1984 were dead by the end of the year despite good initial survival figures.

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Occult advanced cervical cancer

Early, apparently localised carcinoma of the cervix is a common problem in gynaecological practice. Nearly 4000 new cases of cervical cancer were diagnosed in England and Wales in 1978[1] and about half of these presented at an early stage.[2 3] The International Federation of Gynaecologists and Obstetricians allocates patients with pathologically proved invasive cervical carcinoma clinically limited to the cervix to stage IB. The prognosis for these patients is good with reported five year survival rates of 75-90%.[4] Radiotherapy or surgery or both are used in treatment, with no method having been shown to have a consistent advantage.

We believe that within that group of patients with apparently localised disease there is a subgroup with a considerably poorer prognosis. These patients in reality have microscopic spread of disease beyond the cervix. By definition, staging is clinical and based on the results of examination and radiological investigations. When clinical staging is compared with the findings at laparotomy, however, over a quarter of the patients assigned to stage IB prove to have been understaged.[5] Step sectioning of pelvic lymph nodes is superior to the more commonly practised random sectioning,[6] and it is not difficult to imagine that the same process applied to paracervical tissue would show some patients with microscopic extension of disease beyond the cervix. At present micrometastases are not detected, but they will lead to recurrence after apparently successful and adequate surgery.

Patients who have extension of their disease beyond the pelvis have a prognosis dependent on the extent of this spread. Survival rates range from 50% for those patients with spread to one group of nodes unilaterally,[7] to virtually nil for patients with macroscopic spread to the para-aortic nodes.[8] Increasing numbers of nodes and increasing numbers of groups of nodes affected, unilateral spread, and cephalad spread of affected nodes all confer a poorer prognosis.

Laparotomy provides the most accurate basis for predicting the outcome in individual patients. Three other factors influence the risk of unrecognised extension of the tumour beyond the cervix. Firstly, patients with tumours over 4 cm diameter have a less than evens chance of five year survival.[9] Secondly, patients with disease affecting more than two thirds of the thickness of the cervix have recurrence rates of 58-85%.[10] The third factor is the degree of differentiation, which has correlated with outcome in most studies, anaplastic tumours having a poorer prognosis than the well differentiated ones.[11] This is especially true of the keratinising small cell types.[12]

Considerable controversy surrounds the clinical course of cervical carcinoma in young women (below the 35-40 age group). Early studies suggested that the survival in this group was no different from that of those over 35.[13] Recent experience in Britain, however, has suggested that this is not the case.[14] Patients presenting under the age of 40 with stage IB carcinoma of the cervix have a five year survival below 50%. One third have metastases in the pelvic nodes, and well differentiated keratinising tumours occur in only 6%, as against 25% in those aged over 40 (J M Monaghan, unpublished data). Overall, the patient at highest risk of recurrence has one or more of the following features: youth, a large, poorly differentiated tumour affecting most of the cervix, and diseased nodes. The same pattern is seen in patients with stage IB adenocarcinoma of the cervix.[15]

What can be done for these patients? The conventional treatment for patients with spread of disease to lymph nodes is surgery and adjuvant radiotherapy. Unfortunately, no randomised or prospective trial has been performed on the efficacy of this management—but published retrospective data suggest no survival advantage for patients so treated.[2 6 9 16-20] This may be because the tumour is outside the treatment field or the dose of radiation that can be delivered to the treatment field is insufficient.

A systemic approach seems, therefore, to be more logical, but chemotherapy for carcinoma of the cervix has not received much attention. Studies in advanced or recurrent disease have shown response rates of 10-60% with a range of established anticancer drugs either singly or in combination.[21] Until the incorporation of *cis*-diamminedichloroplatinum II (cisplatin) into the combinations these responses had universally been short lived. Two recent reports, however, have suggested long term complete response rates of 20-30% with combinations of cisplatin, bleomycin, and vinblastine with or without mitomycin C.[22 23] Partial responses were seen in a further 14-43%.[18 19] These results approach those achieved in chemotherapy of ovarian carcinoma.

Only one trial has been reported of adjuvant chemotherapy in patients with early disease treated by surgery.[10] In a non-randomised but prospective study using either a single antifolate or alkylating agent a survival advantage was shown

for treated over control patients. This advantage was most definite in those patients with disease in the lymph nodes or with over half the cervix replaced by tumour.

Further adjuvant studies with cisplatin containing combinations are under way in Australia and in the United States.[24] All these studies include radiotherapy in either the control or chemotherapy arm. If survival figures are to be improved trials should be arranged to evaluate the place of chemotherapy alone in this apparently high risk group with "early" cervical carcinoma.

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Libel and medicine

Last week a settlement was agreed in the high court of the libel action brought by Dr Sidney Gee against the BBC, Esther Rantzen, other members of the *That's Life* team (p 1344). As we went to press, the case against Dr Clemency Mitchell and Dr Roger Blackwood was continuing. The case had begun in October last year but had not yet reached the end of the evidence called on behalf of the plaintiff; the legal costs incurred by the two sides are believed to have amounted to about £1 million, and had the case run its full course would probably have been at least double that figure. The action concerned a BBC television programme in June 1983 which criticised the treatment for obesity given by Dr Gee to a named patient.

The *BMJ* has a particular interest in libel since its own experience in 1972, when an action brought against it in respect of an article on dental anaesthesia was discontinued after 30 days of expensive litigation.[1] The lesson to be drawn from those two cases is that the English legal system is a cumbersome and incredibly expensive way of trying to establish whether criticism by doctors of a line of treatment should be considered unfair. Both cases saw lawyers and judges attempting to grapple with the complexities of physiology, pharmacology, and medical decision making. Both caused scores of medical experts to spend months poring over the details of case notes and preparing evidence —and in both cases many of the experts had not given their evidence when the end came.

No legal aid is available for libel, and as our legal correspondent explains at p 1342 the cost for each party of a high court action may be as much as £2000 a day; with only part of the costs being recoverable the most likely outcome of a long action is that everyone is out of pocket. Even the lawyers are unhappy, since the fees they receive for sitting day after day in court do not compensate for their being unable to take on any other commitments.

There must be better ways of resolving disputes of this kind. The present system fails the classic test of justice not only being done but being seen to be done. It is for lawyers rather than doctors to propose reforms, but some means could surely be devised of establishing a consensus among the expert witnesses, so confining the attention of the court to issues such as the reliability of the evidence given by the parties to the action.

The "answer" as to the problem of poor management within the NHS may lie with the chairman of a large retailing chain. Sir Maurice Hodgson, the chairman of British Home Stores, is at the moment—at the request of the Lord Chancellor—chairing the Civil Justice Review, which is examining ways of streamlining civil litigation, making it faster and cheaper. The committee, which includes both lawyers and lay people, has no plans at the moment to consider libel, but surely it should.

1 Anonymous. Discontinuance of libel case [Editorial]. *Br Med J* 1972;iv:254.