life Metchnikov strictly followed his own dietetic rules but nevertheless suffered from ischaemic heart disease and severe atherosclerosis.⁷ He died in Paris in 1916 at the age of 71.—I am, etc.,

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Predicting Survival in Terminal Cancer

SIR,—Dr. C. Murray Parkes (1 April, p. 29) reported on the inability to estimate survival of terminal cancer patients. Our experience with somewhat less ill patients has been that our colleagues are able to forecast survival with some accuracy.

In a controlled co-operative clinical trial designed to study the survival of lung cancer patients treated with methotrexate participating physicians were asked to predict survival prior to entering a patient onto study. Though protocol required that estimated survival be at least two months, seven patients with an estimated survival time of less than two months were admitted to the trial.

TABLE 1—Estimated and Median Actual Survival Times in 178 Patients with Lung Cancer

Estimated Survival (Months)	No. of Patients	Median Actual Survival (Weeks)
Two or less ..	33	6
Three or less ..	46	12
Four or less ..	44	19
Five or more ..	55	22

Table 1 shows the estimated and median actual survival times. The actual survival times are in good agreement with the estimated, and clearly our physicians can distinguish between a patient with a prognosis

TABLE II—Number of Underestimated and Overestimated Survivals in each Prediction Group

	Total	Prediction Group (Months)			
		Two	Three	Four	Five or More
Underestimated (Actual Survival greater than expected) ..	86	15	22	23	26
Overestimated (Actual Survival less than expected)	92	18	24	21	29
Percent underestimated	48	45	48	52	47

of two months or less and a prognosis of five or six months (only three patients had estimated survivals of more than six months). Survival curves in Fig. 1 (plotted on semi-log scale) also show that the physicians can separate the three-month group from both the two-month and the four month group. Differences in survival between the estimated four-month group and the five-month group are small but in the direction expected.

When one looks at data on the individual patient it can be seen that our physicians underestimated survival just about as often as they overestimated. Table II shows the number of underestimated and overestimated survivals for each prediction group. The proportion underestimated in the two-month prediction group was about the same as that for the five-month plus group (no trend in overestimating was seen with increased estimates of survival).

We believe that the ability of our colleagues to estimate survival may provide us with another parameter against which to measure the effectiveness of a treatment. A full report on the trial and on the effects of methotrexate is in preparation.—We are, etc.,

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Radioisotope Detection of Venous Thrombosis

SIR,—Dr. K. Jeyasingh and others (26 August, p. 500) make two assumptions for which they do not provide any evidence. The first is probably true except under particular conditions (for example, trauma) and is assumed by most investigators who use the ¹²⁵I-fibrinogen test. The second can rarely be made for two reasons.

Firstly, vasomotor and in particular venomotor tone is variable. Even if the limbs are elevated local changes of venous capacitance may produce pooling of radioopaque dye or radioisotope. Such changes may cause local alterations in radioactivity,¹ and though these often may not persist for 48 hours they must be taken into account. When comparison is made with the other limb over this period a diagnostic error is unlikely. However, comparison with the precordial count will permit bilateral changes of vascularity to appear as "thromboses." Secondly, the precordial count may be affected by myocardial infarction so that the reference point is not constant.²

It is necessary to establish a new test by some existing criteria—for example, pathological or venographic evidence. The latter may not show small thromboses which the established ¹²⁵I-fibrinogen technique demonstrates. If the latter is their criterion the new

test they are introducing has a high incidence of false-positive results. We still do not know the clinical importance of ¹²⁵I-fibrinogen-positive thromboses. Even the simplest test is time-consuming and must be proved before it should be generally applied.—I am, etc.,

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Guillain-Barré Syndrome after Measles

SIR,—One may question whether the two cases of Guillain-Barré syndrome after measles described by Drs. Gunilla Lidin-Janson and Ö. Strannegård (3 June, p. 572) had either disease. The morbilliform rash described may occur with a variety of viral and other diseases besides measles. Koplik's spots, a characteristic of measles,¹ apparently were not seen. The serologic data are not convincing either, indicating only that both patients had experienced measles at some time. The fall in complement fixation antibody suggests that infection was recent, without pinpointing the time, only if acute and convalescent sera were done in the same test.² Thus, neither the clinical nor laboratory data support the diagnosis of measles "beyond doubt."

Nor should one accept without question the diagnosis of Guillain-Barré syndrome in these patients—rather they would seem to have had primarily encephalomyelitis with a polyneuritis, which has been described previously following measles and other infectious diseases.^{1,3} To diagnose the Guillain-Barré syndrome one should find increased protein in the C.S.F. without an increase in cells.³ The latter data were not provided for either patient.—I am, etc.,

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Levodopa and Arrhythmias

SIR,—I was interested to read the paper by Dr. R. B. Jenkins and others (26 August, p. 512) on levodopa therapy in 40 patients with Parkinsonism and heart disease. Since coronary heart disease and Parkinsonism often occur in the same age group it is reassuring to note that little increased hazard attended the administration of levodopa in their series of cases.