Volunteers (or families) might, however, have a role in maintaining benefit, and indeed the aim of all rehabilitation should be to involve families in longer term support. To this extent we failed, and further studies are needed to confirm our results and investigate ways of maintaining mobility.

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Lipoprotein(a) in cirrhosis

SIR,—The primary site of synthesis of lipoprotein(a) has not been clearly identified. Like J Feely and colleagues,[1] we have measured lipoprotein(a) concentrations using an enzyme linked immunosorbent assay (Immuno, Heidelberg). We studied 18 patients with severe cirrhosis as assessed by the Child Turcotte classification. Cirrhosis was due to chronic active hepatitis in 12 patients and to primary biliary cirrhosis in four; in two others it was associated with hepatocellular carcinoma.

In 14 of the 18 patients lipoprotein(a) concentrations were almost not detectable (mean 23 mg/l, range 0-60 mg/l), which supports the hypothesis that lipoprotein(a) is synthesised primarily by the liver. In contrast, the four other patients had high normal or raised concentrations of lipoprotein(a) (ranging from 150 to 360 mg/l). The cirrhosis in these four patients was due to chronic active hepatitis in two and to primary biliary cirrhosis in one and was associated with hepatocellular carcinoma in one.

Therefore, we support the hypothesis that lipoprotein(a) is synthesised primarily in the liver; non-hepatic tissue may, however, contribute to the concentration of lipoprotein(a) in the serum.

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1 Feely J, Barry M, Keeling PWN, Weir DG, Cooke T. Lipoprotein(a) in cirrhosis. *BMJ* 1992;**304**:545-6. (29 February.)

Hospital admission and start of benzodiazepine use

SIR,—D Surendrakumar and colleagues present data from three general hospitals in which a total of 65 patients had been supplied benzodiazepines when discharged.[1] There is no indication as to what proportion of total discharges this represents and seven (11%) of the relevant records were not scrutinised and no reason was given for their omission. The mean age of patients scrutinised was 74 years, and 60% were male, an unusual population distribution about which no comment was made. Only 17 patients were found to have been first prescribed benzodiazepines during the index admission; five patients had been taking the drugs for up to two months, seven for up to a year, and 20 for over a year. That leaves only nine of the 58 unaccountable, although it had been said that for 12 of the cases details of when the drug had been started were not ascertained.

Discrepant or not, these are trivia. What is not trivial is to report finding evidence of dependence in eight out of 10 patients said to have taken the drugs for more than two years. What evidence is not stated, nor why attempts to stop the drug had been made in only five patients, nor what were the withdrawal symptoms which had occurred in only two patients. Such symptoms, the mainstay of a diagnosis of dependence, can be difficult to extricate both from symptoms for which the drugs were prescribed and from "pseudowithdrawal" symptoms.[2-4] Nor is it trivial to accuse colleagues both of unwarranted prescribing and prescribing without assessment of need: in effect, of negligence. The former is supported by minimal details of just three cases, the latter by no data at all.

It is true that some doctors have a righteous concern about the allegedly careless prescribing habits of other doctors, as referenced in the paper. It is also true that some doctors are equally concerned that prejudiced reporting has led to a situation where patients in need may be denied appropriate treatment.[5-7] The promotion of medicines should reflect accurately and clearly an up to date evaluation of all the evidence. Might it not be appropriate for similar requirements to apply to publications in influential medical journals?

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AUTHOR'S REPLY,—K Woodcock's attitude towards medical audit is unacceptable. Making accusations of inconsistency in data without carefully reading the article is inappropriate. The data are correct and consistent. As is evident from the paper, in 12 cases it was not possible to ascertain whether the patient had started benzodiazepines in hospital or in the community. This number is not applicable to the question of when they started.

It is surprising that Woodcock does not appreciate the brevity of the presentation of results and discussion required for a short report. However, I can now fill in the details he requests. The reasons for not scrutinising some notes were simple administrative difficulties and refusal by one consultant to give permission. Dependence was implied by the presence of statements in the notes to the effect that the patient could not manage without the tablets. A clear statement of increased insomnia or anxiety in the period immediately following a dose reduction was considered to be a withdrawal effect. Although I can be positive that the benzodiazepine medication had been reduced in five cases because of concern, that this was not attempted in the others cannot be ruled out.

It is only through examination of its prescribing habits that the medical profession can move towards rationalisation in therapeutics. Benzodiazepines have done enough harm. The publication of studies whose conclusions encourage doctors to keep within nationally agreed policies can only result in good.

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Side of origin of ovarian cancer

SIR,—D J Cruickshank recently suggested that ovarian cancer arises more frequently on the right than on the left ovary.[1] This finding was discussed in terms of the incessant ovulation hypothesis, on the basis of the observation that ovulation occurs more frequently on the right.[2] Along this line, a paper by C B Johannes and colleagues based on about 300 ovarian cancer cases has shown that 53% of cancers were right sided in origin (compared with 59% in Cruickshank's study).[3]

To offer further data on the issue we have reviewed the pathological diagnosis in 556 cases of ovarian cancer consecutively observed for first line treatment between 1980 and 1991 at two obstetric and gynaecology clinics of the University of Milan. Information on the side of origin of the tumour, histological type, stage of the disease, age, and menopausal status at surgery were retrieved from clinical records. Of the 556 cases, 235 were at stage I, 35 at stage II, 237 at stage III, and 24 at stage IV; in 25 cases the stage was not reported in the clinical records.

The side of origin of the tumour was determined in 333 (unilateral) cases. Of those, 172 (52%) were of right sided origin and 161 (48%) of left ($z=0{\cdot}55$, $p>0{\cdot}05$). The tumour was bilateral in 212 cases, and in 11 the data on the side of tumour were missing. The proportion of right and left sided unilateral tumours was largely similar in strata of menopausal status, stage, and histological type of the disease.

Our analysis was based on pathological data reported in the clinical records, and the hypothesis of the study was not known to the pathologists who performed the histological analysis or to the clinicians who recorded the data. We had no information on right and left dominance in bilateral tumours. This is of some concern, since both in Cruickshank's and in Johannes *et al*'s series the greater proportion of right sided cancers was mainly accounted for by right dominance in bilateral tumours. It should be pointed out, however, that the assumption with bilateral tumours that the side with the larger tumour is the side of origin is merely speculative.

In conclusion, our analysis gives little support to the hypothesis that ovarian cancer is more common in the right ovary.

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2 Potashink G, Insler V, Meizner I. Frequency, sequence, and side of ovulation in women menstruating normally. *BMJ* 1987;**294**:219.
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Medicine in Europe

SIR,—The interesting series of articles on medicine in Europe will have struck a chord in many of those involved in this scene. Many of Tessa Richards's misgivings of the current structures[1] are widely shared.

One of the weakest links is that between the European Union of Medical Specialists (UEMS) and its monospecialist committees, and one can legitimately question both the value and the need for this relationship. The UEMS is constituted on the basis of national representation—which is incompatible with its role as a representative specialist body. One can have either national or specialist representation, but not both.

The figure shows a simplistic view of a medical advisory structure for a country (with the "matching" British organisations shown in brackets) and