Nine thousand patients will be required for the trial to give a reliable and clinically relevant result. Potentially all patients with non-small cell lung cancer will be eligible. Similar large trials have been conducted in breast and ovarian cancer, with considerable success. The "big lung trial" will be the first large scale randomised trial to ask this basic but important question about the treatment of this major disease.

On behalf of the steering committee of the big lung trial

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1 Non-small Cell Lung Cancer Collaborative Group. Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised clinical trials. *BMJ* 1995;311:899-909. (7 October.)

Quality of life was ignored in meta-analysis

EDITOR,—The Non-small Cell Lung Cancer Collaborative Group's meta-analysis suggests that chemotherapy regimens that contain cisplatin may improve survival in patients with non-small cell lung cancer.¹ It was a disappointment to find that, with a median increase in survival of 1.5 months in the group given supportive care, no data are presented on the impact of chemotherapy on patients' quality of life. Surely the time has come when no studies should be funded unless they include an assessment of quality of life, and the Non-small Cell Lung Cancer Collaborative Group should include such an assessment in future meta-analyses.

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It may not be ethical to ask patients to participate in future trials

EDITOR,—Meta-analysis suggests that chemotherapy may have a role in the treatment of non-small cell lung cancer.¹ The authors note that the place of such treatment is uncertain, given the toxicity of platinum based combinations and the small survival advantage. An accompanying editorial suggests that, as the number of people with lung cancer worldwide is large, even a small individual chance of benefit is worth while in terms of population health gain.²

In the developing world, where the epidemic of lung cancer is just beginning,³ health care resources are insufficient for any treatment to be offered to most patients. In England and Wales, if 80% of registered lung cancers are of non-small cell type and radical primary treatment with platinum based chemotherapy was given to all patients aged under 70 with localised and locally advanced disease (estimated at 40% of the total number), there would be an extra 199 survivors at two and five years, who might be potentially cured. If platinum based chemotherapy was also given to 80% of those aged under 70 with advanced disease (the

remaining 20% being considered unfit for active treatment) then 681 more patients might be alive at the end of one year than would otherwise be the case; but for most of these death is only postponed.

For this survival gain to be achieved, 12 492 patients would have to receive pulsed treatment with emetic drugs as an inpatient for up to six months, though some would also experience relief of their symptoms or psychological benefit. Patients with the best prognosis with "standard" treatment may be harmed by the addition of optimal, platinum based chemotherapy (95% confidence intervals for mortality hazard ratios 0.74 to 1.02 and 0.79 to 1.11, respectively (table II in the meta-analysis). The authors conclude with a plea for future trials to be fewer in number and larger in size; hopefully, these will also include outcomes other than survival, as treatment for most patients is palliative rather than curative. A decade ago, however, most experts in lung cancer who responded to a postal questionnaire said that they would decline randomisation into trials of chemotherapy.⁴ Unless the meta-analysis substantially alters professional opinion will it be ethical to ask patients to participate in such trials?

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Allocating census data to general practice populations

EDITOR,—We wish to reply to the two letters¹ commenting on our paper on allocating census data to a general practice population.² Paul Aveyard proposes using the method of Bland and Altman rather than correlation to measure agreement between the number of patients aged over 65 obtained from the family health services authority's register and that calculated from the postcodes of patients and the proportion in their census area. Ronan A Lyons and colleagues suggest that better results could have been obtained in their area, where they achieve a high proportion of matches between postcodes and census areas.

We presented the correlation coefficients since they are what most others in this field (for example, Majeed *et al*)³ have used to justify the use of census data, but we then went on to show, by using a graph and χ^2 tests, how misleading a high correlation can be. The technique of Bland and Altman is not appropriate here since it implicitly assumes that neither proportion has higher validity than the other and so would use the average as the best estimate of the true proportion. In this case, the family health services authority's register, whatever its shortcomings, must be regarded as the most accurate available source of information.

Lyons and colleagues express concern about the number of unmatched postcodes in our study. While this concern may be valid, one of our aims was to investigate how easy or difficult it was to match postcodes in registers of patients with their enumeration district using the postcode to enumeration district directory released with the 1991 census. The number of missing postcodes is an indication of the difficulty that exists. We were looking for a process that could be used straightforwardly and systematically nationally.

Both letters express concern at the use of sample surveys as an alternative way of obtaining data on practice populations. We are aware of the problems and envisaged instead a requirement to collect more details from patients at registration and the collection of more information from practices on a regular basis, in the way that data on chronic disease management are becoming available. The low income scheme index, described by Lloyd *et al*,⁴ is another example of data collected about the practice rather than estimated from another source.

Lyons and colleagues express concern about the transfer of resources from more deprived to less deprived areas. If they examine the figure in our paper they will find that this is exactly what the method that they defend achieves since practices at the extremes have predicted values that are closer to the mean than the true value.

We concede that the decision about whether the estimation of practice characteristics from census variables is "good enough" is ultimately subjective. We believe, however, that the discrepancies that we found with estimating such a gross characteristic as the proportion of elderly people are sufficient to cast grave doubt on the use of characteristics such as permanent sickness, which, because of small numbers, are much more difficult to estimate.

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Learning from primary care in developing countries

Innovations in developing countries have had worldwide relevance

EDITOR,—Paul Johnstone and Isobel McConnan point out that the health service in Britain can learn many lessons from health services in poorer countries,¹ and I agree. However, the push for community based rather than hospital services has been difficult both to initiate and to sustain. In the authors' example of Tanzania, although in the early 1970s the expenditure in hospitals may have been reduced to less than 20% of the health budget, this was difficult to maintain and the proportion has crept up again (G J Ebrahim, personal communication).

The health services in most developing countries are a mixture of traditional-indigenous, private-commercial at many levels, and government provided. Most British people who have worked in developing countries in recent years have worked with charitable non-government organisations, which have the greatest opportunity for innovation and flexibility.

Johnstone and McConnan refer to principles, and I would like to illustrate these with a few specific examples. It was in a non-government organisation in Nigeria that individual child growth and health records retained by the family were pioneered.² Now no reputable fundholding practice or child health trust in Britain would be without these records. It was in Bengal and Bangladesh that oral rehydration therapy for diarrhoea with dehydration was developed into a practical treatment.³ Now it is a basic recom-