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Trends in mortality: east versus west

The new democracies in eastern and central Europe are considering new policies and approaches, and priorities for action are being sought. On p 879 Boys *et al* examine the time trends of age standardised mortality in several former eastern bloc states and western democracies from conditions amenable to medical care and from non-amenable conditions. The failure of all causes mortality to decline during the past two decades in eastern Europe seems to lie mainly, though not wholly, with mortality from non-amenable causes. Boys *et al* conclude that, supported by western aid and the generation of increased economic wealth, the priority in eastern Europe should be towards environmental improvement and the promotion of a healthier lifestyle. Improvements in the quality and efficiency of direct health services, which have been less effective in reducing avoidable deaths in eastern Europe than in the west, should also not be neglected.

Familial hypercholesterolaemia and fatal coronary heart disease

A genetically determined condition associated with a 100-fold increase in risk of fatal disease is a cause for serious concern. On p 893 the Scientific Steering Committee of the Simon Broome Register Group reports a standardised mortality ratio of 9686 for coronary heart disease in men and women aged 20-39 who have familial hypercholesterolaemia. Although this condition occurs in one in 500 of the population, there have been few prospective studies. This life table analysis, based on more than 500 patients identified in specialist lipid clinics, shows a substantial increase in the risk of fatal heart disease in those under 40 but no increase in risk in those over 60. Further research is needed to explain the apparent reduction in susceptibility to coronary heart disease in these older patients.

Treatment for advanced ovarian cancer

Ovarian cancer causes the most deaths from gynaecological malignancy in Europe and North America. Despite over 30 years of research there is no consensus about the most appropriate chemotherapy. In a quantitative overview of 45 randomised clinical trials the Advanced Ovarian Cancer Trialists Group (p 884) has examined the role of platinum and the merits of single agent versus combination chemotherapy for advanced disease. Individual patient data were collected on over 8000 women, but even with this information no firm conclusions could be reached. The results suggest that platinum based combinations are better than either single agent platinum or non-platinum regimens and that cisplatin and carboplatin are equally effective. The trialists group believes that clinical trials have been too small to show reliably the differences in survival which can reasonably be expected with available treatments. Thus a prospective randomised trial of carboplatin versus cisplatin, doxorubicin, and cyclophosphamide has been launched, aimed at recruiting 2000 women worldwide.

Necropsy: valid as monitor of clinical diagnosis?

Continuing and costly expansion of diagnostic facilities in medicine calls for systematic monitoring of the performance of clinical diagnostic procedures, and necropsy is the ultimate reference of diagnostic correctness. Saracci (p 898), however, argues that valid quantitative information for monitoring may be hard or impossible to extract because of distorting influences in selecting cases for necropsy, possible unrecognised errors in postmortem diagnosis, and inappropriate use of indexes summarising the results. Representative case series of reasonable size are preferable to larger and highly selected series, the reliability of the postmortem diagnosis should be assessed, and sensitivity and specificity of the clinical diagnostic process should be used as the key summary indices. Informative monitoring of clinical diagnosis through postmortem findings requires accurate pathological examination with valid study design and analysis.

Quality and health care in Sweden

Surprisingly perhaps, for a nation renowned for the quality of some of its manufactured products, quality assurance and medical audit in medicine have only recently become fashionable in Sweden; there is no legal requirement for either. Reizenstein (p 900) describes some of the audit activities in progress locally and how quality assessment is spreading into primary care. The investigations have disclosed a prevalence of inappropriate medical practice—overutilisation, suboptimal management, and delay—far above that in the best managed industries and accounting for perhaps 10-20% of the health care budget.

How to counsel patients before an HIV test

Doctors may be deterred from offering their patients HIV tests because of the need to obtain their informed consent and the mystique that surrounds pre-HIV test counselling. In order to remove this mystique, Bor *et al* (p 905) explain how counselling should be done. The World Health Organisation and the BMA have issued guidelines on what should be covered by doctors during counselling. The authors give practical advice on how to broach the subject of HIV infection, how to explore patients' hidden anxieties, and how to prepare the patient for a positive result. If done well, counselling provides an opportunity for discussion and education and should pave the way for the continued psychological and medical care of those patients who are found to be positive for HIV.