Letters and Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity

Pre- and postoperative chemotherapy for resectable gastric adenocarcinoma

The possible role of pre- and postoperative chemotherapy in the treatment of resectable gastric adenocarcinoma was one of the main topics for discussion at the recent first open meeting of the Medical Research Council's (MRC's) Upper GI Tract Cancer Group. With an overall 5-year survival rate of less than 40% for patients after resection *(1)*, surgeons at the meeting agreed that even the best of surgery on its own was not enough—chemotherapy in addition had to be reliably assessed.

In 1993, the results of a literature-based meta-analysis of 11 randomised trials of intended curative resection with or without postoperative chemotherapy was published *(2)*. Although this analysis was based on data from 2096 patients, the small survival benefit attributable to chemotherapy was not statistically significant (odds ratio 0.88; 95% confidence interval 0.72–1.08). The conclusion was drawn that surgery alone should be considered standard treatment *(3)*. Nevertheless, when data from two additional trials were added, a significant result in favour of chemotherapy was seen *(4)*. In 1994, the MRC and the British Stomach Cancer Group, joined later by the Dutch Gastric Cancer Group, launched a multicentre randomised trial of surgical resection with or without preoperative and postoperative chemotherapy (the MAGIC trial: ST02).

The trial is important for a number of reasons. Chemotherapy could well prove to be substantially more effective when given preoperatively; tumour regression may be achieved making subsequent surgery easier, and putative micrometastases are dealt with at the earliest opportunity. It might also inhibit tumour growth factors released by surgical trauma and subsequent wound healing, for which there is experimental evidence *(5)*. Also, there is evidence from a randomised trial that in the treatment of advanced oesophagogastric cancer the chosen chemotherapy regimen (bolus epirubicin and cisplatin with protracted venous infusional fluorouracil—ECF) achieves significantly better response and survival rates than the sort of regimen that was used in the past (fluorouracil, doxorubicin and methotrexate—FAMTX), and with acceptable toxicity *(6)*. At the MRC meeting, clinicians involved in the MAGIC trial reported that the ECF regimen was proving highly acceptable to patients and was achieving excellent symptomatic relief.

Thirty-five centres in five countries are already participating in the MAGIC trial, but few centres see large numbers of eligible patients and the rate of intake, although steady, is slow. We would therefore encourage other centres to collaborate in this crucial trial. We need to know whether the modest survival results achieved by surgery alone can be improved by the best available chemotherapy, starting at what we have reason to believe is the most effective time—preoperatively. If you would like to join the trial, or want further information or copies of the protocol, please contact Jill Whaley, the Trial Coordinator, at the MRC Cancer Trials Office (01223 311110).

JOHN BANCEWICZ FRCS
Consultant Surgeon
DAVID GIRLING FRCP
Senior Scientist
WILLIAM ALLUM FRCS
Consultant Surgeon
DAVID CUNNINGHAM FRCP
Medical Oncologist
SALLY STENNING MSc
Senior Medical Statistician

MRC Cancer Trials Office
5 Shaftesbury Road
Cambridge CB2 2BW

References

1 Fuchs CS, Mayer RJ. Gastric carcinoma. *N Engl J Med* 1995; **333**: 32–41.
2 Hermans J, Bonenkamp JJ, Boon MC *et al.* Adjuvant therapy after curative resection for gastric cancer: meta-analysis of randomized trials. *J Clin Oncol* 1993; **11**: 1441–7.
3 Muggia FM. How to improve survival after diagnosis of gastric cancer? It's back to the drawing board. *J Clin Oncol* 1993; **11**: 1437–8.
4 Hermans J, Bonenkamp JJ. Meta-analyses need time, collaboration, and funding. *J Clin Oncol* 1993; **12**: 879–80.
5 Fischer B, Saffer E, Rudock C, Coyle J, Gunduz N. Effect of local or systemic treatment prior to primary tumour removal on the production and response to a serum growth stimulating factor in mice. *Cancer Res* 1989; **49**: 2002–4.
6 Webb A, Cunningham D, Scarffe JH *et al.* Randomized trial comparing epirubicin, cisplatin, and fluorouracil versus fluorouracil, doxorubicin, and methotrexate in advanced esophagogastric cancer. *J Clin Oncol* 1997; **15**: 261–7.

Who decides the need for antibiotic prophylaxis in patients with major arthroplasties requiring dental treatment: is it a joint responsibility?

The controversy, if such it is, about giving prophylactic antibiotics to patients with joint replacements undergoing dental treatment will never be resolved without further argument and Sanhu *et al.* (*Annals*, March 1997, vol 79, p143) are to be thanked for stimulating it. It is remarkable how, in choosing antibiotics, groups of highly trained clinicians can behave like sheep and prescribe according to their 'herd'—whither evidence-based medicine now?

There are only four entirely convincing cases in the

world literature where joint infection has been associated with dental infection or bacteraemia *(1)*. Four in how many million exposures to potential risk? We can only speculate. Staphylococci are the main pathogens and are virtually never identified in dentally induced bacteraemia. Effective intervention is far more rational than blanket prophylaxis with an antibiotic of no proven benefit, and dental and oral sepsis should be treated promptly and effectively in any patient whether immune competent or not.

The analogy with infective endocarditis is a false one. Oral type streptococci are identified in a significant proportion of endocarditis cases, they readily cause the disease in experimental animals, and prevention, which incidentally is aimed at preventing the establishment of infection rather than the impossible task of 'eliminating bacteraemias', can also be modelled experimentally.

It is all too easy to place the burden of prevention of a rightly feared complication on to someone else. The onus is on those orthopaedic surgeons who advocate the therapy to produce evidence of its benefit. The BSAC Working Party who concluded in 1992 that the case for prophylaxis was not made, have kept the literature under review and we have yet to be persuaded to change our opinion.

Promotion of optimum oral health is the one policy to which no one can object, and if there really is any connection with late joint infection then that risk would be reduced at least as effectively as by unnecessary and potentially harmful antibiotic prescription.

DAVID A MCGOWAN MDS PhD FDS
Professor of Oral Surgery

Glasgow Dental School
University of Glasgow

Reference

1 Bartzokas CA, Johnson R, Jane M, Martin MV, Pearce PK, Saw Y. Relationship between mouth and haematogenous infection in total joint replacements. *BMJ* 1994; **309**: 506–8

Role of fine needle aspiration cytology in the management of the discrete parotid lump

(*Annals*, May 1997, vol 79, p198)

A fundamental difference of opinion on the role of fine needle aspiration cytology (FNAC) in the management of discrete parotid lumps is highlighted in the letter of Messrs Lewis and Web and Professor Farndon (*Annals*, September 1997, vol 79, p386). From the perspective of surgical oncology, I hold that FNAC is only of value if it alters treatment. The data *(1–5)* indicate that prognosis for salivary cancer depends principally on size and grade and not histological type.

M MCGURK FRCS FDSRCS
Professor of Oral and Maxillofacial Surgery

UMDS, Guy's and St Thomas' Hospitals
London

References

1 Spiro RH, Thaler HT, Hicks WF, Kher UA, Huvos AH, Strong EW. The importance of clinical staging of minor salivary gland carcinoma. *Am J Surg* 1991; **162**: 330–36.

2 Spiro RH, Armstrong J, Harrison L, Geller NL, Lin SY, Strong EW. Carcinoma of the major salivary glands: recent trends. *Arch Otolaryngol Head Neck Surg* 1989; **115**: 316–21.

3 Frankenthaler RA, Luna MA, Lee SS *et al.* Prognostic variables in parotid cancer. *Arch Otolaryngol Head Neck Surg* 1991; **117**: 1251–6.

4 Spiro RH, Huvos AG. Stage means more than grade in adenoid cystic carcinoma. *Am J Surg* 1992; **164**: 623–8.

5 The relative importance of clinical staging and tumour grade in the treatment of parotid carcinomas. *Br J Surg* (poster 011) 1997; **84**: (Suppl 1): 49.

Surgery for periampullary and pancreatic carcinoma: a Liverpool experience

We enjoyed reading Mr Kingsnorth's account of his experience in setting up a specialist pancreatic unit in Liverpool (*Annals*, July 1997, vol 79, p259). His results were excellent and we are sure there are very few who would disagree with his arguments concerning the centralisation of pancreatic surgery in specialist units.

Mr Kingsnorth used only computed tomography to stage his patients preoperatively. There are good data that conventional CT is relatively unreliable in assessing the resectability of pancreatic cancer *(1)*. His resection rate of 81% is better than many published studies, but there are those who would still feel that 19% of patients having to go through an unnecessary operation is rather more than it should be.

Mr Kingsnorth argues that the "expensive and time-consuming technology of laparoscopy or laparoscopic ultrasound" would only have benefited 3% of the patients in his series. For some reason he fails to include the 14 patients deemed inoperable on the basis of encasement of major vessels. Laparoscopic ultrasound has been shown to be highly reliable in imaging the major vessels related to the neck and uncinate process of the pancreas *(2)*.

In Swansea we are very fortunate to have had laparoscopic ultrasound and endoscopic ultrasound (EUS) available for 2 years. All patients being assessed for resection for pancreatic cancer have been investigated by both modalities (as well as conventional CT). Preliminary results indicate that laparoscopic ultrasound has been the most accurate modality for assessing vessel involvement *(3)*. It may be that with greater experience our results with EUS will improve. The Edinburgh experience of laparoscopic ultrasound in the staging of pancreatic cancer is extensive and well documented *(2)*.

'Expensive and time-consuming' are relative terms. A laparoscopic ultrasound probe now costs around £10 000 and all the rest of the equipment needed is available in any general hospital. Laparoscopic ultrasound for pancreatic cancer can be carried out in 15 to 20 min, as a day case procedure if necessary. One wouldn't need to avoid too many unnecessary operations for this technology to justify its use both in terms of time and money, not to mention the patients' best interests.

Laparoscopic ultrasound in this situation is quick, easy and safe. Like any investigation it is not perfect and certainly is no panacea, but surely it has a role to play. It is not reasonable to dismiss laparoscopic ultrasound as Mr Kingsnorth does.

J MCK MANSON FRCS
Consultant Surgeon

Singleton Hospital
Swansea