There is now an urgent need for rigorous cost effectiveness studies of specific interventions to allow general practitioners to make informed purchasing decisions.

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Have educational value

EDITOR,—We have been providing one variant of specialist outreach clinics for more than 10 years.^{1,2} Our joint quarterly clinic developed out of the pragmatic need to save patients (many, but not all, of whom are elderly or disabled) the need to make a 40 km round trip to use hospital services from this rural practice. The patients best served are those who need predominantly clinical skills, with only a minor technological input. We have found that patients with diabetes, Parkinson's disease, and other common medical conditions can be assessed and monitored not only at their convenience but also to the advantage of both the general practitioner and hospital staff and their systems. Duplication of investigations is avoided, and onward referral for diagnostic or therapeutic facilities is planned and selectively deployed to retain as much care and treatment within primary care as possible.

We think that both the paper¹ and the editorial² on specialist outreach clinics underestimate the clinics' educational value, which enables trainee general practitioners, junior medical staff, and medical students to see truly shared care. The general practitioner and consultant can discuss their ideas directly, and immediately. This has proved valuable to us both. For this to be possible, however, these clinics must be jointly held, with both the general practitioner and the consultant seeing patients together. This occurred in only a small minority of the clinics described by Bailey and colleagues.¹ So much change has occurred in both primary and specialist care that cross fertilisation of ideas and practice, as occurs in such joint clinics, is of benefit to everyone in training and career posts. This is a major advantage, which not only sustains but extends the vision of cooperative care.

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Surgery for pancreatic cancer

EDITOR,—It has been common practice, particularly in Britain, for patients with cancer of the pancreatic head and for some patients with periampullary cancer (which carries a much better prognosis) to be denied surgical assessment. Paul Ellis and David Cunningham rightly state that "patients with pancreatic cancer should not be

denied the surgical option, and assessment by an experienced pancreatic surgeon is essential to achieve the best outcome."¹ We wish to explain why, in the 1990s, surgical assessment is so important in patients with pancreatic tumours.

In the 1960s partial duodenopancreatectomy (Whipple's operation) was associated with a mortality of 30%. This led Crile and others to recommend that, for a disease that in the best hands gave a five year survival of 10%, patients should receive only palliative treatment.² Since then mortality has dropped dramatically owing to better anaesthetic and surgical techniques. Cameron *et al* recently reported a 0% mortality after 145 consecutive Whipple's operations.³ Others have reported mortality below 5%.⁴ Selection of patients has also improved, particularly with regard to the identification of metastases, size of tumour, type of tumour (periampullary or ductal), and invasion of major blood vessels. This has been possible because of better imaging techniques, including ultrasonography, computed tomography, and endoscopic retrograde pancreatography.

A tumour of the pancreas is not necessarily a ductal adenocarcinoma. De Jong *et al* found that, of 353 non-functioning tumours of the pancreas 31 were non-ductal tumours.⁵ These tumours have a much better prognosis than ductal carcinomas, with a five year survival in the region of 50% after curative resection. Periampullary tumours also have a much better prognosis than ductal carcinomas and make up about a tenth of all proximal pancreatic cancers.

It is vital that these patients are assessed properly for surgery, otherwise patients with curable tumours will be assigned inappropriate palliative treatment.

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Multiple myeloma

EDITOR,—In their detailed review on developments in the treatment of multiple myeloma, Ian C M MacLennan and colleagues briefly discussed the results of allogeneic bone marrow transplantation, in particular mentioning the reported high mortality related to the procedure.¹ Our own experience of allogeneic bone marrow transplantation for myeloma is different.

Since 1989 we have undertaken six allogeneic transplant operations using sibling donors for myeloma in patients at various stages of their disease (three in first plateau; two in second plateau, one patient with primary refractory disease). All patients received conditioning with total body irradiation (12 Gy in six fractions) and either cyclophosphamide (120 mg/kg, one patient) or melphalan (110 mg/m², five patients). Additional radiotherapy was also given to major lytic lesions identified by skeletal survey. All patients received cyclosporin and a short course of methotrexate as

prophylaxis against acute graft versus host disease.² Despite a high median age of 46 (range 39-52) years there have been no deaths related to transplants and the incidence of acute graft versus host disease has been low, with no patient having disease higher than grade 1. The pattern of post-transplant infections has not been different from that seen in patients with leukaemia undergoing allogeneic bone marrow transplantation. Of our six patients four achieved complete remission with no relapses with a follow up of more than two years in all cases (range 2-3.5 years); one further patient seems to have achieved complete remission after treatment with interferon alfa.

Our experience, therefore, is that patients undergoing allogeneic bone marrow transplantation for myeloma are not at increased risk of transplant related problems. Given that the median survival time for myeloma patients treated with conventional combination chemotherapy is only 32 months³ and that patients given a transplant early in their disease have the highest complete remission and disease free survival,⁴ we believe that it is justified to offer early allogeneic bone marrow transplantation after initial cytoreduction to all patients with multiple myeloma who are under 55 years and who have a sibling donor.

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Covert surveillance in Munchausen's syndrome by proxy

EDITOR,—The *Dispatches* programme which I as reporter helped make has been criticised by an anonymous correspondent.¹

The principal charge against *Dispatches* is of bias in favour of banning covert surveillance. The complainant also claims that covert video surveillance can be justified "if one child's life is saved or continued abuse halted" and because it will prove innocence as well as abuse. She also states that her own granddaughter's life was "probably" saved by the "special unit" after a long period of "possible" suffering at the hands of a relative. There is no specific mention of covert video surveillance. She asks that the producers of "The Munchausen File," the programme criticised, should make a follow on programme "supporting the methods used."

Nowhere in "The Munchausen File" do we say covert video surveillance should be banned. We highlighted differences in method during procedures leading to covert surveillance and reported the desire of professionals, some of whom were in favour of covert video surveillance, for a national inquiry into the way Munchausen's syndrome by proxy is handled. Children whose lives were genuinely at risk from abuse would continue to be saved by covert video surveillance if such an inquiry decided that recording of events at home