

integrated or related to needs or age, is, however, premature without the research for which he rightly pleads.

It is accepted that not all elderly patients need care in a geriatric department, but we currently lack the information that would allow us to select appropriate individual "geriatric" patients from the whole population of patients. For this reason age may still be a useful marker of need—for example, 55% of the most severely disabled adults are aged 75 or over.² In our experience, the converse, that elderly patients should have access to the full range of medical specialties and technology, is not compromised by the absence of integrated practice provided that the geriatric department has beds in the district general or teaching hospital. It should be remembered that the original stimulus to integrated practice was the shortage of such beds for elderly patients. Indeed, any reluctance of "organ specialists" to allow elderly patients to have access to their specialist practice for fear of being overwhelmed by requests is lessened by having geriatricians who have the continuing responsibility for their elderly patients, many of whom will have multisystem problems. Such a clearly defined service not only acts as a focus for all other hospital departments and for those involved with elderly people in the community but also fulfils important wider educational and research roles. The success or otherwise of any method of delivering health care depends very much on local factors, such as geography, available resources, and, perhaps most critically, personal relationships between geriatricians and their colleagues rather than the type of service operated.

Vitaly important aspects of the geriatrician's work not alluded to by Grimley Evans are early rehabilitation and planning for discharge; these should take place every time an elderly person is admitted to hospital with the aim of preventing that devastating and expensive problem of dependency, which occurs almost exclusively in elderly patients. Good practice in this depends on a team approach, and the nurse should be particularly involved because of his or her role in rehabilitation. It would be ideal if such positive attitudes and skills existed in all hospital wards, but the reality, even in these enlightened times, is far different. Widespread adoption of an integrated service without ensuring that medical and nursing practice was appropriate for a unit with geriatric responsibilities would compromise the patient's rapid and safe relocation in the community.

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SIR,—We agree with J Grimley Evans that physiology not age should determine the type of care provided for elderly people and endorse his argument in favour of physicians who care for elderly people having easy access to other medical specialties and the high technology facilities of district general and teaching hospitals.¹

It does not, however, follow that geriatric medicine must become fully integrated with general medicine to achieve this. Such a development, combined with the current policy of putting elderly people with apparent failure of adaptation into nursing homes after an often cursory medical assessment of their potential, could result in the re-emergence of the two tier system of care of the 1930s and 1940s. Then elderly people with acute illness received good medical care provided by the voluntary hospitals while those seen as having chronic problems were often inadequately cared

for in public assistance institutions. It was this that stimulated the medical pioneers of geriatric medicine to found the specialty.²

Proximity and close cooperation between a distinct speciality of geriatric medicine and other specialties, particularly general medicine, are the essence of a humane, appropriate, comprehensive, and cost effective service for elderly people. A "problem related" geriatric service can provide those unlikely to require high technology facilities (elderly people whose adaptation to their environment is failing) with low technology but appropriate and effective care. Many geriatric services, with a legacy of beds separate from the main hospital, still successfully provide such a service, combining excellent medical management, rehabilitation, and social support for their local populations. Such services need direct access to the local general hospital and a good working relationship with other specialties. Acute geriatric assessment beds—separate from general medical beds and usually operating in a problem related way—now form an integral part of most district general and teaching hospitals in Scotland, in line with the policy of the Scottish Home and Health Department.³ Unlike the "age related" approach, a combination of general medical wards managing patients of all ages and a problem related geriatric service with direct access to the facilities of a general hospital works well and provides general practitioners with a choice of care depending on their patients' needs.

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Chemotherapy in advanced ovarian cancer

SIR,—The overview of randomised clinical trials in advanced ovarian cancer by the Advanced Ovarian Cancer Trialists Group found that no firm conclusions could be reached regarding the optimal treatment of this disease.¹ With more than 30 years of study the age standardised death rate for ovarian cancer is still rising.² Yet again clinical practice has been determined by small, inconclusive trials designed for rapid publication with inappropriate end points, usually response rates.

Despite the acknowledged lack of a significant difference in any of the five comparisons considered the group proposes a randomised study, requiring 2000 patients to compare carboplatin with the highly toxic regimen of cyclophosphamide, doxorubicin, and cisplatin. Although the group states that "in the past clinical trials have been an order of magnitude too small to detect the size of differences which this overview suggests may be realistic," it does not provide any power calculations for the new trial and, in particular, does not quantify the expected benefit in survival that it regards as being worth while. From the published reports that are quoted the median survival for patients with advanced ovarian cancer is less than two years, with five year survival less than 20%. With the drugs available now for treating ovarian cancer surely the time has come to move away from survival as a useful end point and concentrate more on quality of life for both survivors and non-survivors.³ Pursuit of small survival benefits that may be achieved with highly toxic regimens such as that proposed by the Advanced Ovarian Cancer Trialists Group must incorporate a detailed analysis of quality of life.

It could be argued that in the absence of a randomised controlled study with an untreated control group there is no definitive proof that any form of chemotherapy, given routinely to treat advanced ovarian cancer, is associated with a desirable beneficial outcome. Indeed, is it ethical to continue to compare different chemotherapeutic regimens before answering this fundamental question? It may be that palliative, symptomatic treatment is more appropriate. In the absence of any new revolutionary treatment for epithelial ovarian cancer an alternative approach would be to develop a prognosis oriented treatment strategy. By using independent prognostic variables it may be possible to distinguish those patients likely to benefit from current aggressive chemotherapy from those in whom treatment is unlikely to influence the outcome. Highly toxic and expensive chemotherapeutic agents would therefore be restricted to those patients predicted to benefit.

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Condylomata acuminata and risk of cancer

SIR,—Bárður Sigurgeirsson and colleagues conclude from their follow up study of patients with condylomata acuminata that the risk of these patients developing invasive cervical cancer is less than previously thought.¹

We have calculated the probabilities that the study would have declared the relative risk of invasive disease to be significantly different from 1 at $p < 0.05$, assuming various values for the true relative risk between 1 and 10 (table). These calculations assume that the underlying distribution for the occurrence of cases over time is Poisson, with a baseline number of expected cases of 0.6.

We believe that the authors' conclusion cannot be justified by the data they present as the design of their study does not confer sufficient power to detect an increased risk.

The authors also conclude that the risk of carcinoma in situ of the cervix in patients with condylomata may be less than previously thought. They compare the relative risk of 1.5, estimated in their study, with that of 3.8 reported by Chuang *et al.*,² which they state (wrongly) was presented without confidence intervals. Certainly Sigurgeirsson and colleagues' estimate from the Swedish cohort seems to be lower than this figure. However, the possibility that, in the Swedish study, women with warts were more likely to have lower grade neoplastic lesions of the cervix diagnosed and treated than the women in the population as a whole should be considered. If this occurred then the number of cases of carcinoma in situ in the cohort could have been substantially reduced with

Probability that study would have declared relative risk of invasive disease to be significantly greater than 1

True relative risk	Probability of declaring risk significantly greater than 1
2	0.03
3	0.11
4	0.22
7	0.60
10	0.84