priority after initial alarm, inadequate assessment and care plans, avoidance of confrontation, little cooperation between agencies, ineffective interventions, and a lack of policies despite general agreement that they were needed and that elder abuse was important.11

Fisk has suggested that physicians and psychiatrists for elderly people (as well as social workers, primary health care teams, and the police) are especially well placed to detect elder abuse. A lower threshold for suspicion, despite the abused person’s denials, may be required than has prevailed up till now. Once abuse has been confirmed the priorities for action are, firstly, the safety of the victim; secondly, the physical and psychological health of the victim; thirdly, the physical and psychological health of the abuser; and, fourthly, a plan to prevent recurrence of the abuse. Preventive measures might include information packs on caring for elderly people; support groups—self help or supervised; financial support for carers; physical, psychological, and financial support for elderly people; and specialist teams (from health authorities and social services) to detect, intervene in, and prevent elder abuse. Legislation may be needed to provide for mandatory reporting of abuse and protection for vulnerable elderly people.

Some may be sanguine about the effects of the implementation of the white paper Caring for People next April.12 More are deeply concerned that there will be a period of chaotic struggling to assess priorities for scant resources—when the needs of many old people and their carers will not be met. An audit of elder abuse, using the baseline now offered by Ogg and Bennett, should be required by potential purchasers. It may help to give some political ammunition to those who insist that worthy intentions must be seen to work.

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Corticosteroids in advanced cancer

If they are not working stop them

Systemic corticosteroids are used for their specific and general effects in patients with advanced cancer.1 For their specific anti-inflammatory effects they are used in raised intracranial pressure, compression of the spinal cord, and obstruction of the superior vena cava or other hollow organ.24 In addition, in one third of elderly patients with breast cancer corticosteroids result in regression or cessation of progression of their cancer for as long as one year.3 Patients with prostatic cancer may obtain similar benefit.4

The general effects of corticosteroids include improved appetite, mood, and strength. In a controlled trial of methylprednisolone 32 mg a day for two weeks in 40 patients with terminal cancer, appetite increased in 77%, mood in 71%, and activity in 68%.7 Consumption of analgesics decreased in 71%. All patients continued taking methylprednisolone for a further 20 days; most measures had worsened by the end of this time, although there was still significant benefit compared with baseline values. This worsening could reflect either the loss of effect of the drug or the progression of disease, or both.

Another controlled trial also found that the effects diminished with time.1 In this trial dexamethasone 3 mg and 6 mg daily were compared with placebo—the higher dose being comparable with methylprednisolone 32 mg. Subjective improvement in appetite and strength was noted after two weeks but had disappeared by four weeks.

The benefits seen in time limited trials are much better than those reported in this issue of the journal by Needham et al (p 999).9 These authors surveyed corticosteroid use by 100 patients admitted to a hospice for terminal care. On admission 33 patients were taking corticosteroids, and seven had done so in the past. Of the 28 patients who completed the questionnaire, only eight said that they had benefited; nine were undecided and 11 said that they had not benefited. Five of the 11 who said that they had not benefited had started treatment more than one month before; among those who were undecided was a woman who had been taking prednisolone 30 mg daily for two years. Patients who had taken corticosteroids were more likely to complain of anorexia, weight loss, or weakness than those who had not.

Needham et al initiated their survey after three patients had been admitted within a month with severe adverse effects from corticosteroids (proximal myopathy, excessive weight gain, and skin changes). Other reports have also highlighted proximal myopathy and, less commonly, avascular necrosis of bone.8 10 11 Furthermore, in a prospective survey of several hundred patients with advanced cancer who received corticosteroids nearly one third developed oral candidiasis, accounting for four fifths of all such cases in that unit.1 One in 10 experienced hypomania, agitation, hyperkinesia, or insomnia, and in one in 20 treatment with corticosteroids was stopped because of unacceptable adverse effects.1

Pepitic ulceration may occur,12 although the concurrent use of non-steroidal anti-inflammatory drugs may be responsible.13 Necropsy studies in patients with cancer have shown that death may be precipitated by complications of peptic ulceration (such as bleeding or perforation) in 5% of patients receiving corticosteroids compared with 1% of others.13 Although a risk of this order is acceptable in patients with a specific need for corticosteroids, it cannot be ignored in other circumstances.

It is disturbing, therefore, that Needham et al found that more than half of the patients receiving corticosteroids did not know why they were taking the drug or how long they were meant to continue taking it. More than two thirds did not have a steroid card, and a similar proportion did not know that long term corticosteroid treatment should not be stopped suddenly. If this sample is representative it seems that, once started, corticosteroids are stopped only rarely and that the impact of the treatment is not adequately monitored. Needham et al conclude that many doctors do not exercise the same care with
corticosteroids in patients with advanced cancer as they do in
patients with other conditions.

As an essential safeguard, therefore, doctors should state
clearly in their notes why a corticosteroid is being prescribed
and tell their patients why. Except where the aim is to control
the tumour, the corticosteroid should be prescribed initially
on a trial basis for no more than a week: the chances of
obtaining a better response after this time are poor.5 Treat-
ment should be continued only if subjective or objective
benefit occurs. Using corticosteroids for their general effects
(those on appetite, mood, and strength) should be avoided
as far as possible in anxious patients and in patients with
diabetes because of the risk of worsening the associated
condition.

Stopping corticosteroids abruptly after a week is safe if no
more than prednisolone 40 mg a day or its equivalent
(methylprednisolone 32 mg or dexamethasone 6 mg a day)
has been taken.6 Short courses of larger doses and longer
courses of lower doses will suppress the hypothalamic-
pituitary-adrenal axis for prolonged periods, and doses must
be tapered off over several days or weeks according to
circumstances.

Needham et al also point out that advanced cancer and
polypharmacy tend to go hand in hand. Stopping drugs that
are not yielding benefit will therefore help to ease the patients’
burden of tablet taking and may improve compliance with
other drugs. Furthermore, because the biological half lives of
corticosteroids are relatively long (for example, 18-36 hours
for prednisolone and 36-54 hours for methylprednisolone)7
they should be taken once a day unless the number of tablets
precludes this.

An important unresolved question is the choice of dose; in
controlled trials to treat anorexia the dose has varied between
the equivalent of 15 mg and 40 mg of prednisolone a day.8
It may be better to start with a relatively high dose in order not
to miss an effect of treatment and then to reduce to a lower
maintenance dose if treatment is to continue beyond seven
days. In patients receiving anticonvulsants such as phenytoin
and phenobarbitone, starting with an even higher dose may be
advisable because these drugs enhance the metabolism of
corticosteroids.10

Finally, well documented alternatives for treating anorexia
exist. For example, many patients benefit from megestrol
acetate, and the effect is still detectable after two months.19
Megestrol is, however, considerably more expensive.
Given the 50% response to placebo,20 the best initial step may well
be dietary advice with or without multivitamin tablets.

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