solved by sending a copy of the discharge letter (under confidential cover) with the patient to the home's medical officer, as is the practice in Cornwall.

We echo Professor MacLennan's views on the maintenance of standards and the need for proper assessment before admission, particularly when demand is made on the public purse. We should examine the anomalies produced by the private sector's rapid expansion, learning from the experience that has led to this recent growth, and positively respond to the challenge of providing long term care of the highest possible quality.

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1 Anonymous. *Laing's review of private health care*. London: Laing and Buisson, 1987.
2 Anonymous. Rising numbers of very elderly [Editorial]. *Lancet* 1988;i:603.

SIR,—Professor W J MacLennan rekindles the debate about who should be responsible for the longstay care of the disabled elderly (12 March, p 732).

One major criticism he levelled against the private sector provision of such care was that physically alert but disabled people are likely to be placed with those suffering from severe dementia. If the findings from a recent study we conducted on the degree of mental and physical disability in the longstay wards of our geriatric department are representative this is what currently obtains in the public sector. Of 50 randomly selected patients in our longstay wards, 19 were alert, three were suffering from moderate dementia, and 28 (56%) were suffering from severe dementia; all were severely physically disabled, none scoring more than 20 on Barthel's activities of daily living index. In fact the patients with dementia were more severely physically disabled than those who were alert (table). Dementia was the single commonest reason for admission to the longstay wards.

Comparison of activities of daily living scores in patients in longstay wards

	No	Score		
		Mean	SD	SEM
Demented	31	8·52	5·43	0·98
Alert	19	12·21	5·12	1·17

$t=2{\cdot}42$; $p<0{\cdot}02$.

Modern geriatricians are motivated to develop assessment and rehabilitation services which allow the rapid throughput of larger numbers of the ill elderly and must not neglect their responsibility for placing those who require nursing care in a longstay environment.

Standards of care in private nursing homes must be ensured,[1] but so too must those in the public sector. Quality of life may be assessed casually or systematically[2] but there have been few studies of this type in either sector. Studies in the two differing environments might be most illuminating in showing what these elderly disabled people value about good health and what aspects of their ill health and living environments cause most concern.

As a society we are entitled to the most economical way of catering for those in need of long term care, though it seems that the methods used are sometimes determined not by the needs of the patients themselves but by political doctrine. Perhaps, as Dr Tessa Richards points out (5 March, p 659), what is required in Britain is more money spent on research related to the elderly so that among other things the best care packages for the disabled (and demented) elderly requiring long term nursing care can be determined.

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1 Day P, Klein R. Quality of institutional care and the elderly: policy issues and opinions. *Br Med J* 1987;**294**:384-7.
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Controlling symptoms in advanced cancer

SIR,—Dr T D Walsh's and Dr T S West's unbalanced article needs some redressing. May I take the omissions in order.

Firstly, pain from late stage solid tumours can be helped by local radiotherapy. This can even take the form of a single session of treatment—unconscionable in early disease but most convenient in late disease. With multiple lesions half body radiotherapy may be an acceptable short cut as well.

Secondly, four hourly morphine is passé. The sustained release type is now standard issue. The 10 mg tablets are probably too small; one should start with 30 mg twice a day and work up. There is a sustained release dihydrocodeine tablet from the same stable which is also useful in moderate pain. (I once worked a one in one rota, and the concept and desirability of an undisturbed night's sleep that sustained release products afford has not escaped me.) Also, the formulation appears to be less attractive to drug abusers.

Thirdly, I usually leave psychotropic drugs to my hospice colleagues; indeed their services have become indispensible. I am careful not to abuse the service by foisting social problems on them.

Fourthly, respiratory deaths are to be avoided; they equate with death by panic. Good, planned radical radiotherapy for bronchial carcinomas render local recurrence less likely. On an outpatient basis it costs only a few hundred pounds. If a patient has lymphangiitis and has never had radiotherapy why not consider it?

Rather surprisingly, the common problem of multiple lung metastases with dyspnoea has not been addressed. In my view it is an oncological emergency. In the case of a breast primary tumour I would advocate a combination of cytotoxic drugs plus steroids with a clearly greater than 50% chance of working. Such a combination might be ifosfamide plus mesna and (say) epirubicin or mitozantrone. It is no good pussyfooting around with weekly epirubicin or three weekly mitozantrone; these schedules should be reserved for the less acute condition, in which they are finding increasingly widespread acceptance.

Finally, I agree that suicide is rare. I have known a patient seriously overplay his hand with otherwise caring relatives, but psychopaths are not immune from cancer; indeed they do very badly.

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AUTHOR'S REPLY,—Our article was under the title "New Drugs" so Dr Xavier's comments about radiation therapy are redundant, although I am surprised he considers radiation suitable therapy for lymphangiitis carcinomatosis.

At the beginning of the article we gave adequate recognition to the potential benefits of chemotherapy, although this was not the focus of our article. It is, however, noteworthy that the role of chemotherapy used specifically to relieve symptoms in advanced disease is largely unproved.

I strongly disagree that the use of morphine given four hourly is passé. It is an important component of our analgesic drug therapy and the most flexible and efficacious method of dose titration to achieve pain control.[1,2] It is also invaluable as a "rescue" analgesic for pain breakthrough between doses of the sustained release morphine tablets.[3] We did in fact describe the practical use of these tablets and comment on their convenience.

Many radiation therapists and medical oncologists are untrained and unskilled in the symptomatic care of people with advanced cancer, and Dr Xavier's enthusiasm and interest in this subject is therefore welcome.

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Dietary management of gastroenteritis

SIR,—While endorsing the recommendations made by Dr B A Wharton and others (13 February, p 450) on the importance of oral rehydration, the questionable benefit of regrading, the need to continue breast feeding, and the uselessness of drugs in the management of childhood gastroenteritis, be it in Britain or the developing world, I must take issue with the assertion that home made salt and sugar solutions should not be used.

Britain has lagged behind the developing world in treatment by oral rehydration. Reliance on intravenous fluid and slow regrading remains common, leading to prolonged hospital admission and unacceptable "therapeutic starvation."

In Zimbabwe oral rehydration using a home made salt and sugar solution (consisting of 6 level teaspoonfuls of sugar and half a teaspoonful of salt in a 750 ml fruit squash bottle full of water) is one of the main components of the primary health care programme. This solution provides early and effective treatment in the home and is backed by an extensive teaching programme and a philosophy of self reliance in health care. The same solution is used in hospital to reinforce mothers' belief in its efficacy. Recent studies have shown that even illiterate mothers can recall correctly the local formula, understand its use, and make up an acceptable solution.[1]

The only published study comparing salt and sugar solution with the complete formula recommended by the World Health Organisation has shown both to be equally effective in correcting dehydration, although more vomiting occurred in the group receiving the salt and sugar solution and some of these were hypokalaemic.[2] This was not associated with adverse clinical effects or failure of treatment. The occurrence of hypokalaemia has been confirmed in a recent Zimbabwean study and potassium supplementation of salt and sugar solutions is recommended.[3] However, few children in Britain are severely dehydrated or hypokalaemic at presentation.[4]

Parents and doctors may learn from countries

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like Zimbabwe, India,[5] and Egypt,[6] where the widespread use of home remedies has reduced mortality from acute diarrhoeal disease. The principles of oral rehydration in acute gastroenteritis should be common knowledge among parents in Britain (as it is in Zimbabwe) and they should be encouraged to make up solutions as a first aid measure before seeking medical advice.

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Patients' assessment of out of hours care

SIR,—In their paper on out of hours care in general practice (19 March, p 829) Dr Mary Bollam and colleagues acknowledge that their sampling frame contains only patients who succeeded in contacting a practice doctor.

A total of 1027 calls were recorded during a composite four week period and the 177 calls analysed in greater detail resulted in 123 visits. This suggests that 714 visits would have been made by or on behalf of the 59 principals working in the urban group practices which participated in the study, the equivalent of almost 160 out of hours visits per general practitioner per year. If we assume the national average of 2000 patients per principal this represents 80 such visits for every 1000 registered patients and correlates well with previously reported findings from general practice. The number of patients who attend accident and emergency departments outside normal hours, however, is significantly higher and is now more than 100 visits per 1000 population per year. It is therefore possible, and even probable, that the total number of out of hours calls received during the period of study significantly underestimated the number of patients who sought medical advice outside normal hours during that time. Indeed, Dr Bollam and her colleagues acknowledge that parents of children under the age of 16 were consistently less satisfied than older patients, and the letter from Dr Herman in the same issue (19 March, p 860) draws attention to the high number of self referred children seen in accident and emergency departments at nights and weekends.

Some of these hospital attendances may seem to be inappropriate or even unnecessary, but for whatever reasons, and they are often complex, more patients are seen in accident and emergency departments outside normal hours than are visited by a general practitioner during these times. Many of these departments have insufficient medical staff to cope with the increasing demand but they need to recruit about 60% of medical graduates every year to fill the junior posts that do exist. It is not surprising, therefore, that some posts remain unfilled and that the resulting pressure in these departments is immense. The Casualty Surgeons Association is bringing this serious situation to the attention of the Minister of Health in the hope that some solutions can be found to a problem which has been long recognised but remains unresolved.

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Hypnotic drug use among the elderly living at home

SIR,—We agree with Dr Kevin Morgan and others about the high prevalence of hypnotic drug use in elderly people (27 February, p 601).

With the help of a group of general practitioners our department carried out an epidemiological study on a large elderly population living at home in Brescia, Italy. One of the measures assessed was insomnia and the pattern of drug consumption in 1201 70-75 year olds (386 men and 815 women).

Our data indicated that insomnia (subjectively reported) was frequent in the elderly: 38% of men and 54% of women suffered from this sleep disorder. Only 43% of those suffering from insomnia used hypnotic drugs, while 10% took sleeping pills despite the absence of this symptom. Thus 26% of the total elderly population took regular hypnotic drugs, mainly benzodiazepines (82%), barbiturates (15%), and neuroleptics (3%).

Sleep disorders are often related to loss of life satisfaction and worsening of both physical and psychological wellbeing experienced by the aged: insomnia, however, is not a necessary consequence of aging itself. Adequate care of sleep disorders in the elderly should direct our attention not only to the high prevalence of hypnotic drugs used and their possible side effects but also to the high proportion of the elderly suffering from insomnia and not receiving adequate pharmacological or psychotherapeutic treatment.

As physicians concerned in the comprehensive care of the elderly we must address our efforts towards recognising insomnia and at the same time towards a rational therapeutic approach. There would be little benefit to the health of the elderly if our concern for the incorrect use of psychotropic drugs influenced negatively our ability to improve sleep conditions, which are of particular relevance to wellbeing during aging.

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Section 47 of National Assistance Act: a time for change?

SIR,—I agree with Dr J D Fear and his colleagues (19 March, p 860) that section 47 requests often follow a breakdown of social support for the elderly. Community physicians in Birmingham put this information to positive use and attempt to find out and correct weaknesses in the safety net in the provision of care for the elderly.

Social workers are required by the local authority to complete an extensive protocol, while community physicians ask the general practitioners for a joint domiciliary visit for every section 47 request. This is followed by a case conference, and an attempt is made not only to resolve a particular situation but also to ensure that it does not happen again. The system works well.

General practitioners have the competence to provide leadership in such cases as suggested, but I doubt they would have the time and the know how to resolve complex issues of patient care. In maintaining that the community physician should not be concerned with implementing section 47 the Acheson report has grievously misled itself in not appreciating that a report for a section usually points to a service deficiency, which is the bread and butter of community medicine.

A section 47 admission is not carried out in Birmingham if any party to the case conference or relative objects to its use, provided he or she has the needs of the patient as the prime interest. An appeal mechanism or an independent advocate to represent the interests of the patient would be useful only if the independent advocate, for example, would be in a position to provide an alternative source of care.

Changes in the law are always difficult to bring about and new laws are not necessarily any better than the old ones. I believe that the provisions of section 47 are generally used to positive effect with compassion and due regard to the rights of the patient and there is little evidence to show that section 47 is misused or abused.

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A licence for breast cancer screening?

SIR,—Dr J B Witcombe must be applauded for his emphasis on the necessity for quality control in the breast screening programme (26 March, p 909), an aspect of health care often ignored in an era biased towards cost effective policies. As he highlighted, radiological skills remain undeniably the most important front line aspect of the programme. In the final instance, however, mammography merely divides the population into either "normal" or "abnormal requiring assessment." The ultimate diagnosis of benign or malignant breast disease results from the application of cytological or histopathological skill.

It is consequently unfortunate that pathology comprised such a small component of the Forrest report. The stated consultant requirements (0·1 whole time equivalent per week per basic screening unit) are now widely considered to have been underestimated by at least 100%. Also, regrettably, no consideration was given to medical laboratory scientific officer staffing or workload. Pathologists now have the unenviable task of defending such omissions to implementation managers, and, needless to say, financial resources remain inadequate. Even with the necessary resources, however, it is improbable that enough trained cytopathologists will be available in the foreseeable future; these numbers are already inadequate for the cervical screening programme. There must also be doubt whether individuals will want to restrict their professional activities to such limited areas of pathology, especially with the presumed medicolegal implications of false positive cytological diagnosis.

Probably, however, the most serious omission from the Forrest report was a requirement for the quality control of cytology and histopathology. If pathological diagnostic accuracy cannot be assured the value of treatment becomes questionable, and data interpretation becomes pointless. Any overdiagnosis of benign or borderline breast lesions as malignant will be reflected in long term improvements in mortality from breast cancer. Although this mortality trend will be acceptable to the government and will lend support to the value of the screening programme, these improvements will be false and will have been achieved at the

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