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Authors' reply

EDITOR,—Pulmonary emboli can be prevented either by antiplatelet therapy¹ or by anticoagulant treatment with subcutaneous heparin² (figure). More intensive antithrombotic effects could be achieved by more potent anticoagulant regimens, or by regimens that combine antiplatelet and anticoagulant therapies, and trials are in progress to determine which regimens offer the best balance of risk and benefit. But, pending the results of such studies, those responsible for surgical patients who are at appreciable risk of pulmonary embolism should be aware of how strong the randomised evidence already is for perioperative antiplatelet therapy. None of the points raised by Henri Bounameaux can cast serious doubt on this—indeed, many are already answered in the first and third parts of the antiplatelet overview.^{1,3} In particular, it has been shown that this conclusion is largely unaffected by restricting attention to particular categories of trials (such as those that were placebo controlled or that used venography rather than fibrinogen scanning to detect venous thrombi¹).

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On behalf of the Antiplatelet Trialists' Collaboration

Perioperative pulmonary embolism in randomised trials of antiplatelet therapy and of subcutaneous heparin

- Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy. III. Reduction in pulmonary embolism and venous thrombosis observed with

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Accuracy of peak flow meters

EDITOR,—We wish to reply to one of the letters¹ about our paper on the accuracy of mini peak flow meters in indicating changes in lung function in children with asthma.² We agree with T C Barrett and D A Spencer that it is important to address the issue of within child repeatability over time. We have made a complementary analysis of the data presented in our paper (submitted for publication elsewhere), in which we used generalised estimating equations³ and multilevel modelling⁴ to investigate and then adjust for the potentially complex correlation structures that may exist between repeated measurements of peak expiratory flow over time within a child.

The analysis in our paper was deliberately non-statistical, precisely because any quantitative analysis would have required the correlation structure to be taken into account and hence would have required a mathematical presentation. We believe that the qualitative manner in which we presented the data provides a fair summary of them, which leads to appropriate inferences. Furthermore, given the extreme nature of the non-agreement between the portable meters and the spirometer that we reported, it would have been extremely surprising if this had arisen solely as a consequence of our having ignored the correlation structure in our qualitative analysis.

Nevertheless, we wish to reiterate our agreement with the important points raised by Barrett and Spencer. We would be unhappy if anyone inferred from our simple presentation that it was unnecessary to consider the correlation between repeated measurements when analysing data such as these.

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Is there an epidemic of cancer?

EDITOR,—We welcome the attention brought by David Coggon and Hazel Inskip to the large increase in death rates from oesophageal cancer over the past 30 years.¹ However, their conclusion on aetiological factors is flawed by relying on Office of Population Censuses and Surveys data, which fail to differentiate between the different histological types of oesophageal malignancy.²

It is widely accepted that smoking, and perhaps to a lesser extent, alcohol consumption, are important aetiological factors in the development of squamous carcinoma of the oesophagus. There is little evidence that either is implicated in adenocarcinoma of the oesophagus.³ One of

the most important observations is that adenocarcinoma is virtually unheard of in countries with a high incidence of squamous cancer of the oesophagus, and so a common aetiology seems most unlikely. Adenocarcinoma of the oesophagus seems to be a disease of highly developed countries and higher socioeconomic groups. There is increasing evidence of the link between gastro-oesophageal reflux disease, columnar metaplasia of the lower oesophagus (Barrett's epithelium), and transformation to adenocarcinoma.

Although both histological types of oesophageal cancer are increasing, centres specialising in the treatment of this disease are now seeing a dramatic increase in adenocarcinomas.^{4,5} In the past three years, 28 of 52 oesophagectomies in this unit have been for adenocarcinomas. There can be difficulty in differentiating adenocarcinoma of the cardia of the stomach from that arising in the oesophagus, particularly when a hiatus hernia is present, as both diseases have a tendency to longitudinal spread. However, the difference should be recognised by experienced endoscopists and pathologists, and our conclusion is that the incidence of both types is increasing. It is interesting to speculate whether some common aetiological factor for adenocarcinoma arises in the region of the oesophagogastric junction. True adenocarcinoma of the oesophagus almost always develops in metaplastic columnar epithelium. Whether chronic reflux that initiates the malignant change or some other carcinogen particularly affects this area of the gastrointestinal tract is an important question that must be answered as soon as possible.

Adenocarcinoma of the lower oesophagus poses a major therapeutic challenge, only by separating it from squamous cancer will we understand the disease, and in particular its aetiology, better. It is important that we are not diverted by incomplete epidemiological data that may lead us away from the correct conclusion.

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Oral squamous cell carcinoma

EDITOR,—Iain L Hutchison discusses the problems of screening by general dental and medical practitioners¹ but doesn't mention the opportunity to screen medical patients admitted to hospital. An oral examination should be part of clerking. Indeed, many such patients can be regarded as at risk in that they are commonly elderly and of low socioeconomic class and have disease related to alcohol or tobacco.

A simple oral examination with a wooden spatula and pen torch was carried out on 50 random patients (21 female, 29 male) admitted to the medical wards of a teaching hospital. Only 13 patients could recall an oral examination having been carried out, and in only five cases had any record been made in the notes. Interestingly two