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Neutron treatment for pelvic cancer stopped

The government's decision in 1988 to donate £6m towards a new cyclotron at St Thomas's Hospital was criticised by cancer experts and provoked an editorial and flurry of correspondence in this journal. One of the experts' objections was that any decision on further funding of neutron facilities should await the outcome of trials under way at Clatterbridge Hospital into high energy neutron treatment for patients with locally advanced cancer of the cervix, bladder, prostate, or rectum. In April 1990 the news broke that the Medical Research Council had stopped the trial. On p 1045 Errington *et al* describe the events leading up to that decision and present the results on which it was based. They found that the relative risk of death in those who received standard megavoltage radiotherapy was 0·66 compared with those who received neutron treatment, indicating that neutron treatment was less beneficial than conventional treatment.

Penicillin allergy

Penicillin allergy is an overdiagnosed condition. General practitioners are constrained in their use of an otherwise safe antibiotic by mention of possible penicillin allergy. On p 1051 Surtees *et al* report that only four outpatients of 132 who gave a history of immediate type penicillin allergy were allergic on the basis of a radioallergosorbent test to phenoxymethylpenicillin and benzylpenicillin. The remaining 128, who had a negative radioallergosorbent test result, were given oral penicillin without ill effect. The authors conclude that, used critically, this test might be a cost effective, speedy approach to resolve a common situation in general practice, in which patients profess a vague and distant history of penicillin allergy.

Prevalence of risk factors and screening in primary care

The OXCHECK (Oxford and collaborators health check) randomised controlled trial was started in 1989 to assess the effectiveness of health checks by nurses in helping patients to reduce their risk of heart disease. The study has shown an uptake rate of only 82%, even after addresses had been confirmed and systematic invitations sent (p 1057). This suggests that early claims of acceptance rates of 90-95% for health checks were achieved by selectively inviting compliant patients. A high proportion of the patients screened needed some form of intervention; most of them requiring advice on diet or on how to stop smoking. The proportion of patients with a raised total cholesterol concentration was high (37%), suggesting that the workload generated by cholesterol screening will be heavy. The cost of cholesterol lowering drugs could be as much as £400m if all general practitioners in the United Kingdom offered screening to all 35-64 year old patients. The authors conclude that the real work in cardiovascular disease prevention is not in screening but in providing and sustaining follow up and that the major failing of health checks has been to confuse the process of screening with that of intervention and follow up.

Organ donation outside intensive care units

A large shortfall exists in the provision of organs for transplantation. Most studies of the availability of donor organs have been based in intensive care units, but this means that potential donors dying outside these units are missed. On p 1053 Salih *et al* describe a study of hospital deaths with regard to organ donation. Reluctance of staff to suggest donation and refusal of relatives accounted for fairly few lost donors, with relatives of patients aged 20-39 being most reluctant to grant permission. The proportion of younger patients who actually became donors, however, was greater than the proportion of older patients. The authors suggest that the largest potential for increasing the number of donors lies in ensuring that more older patients dying of stroke are ventilated. Elective ventilation for the purposes of organ donation raises ethical questions that require wide debate.

The future of community mental health

In an address given this week the president of the Royal College of Psychiatrists, Dr Andrew Sims, itemises the changes required for the introduction of comprehensive community care in psychiatry (p 1061). Better services for the mentally ill can be provided, he says, without a massive increase in resources—by better deploying the resources already available. He calls for more trained psychiatrists so that consultants can be enabled to be personal physicians to individual patients, thereby ensuring treatment for sufferers from neurotic disorders and providing better care for chronic schizophrenic patients, who might otherwise become homeless and vagrant. These consultants would head multidisciplinary teams—working relationships and responsibility within these teams need to be clarified and working patterns evaluated.

A different view is given by Professor Elaine Murphy, who talks of the need for a new vision of community mental health care (p 1064). Underlying the differences of opinion between pressure groups, interprofessional squabbles, and interagency rivalries she finds a remarkable unanimity about the principles of community mental health care. What is required is a clearer idea of the overall needs of individuals with mental disorder. Patients need one clearly identified person in the health service who is readily accessible to provide support and a listening ear, and for patients with untreatable or chronic conditions this is not likely to be a psychiatric professional. A workforce to support patients' needs would be composed of relatively unskilled workers vocationally trained on the job and able to recognise when specialist psychiatric intervention is needed. Because of demographic changes fewer young people will be entering the health care professions in the future; perhaps sheer necessity will lead to the use of a smaller number of professionals.