

appear in the marrow and peripheral blood. This blastic phase is treated in the same way as acute leukaemia, with 6-mercaptopurine and prednisone, but rarely with any lasting benefit.

### General Management

The diagnosis of leukaemia requires expert examination of the blood and bone marrow, and the decision regarding the necessity or advisability of giving any drug is not always easy. At the present time therapy can be given only under hospital supervision, and frequent examination of the patient and his haematological state are required.

Early signs of remission include a rise in the number of normal granulocytes and platelets with healing of infected lesions and cessation of a bleeding tendency. Later the haemoglobin rises. A fall in the total leucocyte count is not always followed by remission.

Patients with acute leukaemia usually need to be in hospital for initial treatment, and thereafter must attend an out-patient department every one to four weeks even when they seem well. Patients with chronic leukaemia can often be cared for on an out-patient basis, but still have to be seen at least once every three months. If any patient is on maintenance treatment he should attend hospital every four to eight weeks.

Although the incidence of leukaemia is increasing it remains a rare disease, and treatment of these patients is best carried out by people with considerable experience in this field.

### Effects of Treatment

Acute leukaemia in childhood now has a median survival of 12 months, compared with six months prior to the use of modern drugs. About 50% of the patients have remissions, provided the initial treatment is continued for at least eight weeks and great care is taken in the first weeks of treatment to control severe blood loss and severe infection.

Acute leukaemia in adults responds to treatment in only 15% of cases. The difference in the percentage of responses

is probably due to the greater incidence of the lymphoblastic type of leukaemia in children. An adult suffering from acute leukaemia rarely survives longer than 12 months from the date of diagnosis.

Chronic lymphocytic leukaemia may run a very slow course and patients suffering from this disease are frequently not treated unless or until symptoms occur. Prognostication is extremely difficult because although 50% of patients die within four years of diagnosis many remain fit and well for 10 years or more. Some survivors of 30 years from diagnosis have been reported.

Chronic granulocytic leukaemia has 50% survival of just over three and a half years from diagnosis. But again, many patients are alive and well six to seven years after treatment begins.

### Quality of Remissions

When a patient is said to be in clinical remission he feels well, can lead a normal life, and is only restricted by taking the proper medication and paying frequent visits to hospital. If a patient with leukaemia could be kept in this state he would be no worse off than a diabetic, but at some time or other resistance develops and changing to another drug is rarely effective.

While large numbers of patients are being successfully managed on cytotoxic drugs on an out-patient basis it cannot be emphasized too strongly that these agents are highly dangerous. Overdosage may show no immediate toxic effects, and by the time severe marrow damage is obvious effective treatment may not be possible. No patient should be given a large supply of tablets because of the danger of continuing to take the drug without proper inspection of the blood count and because of the danger to other people, particularly children, of taking the drug in error.

**Correction.**—In the "To-day's Drugs" article of October 5 (p. 854) the tablet size of "didrex" (benzphetamine) was incorrectly given as 250 mg. and the recommended daily dose as 250 to 750 mg. The correct tablet size is 25 mg. and the suggested daily dosage between 25 and 150 mg.

## ANY QUESTIONS?

We publish below a selection of questions and answers which are of general interest.

### War Wounds and Death Duty

**Q.**—Is it true that there is a section in the Finance Act exempting from death duties the estates of those dying as a result of war wounds? Does it make any difference whether the war wounds were the direct or a contributory cause of death? Should such deaths be reported to the coroner?

**A.**—Section 71 of the Finance Act, 1952, states that "Estate duty shall not be chargeable by reason of the death . . . of a person in whose case it is certified by the Admiralty, the Army Council, the Air Council, or the Secretary of State that the deceased died from a wound inflicted, accident occurring, or disease contracted at a time . . . when the following conditions were satisfied. . . ." This refers to deaths after March 12, 1952. The conditions are that the person was a member of the Armed Forces of the Crown, or a member of one of the women's auxiliary forces, or was subject

to the law governing any of those forces by reason of association with those forces, and was on active service, or other service of a warlike nature, at the time when the wound, etc., occurred. This section also applies in the case of a person, who otherwise satisfies the above conditions, who suffered from a disease when he joined the Forces and whose death has been due to or hastened by the aggravation of that disease during his war service.

The importance in another connexion, so far as dependants are concerned, of doctors recording on a death certificate a war disability when it is a contributing cause of death has previously been referred to in the *Supplement*<sup>1</sup> and in a recent letter in the *Journal*.<sup>2</sup> It is helpful to ascertain whether the deceased was in receipt of a disability pension.

As will be seen from the above extract from Section 71 of the Act, the Service Departments or the Secretary of State must certify that the deceased "died from

a wound," etc. There might possibly be circumstances where such a certificate could not be issued if the war disability is stated in part II of the death certificate to be a significant condition, contributing to the death, but not related to the disease or condition which caused the death.

Where doubt exists whether a war disability is a cause of death it would be wise to refer the case to the coroner. Reference to the procedures open to the coroner and to post-mortem examinations in the case of war injuries and other pensionable conditions is made in *Jervis on Coroners*.<sup>3</sup>

### REFERENCES

- <sup>1</sup> *Brit. med. J., Suppl.*, 1962, 1, 9.
- <sup>2</sup> *Brit. med. J.*, 1963, 2, 1063.
- <sup>3</sup> Purchase, W. B., and Wollaston, H. W., *Jervis on Coroners*, 9th ed., 1957. Sweet and Maxwell Ltd., London.

### Fetor Hepaticus

**Q.**—How early in liver disease can fetor hepaticus be detected? What is it due to?

**A.**—Fetor hepaticus is a sweetish, slightly faecal smell to the breath encountered in patients with hepato-cellular