secretion of gastric acid and physiological gastro-oesophageal reflux may protect against candidal infection.⁵

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Risk is higher in developing countries

EDITOR,—I agree with Keith R Neal and colleagues that treatment with H₂ receptor antagonists increases the risk of infections.¹ Colleagues and I have conducted studies indicating that people who take H₂ antagonists long term are at high risk of contracting infections, particularly with opportunistic pathogens such as *Candida albicans*² and *Strongyloides stercoralis*.³ This is probably more common in developing and underdeveloped countries because of the lack of safe drinking water; the chances of colonisation once the opportunistic organism is in the favourable environment produced by these antilulcer drugs are increased. In one study we found that in 20% of patients with duodenal ulcers receiving cimetidine treatment the ulcer did not heal and was colonised and invaded by *C. albicans*.² In our opinion this increased risk was not solely due to the hypochlorhydria or achlorhydria; these drugs also cause immune suppression through the T4 lymphocytes.² I believe that indiscriminate use of these drugs should be checked, especially in countries where safe drinking water is not commonly available.

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Clinical oncology information network

Population based registries remain valuable

EDITOR,—S J Karp describes initiatives by clinical oncologists to evaluate their work in cancer treatment centres in Britain.¹ This is an important step forward, but many patients with cancer are treated by general surgeons, physicians, or geriatricians in district hospitals. Sometimes cancer is diagnosed for the first time at postmortem examination. It is important to evaluate the treatment of all patients with cancer and not just those referred for specialist treatment, particularly in a system in which access to care is limited. Clinic based information systems may help to evaluate treatment provided by particular institutions but give an incomplete picture of care provided for people

with cancer in Britain. Karp is therefore incorrect to dismiss the use of data from cancer registries in the evaluation of cancer treatment. Population based registries are important sources of data for evaluating cancer care in Britain.

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Creating a database need not be slow . . .

EDITOR,—We agree with S J Karp that there is an urgent need for a national database covering the treatment of malignant diseases and their outcome for audit and research.¹ We have adopted a different approach to the development of a national audit database for malignant diseases from that adopted by the clinical oncology information network. Eighteen months ago a group of haematologists and oncologists formed a working party to create such a database to cover the range of malignant diseases treated in both haematology and oncology clinics. Money was raised through sponsorship by Schering-Plough to write the clinical case record and data collection module and the program for the central database of anonymised patient data. To ensure complete independence from sponsors and to maintain professional integrity, a charitable trust company (the Clinical Information Research Trust) has been established to raise development funds and steer the project.

After only 18 months from its inception the data collection system has been successfully piloted and is ready for distribution to hospital haematology and oncology departments. An ethics committee is being set up to monitor requests for access to data, which will be transmitted from individual clinical departments through a modem to the central database. The Information Management Group of the NHS Management Executive has agreed that this use of data is ethical so long as patients' identity is protected and patients benefit from the scheme.

The advantage of this approach has been the speed of implementation, with the additional benefit that clinicians can be introduced to the concept of computerised data collection as a part of everyday clinical work while the scope and complexity of the database continue to develop. The system has been designed with inherent flexibility so that specific studies can be supported by the addition of appropriate datafields for only a modest investment.

The independent constitution of the Clinical Information Research Trust has already attracted interest from national bodies doing research into leukaemia and is being considered as a method of collecting data for the Medical Research Council's leukaemia trials.

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. . . with investment from industry

EDITOR,—S J Karp outlines an initiative to set up a clinical oncology information network to carry out national collaborative audit.¹ Readers may be interested to learn of an initiative by the pharmaceutical company Schering-Plough: in 1990 we began to develop an audit database for haematology and oncology clinics, working closely with a small number of enthusiastic physicians. The database is administered independently of Schering-

Plough by the Clinical Information Research Trust and is overseen by an ethics committee of clinicians. Three hospitals began to use the system late last year, and 40 other centres have expressed an interest in being included in the network.

We have not seen the specifications for the clinical oncology information network, but the audit database for haematology and oncology clinics accommodates the minimum dataset specified for the network. Thus the database could serve the exact purpose described for the network but will be operational sooner.

Despite the increasing pressure under which the British pharmaceutical industry operates, much investment and innovation continue. At a time of limited resources for the NHS, academia, and the industry it does not seem wise for a competition to be taking place, the ultimate loser of which would be patients with cancer. Schering-Plough would welcome an approach from the developers of the clinical oncology information network to explore whether we can help speed up a network which we recognise is badly needed.

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Call for more confidential inquiries

EDITOR,—The confidential inquiry into perioperative deaths is proving to be one of the effective means of auditing surgical care. When is a similar system to be established for monitoring chemotherapy and radiotherapy? Most such treatment can be classified only as crude, and therefore an effective impartial overview is long overdue.

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Overruling the parents of child patients

EDITOR,—The trial of Dwight and Beverley Harris for the manslaughter by neglect of their 9 year old daughter, Nakhira,¹ should alert medical staff to the danger of failing to overrule parental decisions and the corresponding need to be fully familiar with correct legal procedure. The failure of the hospital team that diagnosed Nakhira's diabetes to shield her from parental neglect must cause concern. The legal powers available to protect her were extensive. Perhaps the time has come to rehearse them.

A doctor has a duty to provide medical care for his or her child patients. Normally, decisions about that medical care are the responsibility and right of each child's parents. As the House of Lords made clear in 1985,² however, when parents act against the interests of their child they lose the legal right to consent to or reject medical treatment. When doctors and the parents disagree about the course of action that will best serve the interests of a child "the court can decide and is not slow to act. . . . If there is no time to obtain a decision from the court, a doctor may safely carry out treatment in an emergency if the doctor believes the treatment to be vital to the survival or health of an infant."³

If there is time to involve the court, a court case in 1993 recommended application to the High Court for a "specific issue" order under section 8 of the Children Act 1989.³ The "most strenuous

efforts" should be made to secure the attendance of the parents or carers, but if they cannot be notified the application can still be dealt with. Wardship proceedings can also be used. Judges are available on a 24 hour basis to deal with such emergency applications. Hospitals and surgeries should ensure that they have the up to date emergency telephone numbers. If necessary the police can prevent the child being removed from the hospital. If a child must be traced urgently, social services and the police should be contacted; wardship proceedings give access to additional search facilities.

If there is no time to apply to court the procedure laid down by the Home Office should be followed.⁴

Medical staff should fully familiarise themselves with the legal rules if tragedies like the death of Nakhira are to be avoided.

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Long term management after splenectomy

EDITOR,—The long term management of patients after splenectomy has generated much correspondence.¹ Peter J Flegg calls for the development of national guidelines on preventing sepsis after splenectomy.¹ The British Committee for Standards in Haematology is developing such guidelines through a working party of its clinical haematology task force. The members of the working party comprise haematologists from district general and teaching hospitals, a microbiologist, an immunologist, a paediatrician, a paediatric haematologist, a surgeon, a general practitioner, and a medical representative from the Department of Health. The guidelines will soon be reviewed by the British Committee for Standards in Haematology before being submitted for publication. They aim to provide definitive guidance from a balanced group of interested specialists with the Department of Health's backing. One of the working party's main objectives is to unify the many local initiatives in progress, especially by producing a standard fact sheet and card for patients.

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Alcohol intake and mortality

EDITOR,—Having read the Danish paper on alcohol intake and mortality,¹ I am grateful for the sound advice from Ian Robertson that the message that women should drink a maximum of 14 units a week and men a maximum of 21 units a week is clear and unambiguous and should not be lightly given up.² Morten Grønbaek and colleagues conclude that "simple messages about the benefits of total abstinence may not be appropriate," yet their total abstinence group is made up of "hardly ever/never" drinkers, with no information provided on the proportions of lifelong tee-

totalers, former drinkers (recent and long term), and occasional drinkers. No information is provided on the health status or lifestyle behaviour of any of the groups.

We have established that among middle aged British men those who do not drink include a high proportion who have given up drinking as they have grown older and accumulated illnesses and drug treatments not necessarily related to alcohol intake.³ Without providing this information, the Danish workers have no justification for assuming that the excess deaths are attributable to alcohol intake (or the lack of it) or that the other covariates influencing mortality are equal in the different alcohol groups. Such information should have been displayed rather than assumptions being made. To then calculate the number of deaths due to abstinence and the reduction consequent on the entire population drinking is unjustified if not disingenuous.

Men who drink lightly and regularly (1-2 units a day) have the most favourable risk factor status in terms of social class, smoking, body weight, blood pressure, and blood lipid concentrations.⁴ It is therefore not surprising that they have the lowest mortality. The Danish study contains no information on social class, physical activity in leisure time, blood pressure, or blood lipid concentrations.

To focus on mortality from all causes and to use cirrhosis of the liver, a relatively rare disease, as the benchmark for damage due to alcohol is to take a restricted approach to discussing the benefits or disadvantages of alcohol. Robertson is correct in identifying the assault that is taking place on the guidelines of 14 and 21 units, and the medical profession and the media should look more critically at the studies that directly or indirectly advocate their extension.

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Immunity to diphtheria in adults in England

EDITOR,—The recent resurgence of diphtheria in Russia has led to anxieties about the susceptibility of British adults to the disease, and about the organism's potential for reintroduction and circulation in the population. Serological surveys in Scandinavian countries have shown low levels of antibodies to diphtheria toxin in adults, particularly among women over 40,¹ and small outbreaks of diphtheria have subsequently been reported in Sweden and Denmark.² To assess immunity to diphtheria in adults in England we tested 2862 serum samples from adults stratified by age and sex. The samples had been collected during 1991 by the six public health laboratories that receive samples for diagnostic and screening purposes from eight regions in England. Samples were tested by enzyme linked immunosorbent assay (ELISA); concentrations of toxin antibody were measured in international units (IU) by comparison with human diphtheria antibody reference serum 91/534 (National Institute of Biological Standards and Control, South Mimms, Hertfordshire). To allow for the measurement by ELISA of some non-neutralising antibody, samples with

Numbers (percentages) of serum samples with concentrations of diphtheria antibody ≥ 0.1 IU/ml by age and sex

Age (years)	Men		Women		Both sexes	
	No tested	≥ 0.1 IU/ml	No tested	≥ 0.1 IU/ml	No tested	≥ 0.1 IU/ml
15-34	487	383 (79)	491	345 (70)	978	728 (74)
35-54	482	326 (68)	486	329 (68)	968	655 (68)
≥ 55	499	303 (61)	417	220 (53)	916	523 (57)
Total	1468	1012(69)	1394	894 (64)	2862	1906(67)

concentrations < 0.1 IU/ml were considered to show non-immunity; this cut off point is 10 times higher than that of an in vivo toxin neutralisation assay.³

Overall, 1906 serum samples had antibody concentrations ≥ 0.1 IU/ml, the proportion declining with age in both men and women (table). Immunisation was introduced on a national scale in the United Kingdom only in the early 1940s, so immunity in people aged 55 and over will largely be naturally acquired. The significantly lower level of immunity in women aged 15-34 compared with men of the same age ($P = 0.003$) is surprising and cannot be accounted for by booster immunisation of men entering military service because conscription ended in 1960 in the United Kingdom. A lower level of immunity to diphtheria has also been reported in young Israeli women,⁴ suggesting a possible sex difference in response to immunisation.

Our results give no immediate cause for concern: given that our cut off point for immunity was conservative and that the current uptake of immunisation in infants is 93%, the proportion of the total population with protective levels of antibody should be above the 70-75% considered necessary to confer herd immunity to diphtheria.⁵ With the gradual replacement of natural immunity by less durable vaccine induced immunity in older people, however, this proportion may decrease. We understand that the use of low dose diphtheria vaccine combined with tetanus toxoid is now being considered for booster immunisation of school leavers.

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Continuing medical education

EDITOR,—Rajendra Kale's news article on continuing medical education for consultant obstetricians and gynaecologists may have misled readers.¹ Kale puts misplaced emphasis on certain aspects of the Royal College of Obstetricians and Gynaecologists' programme of continuing medical education and is far too definite about some developments that are in their infancy. As chair-