germ cell tumours patients who have them should be managed in specialist centres so they receive optimal surveillance or treatment.

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Growing up with chronic renal failure

Advances in managing end stage renal failure in children have improved both the three year survival—from 80% of those starting in 1976 to 87% of those starting in 1982 (European Dialysis and Transplant Association Registry, 1987 unpublished observations)—and the physical well being of the survivors. Nevertheless, many uraemic children grow poorly and enter puberty late, and all of those who reach end stage renal failure will need medical supervision for the rest of their lives. The quality of their lives may thus be profoundly affected by their psychosocial adjustment, and helping with this presents a continuing challenge to those who care for them. What satisfaction is there in preserving the life of a child if the treatment leaves him an emotionally handicapped adult? Much remains to be learnt about how to help the children who do not adapt well.

In a study of 38 uraemic children, half of them undergoing dialysis, Reynolds and others reported that threats to psychosocial adaptation identified in the early 1970s are still as important and as difficult to treat.¹⁻³ Stress and anxiety in the patients and families may arise from four main sources: adjustment to the uraemic state; problems of growth and unrealistic expectations of the future; practical problems such as enuresis, frequent visits or admissions to hospital, and dialysis itself; and the need for both financial and psychological support for the family.

Difficulties in adjusting to uraemia are particularly great for adolescents and for families with pre-existing marital stress. Families are often ignorant of the available community services, and some suffer from conflicting advice because of poor communication between the hospital services and general practitioners or community agencies. Some parents

can, however, turn the stresses into a source of strength for their marriage,⁴ and we have found that most children undergoing dialysis have indices of self image within the normal range (Winkley and Winterborn, unpublished observations).

The chief requirement for successful psychosocial adjustment seems to be a realistic acceptance by the whole family of the limitations imposed by end stage renal failure. The adjustment will be easier given consistent expert advice, practical and financial help, and, above all, time for giving and assimilating information so that it can be used to change the family's pattern of life. These needs have long been recognised by the medical and nursing staff of paediatric dialysis units, which have enlisted the help of the child psychiatrist, psychologist, social worker, dietitian, and school teacher. The family practitioner has an important job to support the family as well as the patient and to interpret the messages from the dialysis unit. He must be kept well informed. The social worker and family practitioner between them will usually have the most complete knowledge of local community services. Insufficient recognition is given to the telephone network, fostered by parents' meetings, whereby experienced families help newcomers and those whose children have not yet started dialysis.

In helping children and their families come to terms with end stage renal failure everyone must give the same message about the child's capabilities and prognosis; conflicts are common and are likely to hinder adaptation.¹ The most important ingredient of successful adaptation to end stage renal failure is probably time to talk and listen.

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Chemotherapy for stomach cancer

In Britain stomach cancer is still the third commonest cause of death from cancer in men and the fourth commonest in women.¹ An operation is the only cure, and less than 10% of patients survive long term.² Despite distant metastasis being rare at presentation or relapse in most patients, radiotherapy has been considered to have limited value because of the tumour's lack of radiosensitivity. Chemotherapy has therefore been explored as treatment for advanced stomach cancer and as an adjuvant to an operation.

Caution is necessary in interpreting the results of trials of chemotherapy in gastric cancer. Disease response is difficult to measure,³⁻⁵ yet in many studies response rates rather than survival have been used to determine the efficacy of treatment. Comparing trials is not easy because of diverse entry

requirements, differing methods of assessing disease, and variable stratification of known prognostic factors.

Single agent fluorouracil has a response rate of about 20% in patients with advanced stomach cancer.^{6,7} Various combinations of fluorouracil with adriamycin, mitomycin, and lomustine give response rates varying from 20% to 40% but cause greater toxicity.^{6,7} Responses are usually partial and short and do not lead to long term survival. Responders have lived longer than non-responders in many of these studies, but this method of assessing the effect on survival of a particular regimen is inappropriate in these sorts of investigation.⁸ A recent report of combining etoposide, adriamycin, and cisplatin has claimed a response rate of 70%, with 12% of patients attaining complete remission and operation becoming possible in 16%.⁹ These results await confirmation.

No combination of drugs has been proved to be superior to fluorouracil alone¹⁰⁻¹² in terms of overall survival. The combination of fluorouracil, adriamycin, and mitomycin, although suggested as the ideal standard for future studies,¹² has not increased survival compared with other combinations^{11,13-15} or fluorouracil alone.¹¹ No randomised trials have compared single agents with no treatment, but two studies have compared combination treatment containing fluorouracil with no treatment.^{16,17} These failed to show that chemotherapy prolonged survival but can be criticised because the prognostic factors favoured the no treatment arms. Randomised trials have thus not proved that single agent or combination chemotherapy prolongs survival in patients with advanced stomach cancer.

Chemotherapy has been extensively investigated as adjuvant treatment after surgery. Two early trials suggested an improved survival with combination chemotherapy,^{18,19} and subsets of patients seemed to have benefited in some of the large Japanese trials.^{20,21} Most randomised trials have failed, however, to show superiority of either single agent or combination chemotherapy over no treatment.²²⁻²⁷

Although chemotherapy has not been shown to prolong survival in patients with stomach cancer, fluorouracil is the current treatment of choice in patients with advanced disease who are symptomatic or who have difficulty in coping with not receiving treatment. Although response to fluorouracil occurs in only a few patients, the toxicity is modest and symptoms may be relieved. Unless symptoms cannot be alleviated by other means, patients should not receive chemotherapy for gastric cancer unless included in randomised trials or studies investigating new agents. Promising new treatments should be compared with no treatment.

The cure rate for stomach cancer has not improved in 50 years despite chemotherapy.²⁸ New drugs or different treatments are urgently needed.

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Testing for HIV: the medicolegal view

The annual representative meeting of the BMA earlier this year passed a motion to say that in certain circumstances doctors should be able to test for antibodies to the human immunodeficiency virus (HIV) without first gaining the patient's consent. Because of worries about the legality of testing without consent the BMA commissioned an opinion from Michael Sherrard QC and Ian Gatt. Their opinion, which I endorse and which is published in full on p 911, is that doctors could risk civil or even criminal proceedings if they test for antibodies to HIV without the patient's consent. This opinion will not be universally welcomed among the ranks of the BMA, and lawyers are divided on the subject. Some suggest that patients with a "perplexing presentation" might be taken to have given an implied consent to any tests designed to find out what was wrong with them.

There is no case law directly on the question of consent to testing, and the cases discussed by Mr Sherrard and Mr Gatt all turn on the question of consent to treatment rather than specifically to testing. But the doctor owes patients the same duty of care in everything he does for them in the course of exercising his professional skills.