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SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Isolation of patients with bone marrow depression

SIR,—We read with interest the paper by Dr P C Trexler and others (6 December, p 549) describing a modified gnotobiotic system and how it has been used to isolate patients with acute leukaemia. While in no way wishing to criticise the technical achievement of the authors we do have genuine doubts about the value of reports of this kind.

As Dr Trexler and his colleagues rightly point out, there is no evidence whatever that isolation during the induction phase of therapy for acute myeloblastic leukaemia improves the remission rate or length of survival. Similarly, there are no data available as to whether this approach is of value in the management of other conditions in which bone marrow depression occurs. Indeed, the Seattle group who have pioneered human bone marrow transplantation have pointed out recently that there is no evidence that isolation of patients has a place in the management of the severe bone marrow depression which occurs immediately after transplantation and that properly designed trials need to be carried out to examine this problem.[1] Nevertheless, there is an increasing tendency for centres that are dealing with patients with bone marrow depression to feel that they are not fully equipped if they do not have isolation facilities. Indeed, a recent television programme on the management of leukaemia showed that at least one centre in the United Kingdom nurses its acute myeloblastic leukaemics in isolation during the induction phase, and this programme has caused much anxiety to the relatives of patients who are being treated in centres where this type of procedure is not practised.

The median survival for acute myeloblastic leukaemia in adults is about eight months and if the first three to four months of the illness are to be spent in a plastic tent or other gnotobiotic environment, then surely we must obtain evidence that this approach is improving the remission rate or length of survival for these patients. In Oxford we have adopted a totally different philosophy, and provided the patients are in reasonably good clinical state they spend the majority of their induction period at home with their families regardless of their white cell count. They attend hospital for injections and regular surveillance but do have the advantage of spending a greater amount of the short time which is available to them in a more friendly environment than a plastic tent. This approach is, of course, equally uncontrolled but since all the patients are in the Medical Research Council leukaemia trials there should be enough evidence available to determine whether they do much worse if treated in this way and so far this does not seem to be the case.

Surely the centres in the UK that now have relatively expensive isolation facilities should concentrate on producing data on the real value of this approach for leukaemia therapy by means of randomised trials. This seems particularly important at a time when there is relatively little money available in the NHS and when increasing numbers of centres that are looking after patients with leukaemia or other forms of bone marrow depression are being pressured into obtaining expensive equipment, the value of which is totally unproved.

CHRISTOPHER BUNCH
SHEILA T CALLENDER
PAULINE M EMERSON
A A SHARP
D J WEATHERALL

Radcliffe Infirmary, Oxford

[1] Thomas, E D, *et al*, *New England Journal of Medicine*, 1975, **292**, 823.

Geriatric patients in acute medical wards

SIR,—Do Miss Christine McArdle and her colleagues (6 December, p 568) really believe that £20 734·40 would have been saved if 11 patients had been accommodated in geriatric hospitals as soon as they were ready for discharge from the acute medical wards? After all, the authors themselves state that other patients were waiting to fill these acute beds, presumably at the same cost. The question raised in my mind by their article is, why does it cost three and a half times as much to treat patients in an acute teaching hospital as it does in a geriatric hospital?

Some patients in teaching hospitals, especially surgical patients, are justifiably very expensive to treat because they use costly equipment and labour-intensive services; and these few greatly increase the average cost of patient care. The ordinary run of acute medical admissions need not be so very costly, especially if expensive laboratory tests and treatments are used with discrimination. Elderly patients ought to be comparatively expensive to treat because they require, no less than younger ones, to be