patients' rights and their situation since 1 March 1993.

AULIKKI WALLIN
Senior medical officer

National Board of Medicolegal Affairs,
PB 265,
00531 Helsinki,
Finland

1 Sheldon T. Dutch law defines patients' rights. *BMJ* 1994;308:617. (5 March.)

Oral squamous cell carcinoma

Managed by specialists from different disciplines

EDITOR,—Iain Hutchison states that "only six British medical schools offer any formal teaching in mouth examination by oral surgeons" and that "any patient with a red or white intraoral patch should attend their local oral surgery department as a matter of some urgency."¹

The investigation and management of cancer of the mouth and jaws is not the sole remit of oral surgeons but is an area in which there is an interface with many other specialties. As medical students in Glasgow, we were taught the examination of the oral cavity and the management of intraoral carcinoma by general surgeons; ear, nose, and throat surgeons; plastic surgeons; and radiotherapists. In Newcastle Medical School, examination of the oral cavity and the management of oral malignancy is taught to the medical and dental students in lectures and on the wards by ear, nose, and throat surgeons; plastic surgeons; and radiotherapists. Students are also encouraged, should they so desire, to attend one of the combined head and neck oncology clinics run by the above specialties.

It is now time the oral surgeons accept that there are many specialists from other disciplines who currently teach students and treat patients with malignant disease of the oral cavity.

NEIL R McLEAN
Consultant head and neck surgeon

Department of Plastic and Reconstructive Surgery,
Newcastle General Hospital,
Newcastle upon Tyne NE4 6BE

1 Hutchison IL. Improving the poor prognosis of oral squamous cell carcinoma. *BMJ* 1994;308:669-70. (12 March.)

Results of screening are encouraging

EDITOR,—Iain Hutchison highlights the need for action to improve the poor prognosis of oral squamous cell carcinoma.¹ Until recently, there has been no organised screening programme for the detection of oral cancer and precancer in the United Kingdom and Europe despite the fact that screening programmes for cancer elsewhere in the body have led to appreciable reductions in mortality, and dentists themselves have shown a poor degree of diagnostic ability in their practices for early signs of disease.²

In response to a rising incidence of oral carcinoma Marks and Spencer has implemented an oral pre-cancer and cancer screening programme for its staff. All staff aged 40 years and over are invited to attend in their store for an annual examination of the oral mucosa. In addition, staff with one or more risk factors (smoking, excess alcohol intake, depleted haemoglobin levels, and positive family history) are specifically targeted.

During the implementation of the screening it became clear that there was widespread ignorance of oral carcinoma, which necessitated an education campaign to alert staff to the existence of this disease. Evaluation of the early results is encouraging. In an initial study involving staff at the head office an appreciable number of oral white and red lesions were detected.³ Evaluation of the full

programme continues and a review of the results will be published later.

Further initiatives through the Association of Industrial Dental Surgeons have been taken to encourage other companies to set up workplace screening programmes, preceded by education campaigns to raise awareness among employees and other health professionals. Urgent action is required to encourage the further development of screening programmes at the workplace and opportunistic screening in dental practices. This should be preceded by campaigns to raise awareness of oral cancer among health professionals and the public. Measures such as these will contribute to preventing one of the most devastating cancers that can affect the individual and family.

G P FEAVER
Chief dental officer

Marks and Spencer plc,
London W1A 1DN

- 1 Hutchison IL. Improving the poor prognosis of oral squamous cell carcinoma. *BMJ* 1994;308:669-70. (12 March.)
- 2 Nally FF. Oral medicine. *Br Dent J* 1988;165:145-6.
- 3 Feaver GP. Screening for oral pre-cancer and cancer in a general dental practice. *Dent Pract* 1993;31(17):4-5.

Survival in advanced breast cancer

Combination chemotherapy improves outlook

EDITOR,—I E Smith's editorial on palliative chemotherapy for advanced non-small cell lung cancer contains a worrying error of fact.¹ The statement that an average improvement in survival of around three months after chemotherapy is more than has been shown for chemotherapy in advanced breast cancer is not correct.

It is true that relatively ineffective protocols—for example, classic cyclophosphamide, methotrexate, and fluorouracil given over 14 days or mitozantrone, mitomycin C, and methotrexate—often give disappointing results. However, effective combination chemotherapy given to patients with disseminated breast cancer produces an overall response rate of between 45% and 80%, with a median duration of response of 5-13 months and a median duration of survival among responders of 15-33 months. This is an internationally recognised consensus opinion, so widely accepted that it has now been included in standard textbooks of cancer medicine.² Contrary to widespread belief, such protocols can be given with far fewer side effects than in the past, and treatment is always stopped if there is no response, so that no patients receive chemotherapy that is not making them better.

L A PRICE
UK representative,
New York Chemotherapy Foundation

London W1N 1DL

- 1 Smith IE. Palliative chemotherapy for advanced non-small cell lung cancer. *BMJ* 1994;308:429-30. (12 February.)
- 2 Harris JR, Morrow M, Bonadonna G. Cancer of the breast. In: De Vita VT Jr, Hellman S, Rosenberg SA, eds. *Cancer: principles and practices of oncology*. Philadelphia: J B Lippincott, 1993:1321.

Author's reply

EDITOR,—I do not dispute the data on response and survival quoted by L A Price, but these do not constitute evidence for an improvement in survival related to treatment. Data from randomised trials are required for this; to the best of my knowledge these do not exist for metastatic breast cancer (in contrast to non-small cell lung cancer), and certainly Price does not quote any.

IAN E SMITH
Consultant cancer physician

Royal Marsden Hospital,
Sutton, Surrey SM2 5PT

Management of oesophageal cancer

EDITOR,—With regard to future approaches to the management of oesophageal cancer, we suggest an initiative that could be immediately implemented and would improve survival—namely, consideration of the operator's experience.² We have analysed data on admissions to hospital for oesophageal resection for carcinoma of the oesophagus or cardia in the West Midlands region in the three years April 1990 to April 1993 (table). As in Matthews *et al*'s study,² "frequent" operators were defined as those who performed six or more resections a year. Operative mortality was 8.9% for frequent operators and 16.9% for all other operators. There was no difference in the mean age of the patients between these two groups. In Matthews *et al*'s original series prognostic factors were similar in each group and lower operative mortality accounted for the improved five year survival of patients operated on by frequent operators.²

Average number of oesophageal resections per year and number of operative deaths in West Midlands region, April 1990 to April 1993

Consultant's experience	Patient survived and was discharged	Patient died in hospital	Total
Frequent operator*	234	23	257
Other	211	43	254
Total	445	66	511

*Defined as one doing ≥ 6 resections a year.
 $\chi^2=7.23$, $P=0.007$.

The difference is due to the operators' experience rather than the experience of the unit in which they work (anaesthetic management, postoperative intensive care). When we restricted the analysis to hospitals with at least one frequent operator there was still a lower operative mortality among patients operated on by frequent operators (23/257, 8.9%) than among those operated on by all other operators (10/57, 17.5%).

Operative skill presents a challenge both to purchasers of health care, who could move contracts to units with frequent operators, and to the professional audit process in these units. Both purchasing and audit have been introduced since Matthews *et al*'s paper was published: can they effect a change that previous systems did not deliver?

J G WEIL
Senior registrar in public health
S J MUNDAY
Consultant in public health

North Birmingham Health Authority,
Birmingham B16 9SA

- 1 Ellis P, Cunningham D. Management of carcinomas of the upper gastrointestinal tract. *BMJ* 1994;308:834-8. (26 March.)
- 2 Matthews HR, Powell DJ, McConkey CC. Effect of surgical experience on the results of resection for oesophageal carcinoma. *Br J Surg* 1986;73:621-3.

Non-heart beating organ donors

An important source of kidneys for transplantation

EDITOR,—The results of the programme for obtaining organs from non-heart beating organ donors reported by K Varty and colleagues¹ are compatible with those from other centres worldwide²⁻⁴ and show that such donors are an important potential source of kidneys for transplantation. We have been planning a similar programme but have hesitated because of uncertainty about the