community services are provided. They may degenerate into a form of probation, with brief statutory home visits to supervise medication. In their favour, community treatment orders cut both ways. They both commit the patients to treatment and commit psychiatric teams to providing continuing care for these most disabled and challenging patients.

GRAHAM THORNICROFT

Department of Psychiatry and Behavioural Sciences,
Johns Hopkins Hospital,
Baltimore, MD21205

1 Geller J. Rights, wrongs and the dilemma of coerced community treatment. *Am J Psychiatry* 1986;143:1259-64.

Secretor state of patients with insulin dependent or non-insulin dependent diabetes mellitus

SIR,—Like Dr Caroline Blackwell and colleagues (24 October, p 1024), we compared the secretor state of 105 diabetic subjects with that of 97 age and sex matched non-diabetic individuals. Our study group comprised 55 patients with type I diabetes and 50 with type II diabetes, and the secretor state was assessed by a standard haemagglutination method using mixed saliva.¹ Statistical analysis was by χ^2 test. There was no significant difference in the distribution of ABO blood groups between those with type I and those with type II disease (table).

Proportions of secretors and non-secretors. Figures are numbers (and percentages) of patients

Study groups	Secretor state	
	Secretor	Non-secretor
Type I diabetes (n=55)	30 (54.5)	25 (45.5)
Type II diabetes (n=50)	35 (70)	15 (30)
Controls (n=97)	65 (67)	32 (33)

Our data therefore cannot confirm those of Dr Blackwell and colleagues but are consistent with previous reports that the occurrence of diabetes mellitus is independent of ABH (O) secretor state.^{2,3}

P-J LAMEY

L P SAMARANAYAKE
T W MACFARLANE

Department of Oral Medicine
and Pathology,
Glasgow Dental Hospital and School,
Glasgow G2 3JZ

1 Periera M, Dodd BE, Marchant JV. The detection of A, B and H group specific substances in stains from body fluids by absorption-elution and mixed agglutination techniques. *Med Sci Law* 1969;9:116.

2 McAfee AL. Blood group and diabetes mellitus. *J Clin Pathol* 1964;17:39.

3 Doll R, Drane H, Newell AC. Secretor of blood group substances in duodenal, gastric and stomal ulcer, gastric carcinoma and diabetes mellitus. *Gut* 1961;2:232.

Hormonochemotherapy in advanced breast cancer

SIR,—The report by Mrs Margaret W Ghilchik and others (7 November, p 1172) produces yet another regimen in which a high response rate is claimed in advanced breast cancer. Hitherto such claims have turned out to be overexaggerations, and there is no reason to think that this is the exception.

This is not a sequential series, and a group in which response is likely to be excellent can be defined by case selection.¹ If only those patients predicted to have good survival were treated then a very good response rate would be achieved with

any therapy used. The criteria for admission to the study are not described.

The study is not a trial of hormonochemotherapy against some standard therapy such as hormone therapy alone. Furthermore, the judgment of response lacks external review.

R W BLAMEY

City Hospital,
Nottingham NG5 1PB

1 Williams MR, Todd JH, Nicholson RI, et al. Survival patterns in hormone treated advanced breast cancer. *Br J Surg* 1986;73:752-5.

SIR,—The results of Mrs Margaret W Ghilchik and colleagues in 40 patients with advanced breast cancer are most impressive. This is so even when the six patients dying from progressive disease before completing the course are included in the denominator to give an overall response rate of 78%. Also impressive is the high proportion of patients who completed several weeks of daily intramuscular medroxyprogesterone. What I cannot understand is the table, where the figures do not seem to fit with the text.

Firstly, 38 sites are listed for the 34 patients assessed so presumably only four patients had more than one site affected. Sixteen patients (text) had a complete response (all disease sites back to normal for at least four weeks by the definition of the International Union Against Cancer) yet only 12 completely responding sites are listed. The 15 patients who had a partial response (text) have 22 sites listed with average durations of six, five, seven, and six months. Do these figures represent the durations of complete response which occurred in partially responding patients as suggested by the text? If so, then they cannot be "means" since by my calculations only four patients had more than one site affected. They certainly cannot represent the durations of partial remissions by site since for the 15 patients in this category the mean duration is given as 11.6 months. An explanation of these discrepancies should be given in view of the excellent overall results reported.

HELEN J STEWART

Scottish Cancer Trials Office (MRC),
Edinburgh University Medical School,
Edinburgh EH8 9AG

AUTHORS' REPLY,—We could not include all the details we would have liked within a 600 word short report. The criteria for entry to this study (we did not claim to be carrying out a trial) was advanced breast cancer as defined in the paper. Most of the patients were moribund; hence the deaths of six before they could complete one treatment cycle. Our case selection was of a group who were expected to do badly and the results are not an overexaggeration but an account of the results we obtained.

Regarding points raised by Ms Stewart, eight of the 34 patients had disease at more than one site in addition to large tumour size, with all sites being used to assess response. The average duration of disease free interval for patients with disease at different sites who showed a partial response does represent the mean duration before progression of disease. The mean disease free interval of 11.6 months for patients showing a partial response included the results from two patients who had a long term arrest of disease (five and three years) but who were not disease free. The average duration of disease free interval calculated without these two patients was 6.5 months.

Current results of treatment of disseminated breast cancer are not so good that we should not explore new treatments, particularly in the light of

recent scientific advances in our understanding of the disease and in the progress in treatment of other solid tumours. Our results are encouraging and warrant a comparative trial. We would welcome collaboration from other centres in Britain in such a trial and agree with Professor Blamey that external review of response would be required.

M W GHILCHIK

N A SHAIKH

P A BERANEK

M J REED

St Charles Hospital,
London W10 6DZ

SIR,—The encouraging report from Mrs Margaret W Ghilchik and colleagues described a response rate for metastatic breast cancer of 91% to cyclical sequential hormonochemotherapy (7 November, p 1172).

Response to treatment in the 34 patients who were evaluated was assessed using the International Union Against Cancer guidelines¹ described a decade ago, when perhaps the most important criterion laid down was that of external review of all clinical and radiological data. Too often this criterion is not fulfilled. It is most important when reporting such dramatic improvements in overall responsiveness of advanced disease that a statement should be included to allay fears that external review had not been obtained.

We are also concerned that the duration of response should be sufficient to confirm real benefit for the patients studied. We note that in this report the mean duration of partial response was not more than seven months in any subgroup of patients studied. In those patients with bone metastases (the commonest site for distant metastasis) the mean duration of partial response was five months only. The British Breast Group² has suggested that response should be defined as any objective remission of at least six months, and the fulfilment of this stipulation would promote consistency when reporting therapeutic trials.

The enormous variation in reported response to similar treatment will continue until a truly objective assessment of therapeutic benefit is possible by the use of biochemical markers.

M R WILLIAMS

Dudley Road Hospital,
Birmingham B18 7QH

M P MOHAJER

City Hospital,
Derby

1 Hayward JL, Carbone PP, Heuson JC, Kumaoka S, Segaloff A, Rubens RD. Assessment of response to therapy in advanced breast cancer. *Cancer* 1977;39:1289-94.

2 British Breast Group. Assessment of response to treatment in advanced breast cancer. *Lancet* 1974;ii:38-9.

Euthanasia in The Netherlands

SIR,—Dr Mary Bliss and others state that "voluntary euthanasia has been effectively legalised in The Netherlands for several years" (14 November, p 1276). This information is not correct.

Euthanasia is still a criminal offence in The Netherlands. Under article 293 of the penal code any person who terminates the life of another person at the latter's request is liable to up to 12 years' imprisonment.

For the past 10 to 20 years the public debate has focused on the question of whether the criminal law on the termination of life on request should be amended so that a doctor who performs euthanasia on a patient who is undergoing intolerable (not necessarily merely physical) suffering is no longer liable to punishment. In July 1985 the State