American studies suggest that appropriate measures of abusive behaviours can be achieved. However, pilot studies with in depth interviews at our hospital found several methodological problems. These included the obtaining of informed consent to participate in research on family violence, access to potential respondents, and ethical dilemmas about procedure if abuse is uncovered during research. Further British research will therefore need to address these problems before large scale studies of elder abuse are conducted.

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Steroids in advanced cancer: survey of current practice

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Steroids are commonly prescribed for patients with malignant disease.[1] At St Joseph's Hospice three patients were admitted in one month with severe side effects of steroids in whom the rationale for using steroids was not clear. This prompted us to look at steroid use in a series of patients admitted to the hospice.

Subjects, method, and results

In 100 patients admitted consecutively with advanced cancer, information regarding steroid use and usefulness was sought from the patient, the patient's family, any accompanying documentation, and doctors outside the hospice involved in the patient's care. A total of 33 of the patients were taking steroids at the time of admission. Most had been taking them for more than one month. Reasons for steroids and durations of use are shown in the table.

Ten patients were admitted from the hospice home-care team with detailed notes. Of the 23 patients admitted from general practitioners or hospital doctors, only two had accompanying documentation giving indications for and dose of steroids. In two letters steroids were not mentioned. Three patients arrived with no documentation at all. After extensive telephoning we were unable to establish the reason for steroid use in four patients.

In most cases the response to steroids did not seem to have been monitored. Of the 28 patients who could answer questions, only eight felt that steroids had been beneficial, nine were uncertain, and 11 did not perceive any benefit. Five of these 11 had been taking them for more than one month. Of nine patients taking steroids solely for anorexia and weakness, only one had perceived any improvement.

Nine patients had steroid cards. Only eight of the 28 patients who could answer questions knew of the dangers of stopping steroids suddenly. Fifteen did not know why they were taking steroids, and 16 did not know whether the dose was to be reduced or continued. Six patients had distressing side effects attributable to prolonged steroid use. Four had a moon face, one a debilitating proximal myopathy, and one severe osteoporosis (she had been taking 30 mg prednisolone for two years without clear benefit to her anorexia and weakness).

Reason for and duration of steroid use

Reason for use	Duration of use (weeks) <1	1-4	5-52	>52	Unknown	Total
Anorexia/weakness	2	3	2	1	1	9
Anorexia/weakness and pain			2			2
Anorexia/weakness and hepatomegaly		1				1
Anorexia/weakness and vomiting			1			1
Raised intracranial pressure		1	5			6
Painful neuropathy			1			1
Facial palsy and radiotherapy			1			1
Chronic obstructive airways disease				1		1
Pain	1		1			2
Spinal cord compression	1					1
Intestinal obstruction			1			1
Lymphoma		1				1
Eczema			1			1
Part of chemotherapy regimen		1				1
Unknown	1	1			2	4
Total	5	8	15	2	3	33

Comment

Steroids can be prescribed for a number of reasons in advanced malignancy,[1,2] the best known being their stimulant effect in anorexia and weakness[3,4] and to reduce oedema around cerebral tumours.[5] They confer clear benefits in 40% of patients overall[1] but, particularly when used for more than a month, they can seriously impair quality of life as well as adding to the drug load in patients often already subject to polypharmacy. It is therefore of concern that steroid benefits are not routinely monitored, that patients are not aware of the risks, and that communication between doctors about steroid prescription is poor.

There is no universally accepted dose or monitoring regimen for steroids in advanced cancer, but a review of the literature suggests that typical starting doses would be 4 mg of dexamethasone daily in anorexia and weakness and 16 mg daily for the reduction of cerebral oedema or for spinal cord compression. Results can be assessed after one week, when the drug can be stopped if there has been no therapeutic response. If there is improvement in symptoms it seems sensible to reduce to the minimum dose which maintains benefit.[5] If steroids are continued it should be the responsibility of the prescribing doctor to ensure that the patient or family is aware of the dangers of stopping steroids suddenly and that response and adverse effects are clearly recorded.

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