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CORRESPONDENCE

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- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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District cancer physicians

SIR,—As a medical oncologist who has emigrated to Canada, I am a spectator at the debate on the future of cancer services in Britain. Even so I should like to add my strong support to the comments of Professors T J McElwain and J S Malpas (31 October, p 1136).

On behalf of the Association of Cancer Physicians McIllmurray put forward a carefully constructed, thoughtful, and realistic blueprint for improving the delivery of cancer care.[1] Dr Liam Donaldson's leading article (19 September, p 682) was extremely disappointing. Britain has too few radiotherapists and far too few medical oncologists. Dr Donaldson's suggestion of strengthening and coordinating services is meaningless unless numbers of physicians in both disciplines are increased. Improvements in cancer services cannot be achieved with a handful of hard pressed medical oncologists. The choice is simple: either the consultant grade must be expanded or the public must be told that cancer services will not be improved. Any improvements will incur some expense (although a cancer physician's job includes identifying patients who will not benefit from expensive or toxic treatment, and the careful evaluation of the efficacy—or inefficacy—of current treatment).

Canada has about 200 cancer physicians for a population of 25 million; Britain has about 70 for a population of 55 million. The model proposed by the Association of Cancer Physicians is very similar to the current system operating in Ontario, and the coordinated care delivered by cancer centres linked to cancer physicians in district general hospitals here is impressive. The proposals put forward by the Association of Cancer Physicians are both realistic and modest—they can work and will work if they are implemented. These proposals deserve serious consideration rather than the combination of mean spiritedness and flippancy put forward by Dr Donaldson, who, perhaps, might be interested to see the Canadian system in action before drawing any further conclusions.

Had these plans been in effect eight or nine years ago many of the British trained senior registrars in medical oncology who have emigrated to Australia, New Zealand, Canada, and the United States might have reconsidered. British medical oncologists all share two characteristics: individual talent and scarcity. They—and British patients with cancer—deserve better.

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1 McIllmurray MB. District cancer physicians: report of a working group of the Association of Cancer Physicians. *J R Coll Physicians Lond* 1987;21:117-21.

Response to deoxycoformycin in mature T cell malignancies

SIR,—Dr Claire Dearden and colleagues (10 October, p 873) suggested that remission in response to deoxycoformycin correlated with immunological phenotype. According to their observation, remissions were obtained "only" in patients with CD4+, CD8− membrane markers (five complete remissions and two partial remissions out of 10), and no responses were achieved in nine patients with a different phenotype.

The relatively high rate of "complete" responses is encouraging. No definition of complete remission, however, was given in this paper. Complete remission, as defined by disappearance of all objective evidence of disease in peripheral blood and bone marrow, could rarely be achieved in patients with T chronic lymphocytic leukaemia and prolymphocytic leukaemia.[1] Deoxycoformycin was given "weekly or twice weekly" but no stipulations for administering once or twice a week were defined. Is it possible that response correlated with administration twice weekly instead of with phenotype?

In the leukaemia cooperative study group of the European Organisation for Research into Treatment of Cancer, we are concurrently conducting a phase II trial on the efficacy of deoxycoformycin in refractory lymphoid neoplasms.[2] The drug is given at a dose of 4 mg/m^2 intravenously once weekly for the first three weeks then once every 14 days for the next six weeks. At present, 15 patients with chronic T cell leukaemia can be evaluated for response. A partial remission, defined as a greater than 50% reduction in all measurable tumour indices for at least four weeks, was achieved in three of eight patients with Sézary syndrome, two of five patients with T chronic lymphocytic leukaemia, and one of two patients with T prolymphocytic leukaemia. No patient attained a complete remission. Immunological phenotypes were available in nine patients and the correlation to clinical response is summarised in the table.

Thus according to our experience, patients with CD8+ or CD4+, CD8+ phenotypes respond to deoxycoformycin as well as patients with CD4+ phenotype. Our preliminary data suggested a correlation between biochemical indices and