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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- 2 Harris A. Specialist outreach clinics. *BMJ* 1994;308:1053. (23 April.)
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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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- 1 Ellis P, Cunningham D. Management of carcinomas of the upper gastrointestinal tract. *BMJ* 1994;308:834-8. (26 March.)
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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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- 1 MacLennan ICM, Drayson M, Dunn J. Current issues in cancer: multiple myeloma. *BMJ* 1994;308:1033-36. (16 April.)
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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

followed by covert video surveillance is the appropriate means of diagnosis when all the issues are taken into account.

Dispatches showed that in one case the failure to detect abuse under surveillance was not sufficient to prove the innocence of a mother accused of suffocation.

We were hampered in preserving balance by the reluctance of members of North Staffordshire Hospital's paediatrics department to appear in the programme to explain their methods. We attempted to present their known opinions fairly. The executive producer and the producer travelled to Stoke on Trent in October 1993 for a meeting with the hospital's senior staff because we believed that their contribution would have been very important. We kept a place for them in the filming schedule until the last moment possible. The decision was made that the issue was too important to be shelved simply because one of the protagonists would not appear.

We still believe this; we believe the programme was fair, and its conclusions still stand: principally, that a national inquiry into procedures for the diagnosis of Munchausen's syndrome by proxy is needed.

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1 Covert surveillance in Munchausen's syndrome by proxy [letter]. *BMJ* 1994;308:1101. (23 April.)

Drug use in prison

EDITOR,—Michael Ross and colleagues point to the problem of drug use and injecting in English and Welsh prisons and the threat this poses for HIV transmission.¹ Previous studies of injecting drug users have consistently shown that the majority will at some time be imprisoned and that about a third of this group will inject in prison, of whom about three quarters will share needles and syringes.²⁻⁷

Our recent data show no improvement in the situation. From a sample of 507 injecting drug misusers in London interviewed in 1993 in a study funded by the Medical Research Council, 99 were randomly selected to answer questions about their prison experiences. Seventy six had experienced imprisonment. Of these, 45 had received no treatment, advice, or help for their drug problem the last time they were in prison. Injection in prison was reported by 21, and, of these, 14 shared needles and syringes on a mean of 20.2 (range 2-100) occasions.

These findings show no change over previous studies (table) and are complemented by a recent study of drug injecting practices in prison conducted in 1993-4 with recently released prisoners (funded by AVERT).⁸ These ex-prisoners were established drug users who were dependent on opiates or chronic users of other combinations of drugs. All 44 continued to use drugs while in prison. Nearly all (39) experienced withdrawal symptoms in prison. Most considered that using drugs was unavoidable and necessary to alleviate withdrawal symptoms or insomnia. Medication (offered to 22/40) was primarily to aid short term withdrawal; most were given diazepam.

Drug injectors who reported injecting and sharing syringes in prison

Location and date of study	% (No) who injected in custody	% (No) who shared equipment in custody
London 1989 ^a	66 (33/50)	76 (26/33)
Wales 1990 ^a	51 (35/65)	74 (26/35)
England 1989-90 ^a	25 (118/474)	62 (74/119)
England, Wales, Scotland 1988 ^b	23 (32/139)	75 (24/32)
London and Bristol 1990 ^c	27 (30/111)	63 (19/30)
England 1990 ^c	27 (45/168)	71 (32/45)

Seven were prescribed short (less than one week) reducing doses of opiate substitutes. Drug users considered that doctors' judgments were often moral rather than clinical; drug withdrawal was viewed as a self inflicted problem. Sixteen injecting drug users continued to inject. All needles and syringes were reused, and disposal of used injecting equipment was rare. Although nine shared needles and syringes, all made some attempt to clean them. However, appropriate cleaning materials were not available and the conditions of injecting made the possibility of adequate cleaning unlikely. Other paraphernalia shared included spoons, containers for mixing drugs and cleaning equipment, and filters.

The high risk behaviour in prisons reinforces previous data on the situation; the Health Care Service for Prisoners is well aware of this data. The call for improved provision of medical care for drug users in prison¹ needs to be supplemented by decontaminant distribution, improved education about drugs and AIDS, and steps to maximise the opportunity prison provides to help prisoners with drug problems.

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Mental disorders in the developing world

EDITOR,—The issues raised by Melanie Abas and Jeremy Broadhead, particularly the suggestion about the use of local resources in developing intervention programmes, are relevant to mental health care delivery in the developing world.

Many developing countries, however, have other major health problems related to poverty and ignorance, besides those shared with the more developed countries. This makes generalisation of health priority statistics meaningless, and such issues should be left to be determined locally. It is also unlikely that concentrating on minor disorders will improve the image of psychiatric services among either the politicians or the populace, whose felt need is likely to be different, irrespective of beliefs about causation.

Most developing countries are still striving to establish a functional primary health care structure. Hence, observable deficiencies in the mental health component only mirror the state of primary health care in general, rather than a specific inadequacy of mental health training. Attention should be paid to the development of a solid primary care framework, with international support.

Alternative practices also need to be carefully studied and evaluated, and those found harmless and effective should be encouraged, to ease the

burden on meagrely resourced mental health services. Useful collaboration can be established with such practitioners as a way of monitoring their practices.

These measures, along with Abas and Broadhead's suggestions, will go a long way to making essential mental health care not only available but also acceptable, accessible, and affordable in most developing countries.

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Cancer of the upper gastrointestinal tract

EDITOR,—In their letter J G Weil and S J Munday provide further evidence of surgeons' experience as a prognostic factor and in their subsequent editorial S O'Reilly and A Forastiere draw attention to the potential value of multimodality in the management of oesophageal cancer. We wish to emphasise the worldwide paucity of randomised trials in this disease; this could well be delaying improvements in treatment. To help rectify this situation, in 1990 the Medical Research Council's Cancer Therapy Committee set up a working party to conduct a programme of multicentre randomised trials on treatment. This programme is progressing well.

Firstly, 204 of a planned intake of 1000 patients have to date been entered into an international trial of simple design, started in 1992, comparing surgical resection with or without two cycles of preoperative chemotherapy (OE02 trial). This complements the similar intergroup trial in the United States mentioned by O'Reilly and Forastiere; indeed, we are discussing the possibility of a joint analysis.

Secondly, we are processing updated individual patient data from four of the five randomised trials (two of them cited by O'Reilly and Forastiere) that have investigated surgical resection with or without preoperative radiotherapy for a meta-analysis, and expect to receive data from the fifth trial soon. This will give us the best currently available assessment of the role of preoperative radiotherapy.

Thirdly, we are piloting a regimen of intended "curative" radical radiotherapy plus chemotherapy in patients with locally limited disease unsuitable for surgical resection. If this regimen proves acceptable, we plan to undertake a large multicentre randomised trial comparing radical radiotherapy with or without chemotherapy (OE03 trial) with survival and the control of dysphagia as the main end points. The previous randomised trials addressing this question were small and collectively were inconclusive; O'Reilly and Forastiere did not mention a trial that showed significant advantage over radiotherapy alone.¹

Finally, in patients with advanced cancer, we are piloting a policy of intraluminal treatment—using, for example, laser, brachytherapy, or alcohol injection—plus a simple regimen of two fraction or single dose palliative external beam radiotherapy. If this policy looks promising, we again aim to