p 953 and 955), but their twin papers highlight the inadequacy of conducting psychiatric research along the same lines as medical trials of physical disorders.

I am concerned that 20% of the study group in the second paper were excluded from the analysis. More important from the psychiatric point of view is the complete absence of important information about the personal history of the people studied. Nevertheless, for the sake of argument let us assume all were products of a happy childhood, in stable adult relationships, and with secure jobs with good pension schemes when they were diagnosed as suffering from cancer—albeit from the doctor's point of view a curable cancer.

Is it really surprising that only 12 months after this diagnosis the patient is subject to bouts of anxiety or depression? Surely an inability to resume normal activities is a fairly hard sign of continuing depression? Anyone experienced in bereavement work knows that many anniversaries must pass before someone can begin to feel whole again after a loss. In this case the patient is suffering from the loss of health and has had to come to terms with his or her mortality. To expect this to be complete within 12 months is too much. In any case cancer treatment is usually measured by five or 10 year survival rates, so to be convinced of a cure at 12 months could be considered almost foolhardy.

In practice the work of supporting patients with cancer and helping them to express their fears and anxieties lies with the primary care team, and we are happy to do this task, which can be very rewarding. Our job would be much easier if oncology wards employed trained counsellors who were as much a part of the protocol as vincristine or radiotherapy.

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SIR,—I was interested to read the study by Dr Jennifer Devlen and others on psychiatric morbidity in patients with non-Hodgkin's lymphoma. Their results confirm the suspicion of many clinicians that the price to be paid for increased survival in haematological malignancies is not limited simply to the unpleasant physical side effects of treatment. Doctors looking after patients who are potentially cured of serious illnesses do so from the standpoint of healthy individuals. They often expect patients to regard the rest of their lives as some kind of unexpected bonus. That this is not so has been shown in the above study. One problem worth emphasising is the intense fear of relapse felt by some patients when treatment is discontinued. While treatment is in progress the patient has a definite goal—that is, the eradication of disease, the end of chemotherapy, and restoration to normal health. Paradoxically, when remission is obtained and treatment ends the goal is lost, and the absence of treatment may fuel fears of relapse. This point is illustrated in the following case, which also highlights possible consequences of failure to recognise pre-existing psychiatric morbidity.

A 29 year old man was admitted for investigation of a pleural effusion. Shortly after admission he became oliguric and a computed tomogram showed the presence of massive deposits of intra-abdominal lymphoma. Cytology of the pleural aspirate and of the bone marrow confirmed a high grade non-Hodgkin's lymphoma and intensive chemotherapy was instituted without delay. He made a good response to treatment, which was discontinued after eight courses. He was rather obsessive and introspective and had been seen by a psychiatrist three years before when he had expressed morbid fears of developing cancer. Several side effects occurred during treatment but he constantly expressed gratitude to the medical staff, whom he regarded as having saved his life. After treatment was stopped he remained clinically well with no sign of recurrence. He required much reassurance about his physical wellbeing and was constantly anxious about the discontinuation of chemotherapy. On the final occasion that he was seen he broke down and admitted to being obsessed with fears of the relapse of his disease and with guilt that in view of his state of mind the efforts of his doctors had been wasted on him. He was counselled in the clinic and referred urgently to a psychiatrist. A few days later, however, he was found dead in his car, having left the engine running with the vehicle in a closed garage.

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Reducing publication bias

SIR,—Dr R Newcombe (12 September, p 656) highlights the main consequence of selective publication bias—namely, an excess of false positive findings and exaggerated estimates of treatment benefits in the published literature. As Dr Newcombe suggests, this bias can be considerably reduced by basing inference about the likely effects of a particular treatment on a systematic overview (or meta-analysis) of all trials of a particular question unpublished as well as published.

Identifying published trials using computer aided methods—Medline, for instance—supplemented by manual searches of the journals and the reference lists of relevant articles is relatively straightforward. This is not the case, however, for information on unpublished trials, which may require extensive and laborious correspondence with all the investigators who have conducted such studies in the past. Some help in these searches is provided in certain disciplines through prospective registries of randomised trials. For example, there is a European registry of antithrombotic trials[1] and a registry of all trials in perinatal medicine.[2] Since registration generally occurs before results are available these registries, if reasonably complete, provide an unbiased database of all trials and can help to minimise substantially any effects of publication bias in the assessment of treatment. Obtaining regular information on all relevant trials being conducted throughout Britain is difficult and time consuming, however, so that many of the current registries are limited by an unavoidable failure to include an accurate and up to date log of all trials.

One potentially valuable source of such information might be the research ethical committees, since almost all clinical trials conducted in Britain (as in many countries) require prior ethical approval. If these committees were prepared to send routinely a list of all approved randomised trials to some central agency (perhaps the Medical Research Council or, in the case of cardiovascular trials, the British Heart Foundation) then comprehensive and multidisciplinary registries could be established. Not only would these registries serve as a means of assessing treatment effects more reliably, with the potential for encouraging closer collaboration between researchers working in similar areas, but they would also provide information about the range and general direction of research activities in the United Kingdom.

Successful establishment of such a central trials registry through the ethical committees in Britain might also encourage investigators and central funding agencies in other countries to do likewise.

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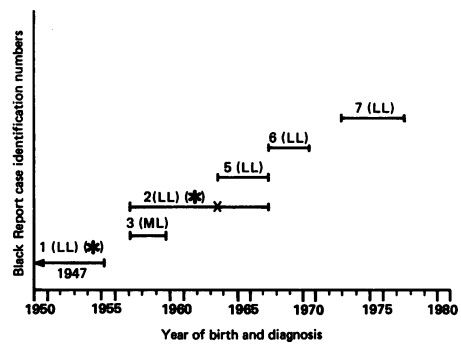
1 Verstraete M. Registry of prospective clinical trials. 6th Report. *Thromb Haemost* 1984;51:283-90.
2 Oxford database of perinatal trials. Developing a register of published reports of controlled trials. *Controlled Clin Trials* 1986;7:306-24.

Children born in Seascale

SIR,—The Seascale schools and birth cohorts studies of Dr M J Gardner and colleagues (3 October, p 819) provide confirmation of an excess of deaths from leukaemia in a village which has experienced high population mobility—that is, in a community for which accurate expected rates are difficult to obtain. I would question, however, whether the childhood leukaemia case data for Seascale[1] (see figure) would justify Mr David Crouch's concentration on 1957 (24 October, p 1066)—the year of the fire at the number one Windscale pile—or on any other particular interval of time.



Years of birth and diagnosis of the childhood (under 15 years old) leukaemia cases resident in Seascale at diagnosis. (LL=lymphatic leukaemia, ML=myeloid leukaemia, *=born outside west Cumbria, X=year first resident in Seascale.)

Mr Crouch also mentions the cases of leukaemia occurring in the under 25 year olds of Millom rural district outside Seascale; but these cases occurred predominantly in the 15-24 age range, rather than the 0-14 age range which characterises the Seascale excess.[2] It is doubtful whether any in utero effect which might be responsible for the Seascale childhood leukaemias could also be responsible for the cases occurring in the young adults of the rest of Millom rural district.[3]

Any explanation of the excess of leukaemia in Seascale children in terms of a specific causal factor must be capable of describing both its apparent confinement within a very limited geographical area and its protracted action over (at least) three decades.

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1 Independent Advisory Group (Chairman Sir Douglas Black). *Investigation of the possible increased incidence of cancer in west Cumbria*. London: HMSO, 1984.
2 Wakeford R, Wilkie D, Hargreaves R. A re-examination of the epidemiological data for Cumbrian coastal areas. In: *Health effects of low dose ionising radiation—recent advances and their implications*. London: British Nuclear Energy Society (in press).
3 Kneale GW, Stewart AM. Age variation in the cancer risks from foetal irradiation. *Br J Cancer* 1977;35:501-10.

Turning patients into people

SIR,—It is a very welcome commitment of the council of the Association of British Neurologists that "neurologists are willing to play an increasing part in managing neurological disability," despite