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# BRITISH MEDICAL JOURNAL

SATURDAY 8 NOVEMBER 1986

## LEADING ARTICLES

Biosynthetic growth hormone: whom to treat?	M A PREECE	1185
A better way to detect growth failure	C G D BROOK, P C HINDMARSH, M J R HEALY	1186
Acquired cystic disease of the kidney: serious or irrelevant?	C J RUDGE	1186
Easeful death	JANE DAWSON	1187
Use of the general health questionnaire in clinical work	DAVID GOLDBERG	1188
Subnutrition in the elderly	W J MACLENNAN	1189
Reviving the CMA	GORDON MACPHERSON	1190

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Hypogonadism in chronic liver disease: impaired release of luteinising hormone	P BANNISTER, TINA HANDLEY, C CHAPMAN, M S LOSOWSKY	1191
Isolation of <i>Mycobacterium avium-intracellulare-scrofulaceum</i> complex from faeces of patients with AIDS	ANDREW R STACEY	1194
Effect of near normoglycaemia for two years on progression of early diabetic retinopathy, nephropathy, and neuropathy: the Oslo study	KNUT DAHL-JØRGENSEN, OLAF BRINCHMANN-HANSEN, KRISTIAN F HANSEN, TROND GANES, PETER KIERULF, ERLEND SMELAND, LEIV SANDVIK, ØYSTEIN AAGENAES	1195
Prognosis for infants born at 23 to 28 weeks' gestation	V Y H YU, H L LOKE, B BAJUK, W SZYMONOWICZ, A A ORGILL, J ASTBURY	1200
Hip fractures in healthy patients: operative delay versus prognosis	R N VILLAR, S M ALLEN, S J BARNES	1203
Trial of early nifedipine in acute myocardial infarction: the Trent study	R G WILCOX, J R HAMPTON, D C BANKS, J S BIRKHEAD, I A B BROOKSBY, C J BURNS-COX, M J HAYES, M D JOY, A D MALCOLM, H G MATHER, J M ROWLEY	1204
Arthritis and HLA-B27 in Papua New Guinea	J E RICHENS, M L PRASAD, K BHATIA, M TUNG	1209
Acquired cystic disease of the kidney: an indication for renal transplantation?	B J THOMPSON, D A S JENKINS, P L ALLAN, R J WINNEY, J C B DICK, S R WILD, J L ANDERTON, G D CHISHOLM	1209
Severe illness associated with appearance of antibody to human immunodeficiency virus in an African	ROBERT J BIGGAR, BRUCE K JOHNSON, SHEM S MUSOKE, JOHN B MASEMBE, DAVID M SILVERSTEIN, MAJID M WARSHOW, STEVEN ALEXANDER	1210
Transient ascites in progressive systemic sclerosis	J J A MCALEER, S R CUNNINGHAM, W DICKEY, D BURROWS, M E CALLENDER	1211
Attitudes to and knowledge about the acquired immune deficiency syndrome: lack of a correlation	A D MORTON, I C McMANUS	1212
In aid of doctors suffering from complaints about AIDS	J S NORELL	1213
Medical facilities used by heroin users	AIDAN B V BUCKNALL, J ROY ROBERTSON, KIRSTY FOSTER	1215

## MEDICAL PRACTICE

Does breathing other people's tobacco smoke cause lung cancer?	NICHOLAS J WALD, KIRAN NANCHAHAL, SIMON G THOMPSON, HOWARD S CUCKLE	1217
Working abroad: stresses and solutions	KIM WINTER	1223
Pelvic inflammatory disease	M J HARE	1225
Medicine and the Media—Contributions from	STEPHEN LOCK, ROSALIND DAINTREE	1228
Recurring meningitis: beware the normal looking ear	L DURHAM, I J MACKENZIE, P FOY, A BOWDEN	1230
Clinical Curio: Chronic venous leg ulceration in obesity	M E ARDRON, I A MACFARLANE, E D VAUGHAN	1224
Medicine and Books		1231
Personal View	G J BARTHOLOMEW	1235
Correction: Severe hypermagnesaemia	COLLINSON AND BURROUGHS	1222

CORRESPONDENCE—List of Contents	1236
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OBITUARY	1247
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## NEWS AND NOTES

Views	1244
Medical News	1245
BMA Notices	1245
One Man's Burden	MICHAEL O'DONNELL 1246

## SUPPLEMENT

The Week	1249
Electioneering on the wards	JOHN WARDEN 1250
Career prospects in general surgery in England and Wales	THOMAS C B DEHN, DULCIE GOODING, M H GOUGH 1251
Pay parity for clinical academic staff	1254

# CORRESPONDENCE

<b>Neurological and neurosurgical approaches in the management of malignant brain tumours</b> J D Miller, MD, and others; K G Davies, FRCS, and others; J N Wilden, FRCS . . . . . 1236	<b>Asthma and climatic conditions: experience from Bermuda</b> J G Ayres, MRCP, and G E Packe, MRCP . . . . . 1239	<b>Homerton Hospital</b> T J Hoare, MB . . . . . 1242
<b>Availability of organs for transplantation</b> D J Hill, FFARCS . . . . . 1237	<b>Angina pectoris-like pain provoked by intravenous infusion of adenosine</b> C Sylvén, MD . . . . . 1240	<b>Mrs Wendy Savage and the report of the Munro inquiry</b> B Raymond . . . . . 1242
<b>Whooping cough immunisation for children with cerebral irritation or damage in the neonatal period</b> S Lingam, MRCP, and others . . . . . 1237	<b>Glue ear and speech development</b> A G D Maran, FRCSed, and Janet A Wilson, FRCS . . . . . 1240	<b>Drug points</b> Malaria prophylaxis (A G Bynoe and J K Bynoe); Dependence on dextromethorphan hydrobromide (M W Orrell and PG Campbell) . . . . . 1242
<b>Respiratory symptoms and bronchial reactivity</b> Isabella Annesi, MSC, and others . . . . . 1237	<b>Halothane and the liver</b> T B Boulton, FFARCS; R I Keen, FFARCS . . . . . 1240	<b>Excessive blinking associated with combined antidepressants</b> (M A Cooper and T R Denning); Fixed drug eruption associated with mefenamic acid (C Wilson and A Otter); Amphotericin B hepatotoxicity (F J Abajo and others); Angioneurotic oedema associated with two angiotensin converting enzyme inhibitors (D R J Singer and G A MacGregor) 1243
<b>Serum concentrations of sex hormone binding globulin in lung cancer</b> M J Diver, MSC, and others; T Spector, MRCP, and W S L Stebbings, FRCS; T P Corbishley, BSC, and others; M Dowsett, PhD, and others 1238	<b>Plasminogen activators in human colorectal neoplasia</b> D A Ramsay, MRCP; J S K Gelister, FRCS, and others; G T Layer, FRCS, and others . . . . . 1240	<b>Correction: Drug induced parkinsonism</b> (Wilson and Primrose) . . . . . 1243
<b>Sleepwalking as a symptom of bulimia</b> J A Bell, MB, and J S Tomkinson, MRCPsych 1239	<b>"Near miss" sudden infant death and episodic hypothermia</b> E L Lloyd, FFARCS . . . . . 1241	
	<b>Immunisation rates and the good practice allowance</b> J James, MB, and Carol Clark, HV . . . . . 1242	

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the *BMJ*.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

## Neurological and neurosurgical approaches in the management of malignant brain tumours

SIR,—Dr S J Wroe and colleagues have provided an interesting account of the attitudes, policies, and practices in the management of malignant glial brain tumours in a single clinical neurosciences centre (18 October, p 1015). Although their comparison of the approaches by neurologists and neurosurgeons showed a difference in the readiness to obtain histological confirmation of the diagnosis by biopsy, the numbers of patients submitted to formal craniotomy and surgical decompression were rather lower in both groups than would be the case in several other neurosurgical units. This is only one of the reasons why we are concerned lest the findings of this study be taken as recommendations, rather than as an account of the practice in a single centre.

Their 95% accuracy of computed tomography in diagnosing malignant brain tumour may be impressive, but the authors make no mention of the accuracy with which tumour type and grade could be predicted. This is important when the predicted survival may range from a few months to many years. With increasing numbers of scanners installed outside neuroscience centres such high diagnostic accuracy is unlikely to be maintained. In any case, for the small number of cases with a wrong diagnosis on computed tomography the consequences may be profound.

Failure to perform biopsies on solitary brain tumours diagnosed by computed tomography can lead to serious errors. In a survey by this department of all cases of solitary brain tumour diagnosed by computed tomography and isotopic brain scan in south east Scotland in one year half of the patients diagnosed on computed tomography as having a solitary metastasis and then submitted to biopsy had a different diagnosis on biopsy, carrying a better prognosis. Eleven per cent of patients diagnosed on computed tomography as having glioma and submitted to biopsy had other

diagnoses. Of most concern in our series was that in over half the patients diagnosed by computed tomography or radioisotope scanning as harbouring a solitary brain tumour no referral to a neurosciences centre was made and no histological diagnosis was ever obtained.

We disagree with their statement about the high morbidity of biopsy for brain tumour. Introduction of steroid cover has made the procedure acceptably safe and the figures quoted by the authors in support of their assertion refer largely to older studies carried out before the introduction of steroid therapy and computed tomography.

If the morbidity of burrhole biopsy—a diagnostic, not a therapeutic, procedure—is worse than that of no treatment, surely alternative measures that combine diagnosis with treatment, even of a palliative nature, are to be preferred? Recent reports suggest that surgical decompressive and cytoreductive procedures in selected patients improve the quality of life.<sup>1,2</sup>

We also disagree with the assertion that radiotherapy is of no value. On the contrary, it is at present the most consistently effective treatment for malignant gliomas, doubling mean survival time and increasing two year survival from less than 1% to 11%.<sup>2,4</sup>

Everyone knows that the outlook is poor for patients with malignant brain tumours. If a nihilistic policy of no diagnostic confirmation and no treatment is advocated this will always remain the case. Surely the public deserve something better than this from the medical profession?

J DOUGLAS MILLER  
ELIZABETH S MILLER  
N V TODD  
I R WHITTLE

Department of Clinical Neurosciences,  
University of Edinburgh

- 1 Ransohoff J, Kelly P, Laws E. The role of intracranial surgery for the treatment of malignant gliomas. *Semin Oncol* 1986;13: 27-37.
- 2 Shapiro WR. Therapy of adult malignant brain tumours; what have the clinical trials taught us? *Semin Oncol* 1986;13: 38-45.
- 3 Saleman M. Survival in glioblastoma; historical perspective. *Neurosurgery* 1980;7:435-9.
- 4 Walker MD, Green SB, Byar DP. Randomised comparisons of radiotherapy and nitrosamines for the treatment of malignant glioma after surgery. *N Engl J Med* 1980;303:1323-9.

SIR,—Dr S J Wroe and colleagues comment that patients referred to neurologists were more likely to leave hospital with only moderate or lesser disability, yet scrutiny of the relevant table reveals that those in the surgical group were even less likely to have moderate disability at discharge (9% compared with 21% of neurological cases). We note that there is a misprint in the table and the statistical significance refers to these cases and not those making a good recovery, but nevertheless almost twice as many surgical cases as neurological ones made a good recovery, and, whereas 79% of medically managed patients were disabled to some degree, only 63% of surgically managed patients were in this category. The difference is obviously due to the higher incidence of death and good recovery in the neurosurgical group. The claim that "short term morbidity in patients referred to neurologists is rather less" is therefore unfounded.

The higher mortality rate before discharge among the surgically managed patients is, we would suggest, due to the higher incidence of raised intracranial pressure in cases referred to the neurosurgeons, since this is known to be an important factor in mortality from burrhole biopsy.<sup>1</sup> The figures in table II support this, showing that patients with focal signs tended to be referred to a neurologist, whereas the incidence of papilloedema was almost 10% more in those