phosphamide, and melphalan given individually produce a remission in a quarter to a third of patients with advanced ovarian tumours, but combinations of these drugs have been disappointing, with no increase in that proportion. The addition of cis-platinum diamminodichloride even in relatively low doses has doubled these response rates.[16] Other agents, such as hexamethyl melamine, adriamycin, ifosfamide, peptichemio, and the new podophyllotoxins (including VP16), are being evaluated. Even the best chemotherapeutic combinations, however, may be ineffective without surgical treatment to reduce the bulk of the tumour.

Current management of advanced ovarian carcinoma requires the removal of as much tumour as safely possible at initial laparotomy, along with both ovaries, uterus, and omentum (in which sites occult disease may reside). In order to render any inoperable disease removable, a chemotherapeutic response should be established as soon as possible, and, after maximum response, another laparotomy should be performed to remove any residual tumour, along with multiple biopsies of suspicious areas. Further adequate chemotherapy is indicated to eradicate any residual macroscopic or microscopic disease. Greater accuracy in the choice of chemotherapy for individual patients may, in the future, be obtained by drug selection challenges on the xenografted tumours in immune deficient mice or cell colonies obtained from laparotomy specimens.

Advanced ovarian carcinoma is found in as many as 70% of all patients at presentation. The median survival is about eight months from diagnosis. Any improvement on that grim prognosis requires a combination of surgical expertise and determined chemotherapy; and compromise in either modality is likely to result in relapse and rapid death.

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Transplant Olympics

Last month 200 men and women between the ages of 14 and 44 assembled at Castle Field in Portsmouth to take part in the second Transplant Olympics. As athletes they shared one characteristic: each had a well-functioning kidney transplant. Their performance in the 33 separate events may not have reached Olympic or even sports clubs standards, but their times were certainly better than might be expected from, say, their doctors. The 1500 metres was won in a modest six minutes by Paul West of Liverpool—the sort of time that any ordinary young man or woman in the street might be able to accomplish with some training. Again, the tennis champions, men and women, were certainly not of Wimbledon class but they would have felt comfortable on the first ladder of their local club.

These games were not, then, for the handicapped: they were for men and women with transplant kidneys, of one to eight years' vintage, who wanted to demonstrate their normality. Competitors (six for each team) came from England, Scotland, Wales, and Northern Ireland and from countries overseas as far afield as Mexico, Israel, and Greece. Their aim was to be ambassadors for kidney transplantation and to draw attention to their normality in the hope that this would persuade the spectators to become potential kidney donors and thus help the thousands of patients on dialysis to achieve a similarly normal, independent state of existence. Over 5000 donor cards were signed at the meeting and taken away.

The organising committee and its chairman, transplant surgeon Mr Maurice Slapak of St Mary's Hospital, Portsmouth, decided that no individual records of times or distances would be kept, though gold, silver, and bronze medals were awarded to the winners of the varying events. The champion team was Eire, with its flying Irishman Maxie Scully, the winner of three gold medals in highly creditable times. The most colourful entrant was a Mexican who did not compete—he had a wooden leg—but instead he entertained the others with his guitar.

Six separate bids were entered by countries who wanted to stage next year's Olympics, including an imaginative Canadian bid for a Winter Olympics in 1981 in the Rockies. The International event was awarded to the United States and will be staged in September 1980 at Lake Placid. The Transplant Olympic Games to choose the British team will be staged in August 1980 in Birmingham.

Liver dysfunction in inflammatory bowel disease

Patients with ulcerative colitis or Crohn's disease may develop extraintestinal complications of the skin, eyes, joints, or renal tract.[1] Various hepatobiliary disorders are also associated with inflammatory bowel disease, including pericholangitis,[2] fatty change, chronic active hepatitis, cirrhosis, granulomas, amyloidosis, hepatic abscesses,[3] gall stones,[4 5] sclerosing cholangitis,[6] and carcinoma of the biliary tract.[7 8]

Minor histological abnormalities are equally common in Crohn's disease and ulcerative colitis, but their prevalence depends on the source of the pathological material. Roughly two-fifths of surgical biopsy and postmortem specimens show fatty change, a reflection of the poor nutritional state or septicaemia of some patients during an acute attack.[9 10] Pericholangitis, also called portal triaditis, is recognised histologically by cellular infiltration of the portal tracts, portal fibrosis, and concentric fibrosis around the bile ducts, and is found in over half of surgical biopsy specimens.[9 10] In clinical studies most liver biopsy samples have been obtained from patients with abnormal serum enzyme concentrations or bromsulphalein retention, and in one such series fatty change and pericholangitis were each found in about 7% of patients with inflammatory bowel disease.[11 12] It is important not to mistake such histological changes, which are of little clinical importance, for those of serious liver disease. Fortunately the latter is