help exclude pre-existing cervical infections. There is even a device that releases levonorgestrel which could possibly even protect against pelvic inflammatory disease.[10]

If teenagers could take their fertility control somewhat for granted during the most precarious stage of their sexual careers then the ability to negotiate other complex aspects of their sexual wellbeing could be enhanced. We owe it to them to at least consider the evidence and have the best options at hand.

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BD has no association with any manufacturers of contraceptive products and does not insert intrauterine contraceptive devices.

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Telling children about a parent's cancer

Parents want help but don't get it

No one finds it easy to break bad news. Doctors' frequent failure to do this well has been extensively documented and analysed. The need for better training has been recognised, and our practice is, hopefully, improving. But recipients of bad news then have to decide how to tell those close to them. Knowing what to say to children can seem particularly difficult. A study in this week's *BMJ* (p 479) suggests that there is an unmet need in giving help with this task.[1] Barnes and colleagues interviewed 32 mothers with stage I or stage II breast cancer four to six months after they had been diagnosed to explore the timing and extent of communication about the diagnosis to their children. A fifth of children had been given no information at the time their mothers had surgery. Women who had higher levels of education gave less information to their children. Many women expressed a wish to meet with "a health professional with expertise in understanding and talking to children" to discuss how to communicate the diagnosis: only a few had actually been given such help.

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Who might those health professionals with expertise in understanding and talking to children be? It is not clear who the investigators or the women had in mind. But given the frequency with which this kind of problem is encountered, and given the enormous disparity between the supply of and demand for specialist child psychological and psychiatric services, much of this work would have to be done in primary care.

Hospital cancer clinics sometimes have personnel with the time and skills to take on the task. We in primary care must acquire what expertise we can, but we must not allow a perceived lack of expertise to inhibit us from doing our best to assist parents in helping their children to understand difficult or painful truths. Having a greater concern about the need for expertise in these matters may underlie the paradoxical finding of this study that more highly educated women communicated less with their children.

Women in the study identified why children must be told something about matters causing pain and anxiety to their parents: "They can sense that something is wrong." Aware that parents are facing a serious problem but not having been told about it and feeling unable to ask, children fantasise explanations. These fantasies may be more distressing than the truth.

Children can be deeply hurt by the impression or the discovery that they have been excluded from something important to them and their family. This may be more painful than the truth that has been withheld. In a book on the damage caused by family secrets the French psychiatrist Tisseron says that children subjected to a secret can never really get out of their mind painful questions like "Are my parents lying to me?" and above all "Why would they lie to me?"[2] The child's trust in the parents, and by extension in the adult world in general, may be undermined. Tisseron concludes that the more painful a new event is for us, the more important it is to talk about it with our children and that it is better to talk badly about things than not to talk about them at all.

So how can we help? We should remember to include a discussion about what and how to tell children whenever we break difficult news to someone for whom this will be part of the problem. We should offer to make this the subject of a separate meeting on a later occasion, because this will often be necessary, and should encourage both parents to attend. Careful thought, preparation, and agreement between the parents is valuable in deciding what and when to tell children, but we should try to avoid giving the impression that special expertise is necessary. A meeting of this kind can be valuable not just for its stated purpose but also for achieving a better shared understanding of the

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illness for the couple. Trying out different forms of words for explaining the illness to children may make it easier for the patient or partner to express concerns or expectations not previously shared, and it may be an avenue to better and more supportive communication between the partners.

Children need truthful explanations

We should explain that children do not need every detail: what they crucially need is a truthful and convincing explanation for their parents' distress. We should introduce the possibility of asking children whether they have their own ideas about why this bad thing might have happened. Children (like adults) may need to be relieved from irrational feelings of guilt. We should offer to be there when the children are told if the parents would find this helpful. Such an offer will often be declined if the parents feel adequately prepared. If time has been spent dealing with the issue of communicating the diagnosis to the children this should be mentioned in communications between those who provide primary care and hospitals. Referrals to child psychiatric services should be considered in particularly difficult situations or when children develop overt and important psychological or behavioural problems

Why do we not always do as much of this sort of family support as we might? We have many other demands on our time, but we also find it difficult to witness situations which bring to mind our own fears or memories of pain, separation, and loss. None the less, we should be prepared to offer help to our patients in deciding what to tell their children about a serious illness. And when we do become involved in work of this kind we must be aware of our own needs for support.

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Gastro-oesophageal cancer: death at the junction

Understanding changes at molecular level could lead to screening opportunities

The death rates from cancers of the oesophagus and gastro-oesophageal junction, adjusted for age, have risen steadily since the early 1970s (from 3 to 6 per 100 000 and from 1.5 to 3 per 100 000 population in the United Kingdom respectively).[1] These figures are comparable to those in northern Europe and the United States. The incidence of Barrett's adenocarcinoma in the United States has increased from 0.3 per 100 000 to 2.3 per 100 000 over the past three decades.

Despite improvements in multimodality therapy, especially chemotherapy regimens of combined epirubicin, cisplatin, and fluorouracil combined with surgery, survival has not improved significantly, suggesting that alternative strategies for identifying and treating these conditions are needed.

The incidence of intestinal metaplasia of both the oesophagus (Barrett's oesophagus) and the gastro-oesophageal junction are also increasing. This metaplastic tissue is believed to have a premalignant potential, and Barrett's oesophagus is related to bile and acid reflux disease.[2] About 8% of patients undergoing routine endoscopy and 3% of the adult population have at least 1 cm of Barrett's oesophagus.[3] Furthermore, 17% of patients undergoing routine endoscopy and 6% of the adult population may have intestinal metaplasia of the gastro-oesophageal junction.[3 4] These metaplastic lesions are characterised by mucin-secreting epithelium, containing goblet cells, that replaces the native stratified squamous or transitional zone epithelium.

Metaplastic changes may progress from dysplasia to adenocarcinoma.[2] About 5-15% of people with Barrett's oesophagus and 2-5% of those with intestinal metaplasia of the gastro-oesophageal junction also have dysplasia, which in the case of Barrett's oesophagus increases the risk of cancer between 30-fold and 150-fold. The risk of cancer for people with metaplasia of the gastro-oesophageal junction has so far not been quantified.

This has led many centres to establish surveillance programmes to identify dysplastic changes or early adenocarcinomas.[5] However, although these programmes detect cancers earlier, there is controversy about their cost effectiveness.[6 7] Interest has therefore been rekindled in strategies to prevent the onset of Barrett's oesophagus or intestinal metaplasia of the gastro-oesophageal junction and to find other risk factors that more accurately detect the subgroups of patients who will progress to malignancy.

Rare inherited syndromes of colorectal cancer have given valuable information about tumour initiation. Syndromes of familial gastro-oesophageal cancer are rare and heterogeneous and account for only 1-5% of cases, but they have also provided valuable information.[8] In particular, inherited germline mutations of the E cadherin gene, involved in cell adhesion, leads to loss of E cadherin expression.[8] E cadherin is not only a cell adhesion molecule but also a tumour suppressor gene. Reduced expression of adhesion molecules on the surface membranes of cancer cells makes them far more likely to have invasive properties. Furthermore, analysis of sporadic gastric cancer shows that the stage and invasiveness of gastric tumour is also associated with reduced expression of E cadherin. E cadherin binds with an intracellular protein called β catenin, to form adhesion complexes. β catenin levels are tightly regulated within the cell, and free, unbound β catenin is

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