As a result the Royal Pharmaceutical Society of Great Britain issued a statement to pharmacists last April, saying that all dispensed oral liquid medicines should be supplied in a child resistant container from 1 January next year. As supplies of these bottles and caps become available during this year they will begin to be used by pharmacists.

Discussions are currently taking place between the society and the pharmaceutical industry about the use of child resistant containers for original pack oral liquid medicines; it is hoped that the containers will be used for these by 1 January 1996.

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Melanoma in Britain and British Columbia

EDITOR,—Joan Austoker's review of malignant melanoma omits to compare the incidence of the disease, and survival from it, in Britain with that in the rest of the world.¹ The table compares the British figures quoted with those from British Columbia, Canada, over a similar period.² Such differences in incidence and survival should be a cause for concern in Britain.

Depth of primary tumour, five year survival, and proportion of primary tumours on extremities in patients with melanoma in Britain and British Columbia. Values are percentages

	Primary tumours with depth <1.5 mm	Survival at 5 years		Primary on extremity	
		Men	Women	Men	Women
Britain	39	52	75	42	73
British Columbia	60	70	83	28	62

Better prognosis for women compared with men in British Columbia was related to thinner primary tumours (median depth 1.1 mm in women and 1.45 mm in men).² The duration of symptoms in men and women was 5.6 and 6.2 months respectively, suggesting that differences in survival between the sexes are not related to earlier recognition of melanoma. The difference in survival between the sexes is attributable to longer intervals to recurrence, while survival after recurrence is equivalent.²

Ethnic differences are unlikely to contribute to the differences in the incidence of melanoma and survival between British Columbia and Britain since the population of British Columbia is mostly of Scottish origin. The distribution of the primary site favours British patients (more melanomas on the extremities), yet survival favours patients in British Columbia.

Differences in education and medical practice have to be considered as potential reasons for the observed differences in the depth of melanoma and survival between British Columbia and Britain.

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1 Austoker J. Melanoma: prevention and early diagnosis. *BMJ* 1994;308:1682-6. (25 June.)

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Bone marrow transplants from peripheral blood

EDITOR,—Reinfusion of peripheral blood stem cells to repopulate the bone marrow after myeloablative chemotherapy is being increasingly used to intensify treatment for haematological and other malignancies.¹ We could find no published data on the practicalities of returning the cells to the patient through a central venous line. One method is to inject the stem cell suspension with a syringe, but problems may occur in maintaining sterility; in addition, too rapid injection may result in an adverse reaction to the cryopreservative (dimethyl sulphoxide) in which the cells are suspended.

An alternative method is reinfusion with a standard blood giving set, but, using this technique, we have observed accumulation of cellular sediment within and around the 170 µm filters of such sets. Since the cell suspension harvested with a Haemonetics V50 cell separator contains platelets of the order of 10¹²/l these were probably contributing to the cellular sediment in the filter bulb, but we were concerned that stem cells might also be trapped and wasted in the sediment. Three patients who had received myeloablative treatment for high grade lymphoma each received reinfusions of two bags of stem cells. The concentration of CD34 positive cells (putative stem cells) in individual bags of harvested cells was measured before and after the cells' passage through blood giving sets. There was no significant change in concentration of these cells ($P > 0.05$, paired t test), and the procedure was successful in all three patients.

It is reassuring that peripheral blood stem cells can be returned to a patient in a sterile and easily controlled way with a standard blood giving set without appreciable loss of cells.

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Assessing change through audit

EDITOR,—In his commentary¹ on the multicentre criterion based audit of the management of induced abortion in Scotland² Ken MacRae makes a telling point about the risk of double standards in the assessment of audit rather than research papers. He is right to challenge the view expressed in "Editor's choice" that without such double standards "the *BMJ* would rarely have published any papers on audit." The methodology of research needs to fit its purpose, and the current accepted gold standard of the randomised controlled trial is appropriate when research compares different interventions. It would be unhelpful to suggest that a lower standard is acceptable merely because a study is called an audit.

There is potential confusion, however, about the nature of the intervention being studied here. The intervention being tested is not priming with mifepristone but the effectiveness of the audit process in generating changes in service derived from expert review. MacRae's points about the robustness of the conclusions to be drawn from the study still hold, but the consequences of publishing an erroneous finding are much less. At

worst, other groups will misguidedly use the authors' methods for disseminating information on good practice when in fact the improvements were due to confounding effects, such as parallel publication. If, however, the authors had claimed from the results of such a study that morbidity had changed as a result of increased use of mifepristone then MacRae's strictures would have been crucially important.

The debate about appropriate methodology for audit is complex, but two further points are relevant. Firstly, the audit process often challenges received wisdom in medicine, which itself may never have been subject to randomised controlled trials. In this situation it is helpful to publish provisional findings, which can then be scrutinised more exactly. Secondly, there is an assumption that the best methodology is always a randomised controlled trial. Audit requires a diversity of methods that are optimal for different questions. Measurement of "clinically significant change" might be a useful technique for locating individual patients in an audit within a framework delineated by reliable measures of change derived from larger samples. Howard *et al* suggest that the limits of randomised controlled trials need to be considered when appropriate audit methods are chosen: the difficulties of attrition, generalisability, the need for unambiguous main effects.⁴ All of these are challenges to the utility of the randomised controlled trial as the best available methodology in systematic audit.

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2 Penney GC, Glasier A, Templeton A. Multicentre criterion based audit of the management of induced abortion in Scotland. *BMJ* 1994;309:15-8. (2 July.)

3 Jacobson NS, Truax P. Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology* 1991; 59:12-9.

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Complementary therapies used by patients with cancer

EDITOR,—S M Downer and colleagues found that 16% of patients with cancer had used complementary therapies.¹ We wish to report a study that we are carrying out.

Between September and 31 October 1993, 327 consecutive unselected patients starting treatment with radiotherapy at Mount Vernon Centre for Cancer Treatment were asked to complete detailed questionnaires about their treatment and psychosocial support. These included a hospital anxiety and depression scale, a cancer locus of control, and the European Organisation for Research and Treatment of Cancer's quality of life questionnaire C30 (a general quality of life questionnaire). We also collected detailed clinical, social, and demographic data. Of the 268 patients who consented, 174 were receiving radical radiotherapy as opposed to palliative radiotherapy. One hundred and fifty eight patients were women, and the age range was 22-88 (mean 62.8) years.

Results from a questionnaire listing 40 complementary therapies show that 86 patients had used such treatment. While 22 patients had used only one treatment, 15 had used eight or more. Unlike Downer and colleagues, we regarded counselling, telephone helplines, and support groups as complementary therapies (table). While many patients availed themselves of these three services, this cannot account for the overall higher uptake in our study compared with Downer and colleagues.