

## Treatment for cancer pain in France

EDITOR,—François Larue and colleagues draw attention to the persisting problem of undertreatment of cancer pain.<sup>1</sup> In their French multicentre study of patients (most of whom were inpatients) 30% (84/279) of patients with cancer pain received no analgesic drugs. Of those patients given analgesics, 51% (137/270) received inadequate treatment for their pain. Discrepancy between physicians' and patients' pain ratings, young age of the patient, absence of metastatic disease, and better performance status were predictors for the undertreatment of cancer pain. The authors conclude that poor assessment of cancer pain is an important factor in the undertreatment of such pain.

The observation that less "seriously ill" patients with cancer are more likely to be undertreated prompts the speculation that physicians may be overcautious about using opioids in these patients owing to an ill-founded fear of addiction. We suggest that the poor assessment of pain described by Larue and colleagues is only one part of a widespread lack of knowledge on the part of physicians about managing cancer pain.

We have analysed the prescribing patterns of German physicians in the treatment of cancer pain.<sup>2</sup> We found that only 322 of 16 630 (1.9%) patients with cancer received strong opioids. In all, 191 of 328 (58.2%) practices did not prescribe a single strong opioid to their patients with cancer in three years; 295 (31%) of the prescriptions for morphine and buprenorphine were written for an inadequate intake schedule. Few patients who were receiving strong opioids received treatment for side effects of opioids (laxatives were given to 48 (14.9%) patients and antiemetics to 49 (15.2%)). Only 75 (23%) patients receiving strong opioids also received non-opioid analgesics. We conclude that patients with cancer pain in Germany are severely undertreated.

Our data suggest that restrictive laws on prescribing strong opioids, lack of knowledge about health care providers, and prejudice against opioids impede effective management of cancer pain in Germany. While some European countries, particularly Britain and Denmark, have achieved a satisfactory level of care for patients with cancer pain, most European countries are still far behind this standard.<sup>1-4</sup> Further education in the management of cancer pain and the dissolution of prejudice against opioids is warranted. Govern-

ments should be forced to liberalise restrictive laws on opioids. As long as penalties of up to DM50 000 (£23 000), as in Germany, impede the prescribing of opioids, the situation for patients with cancer pain will not change. We hope that Britain does not have to introduce laws on opioids similar to Germany's as a result of the European Union.

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- 1 Larue F, Colleau SM, Brasseur L, Cleeland CS. Multicentre study of cancer pain and its treatment in France. *BMJ* 1995;310:1034-7.
- 2 Zenz M, Zenz T, Tryba M, Strumpf M. Severe undertreatment of cancer pain in Germany—a three years' survey. *Journal of Pain and Symptom Management* 1995;10:187-91.
- 3 White ID, Hoskin PJ, Hanks GW, Bliss JM. Analgesics in cancer pain: current practice and beliefs. *Br J Cancer* 1991;63:271-4.
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## Strategy needed for adolescent patients with cancer

EDITOR,—The care of children with cancer in the United Kingdom has rightly been cited by many professionals as being an outstanding success, translating into year on year improvements in survival for a wide range of haematological and solid cancers. In contrast, the care of adolescents with malignant disease has been unsatisfactory for various reasons and requires a new approach.

Adolescent patients span an age range from early teenage to the early 20s. The tumour types are rare and often complex. From an organisational standpoint the care of adolescent patients is often seen as neither the preserve of adult oncologists nor the preserve of paediatric oncologists. Adult oncologists are unpractised in managing rare sarcomas and certainly untutored in the arrangements for ancillary medical, psychological, and educational support that are so important to people who are facing dangerous diseases and taxing treatment at a vulnerable time in their lives. Paediatric oncologists are often expert in treating the diseases seen in young teenagers and well versed in organisational aspects and supporting care, but they have little or no experience of epithelial tumours or some of the other tumours common in late adolescence.

The very difficulty of defining the age limits of adolescence illustrates some of the complexity of the issues that require addressing. There seems to be a good case for re-examining the divisions between cancer care for adults and children to provide an appropriate service.

An audit based on cancer registry data indicates that there may be up to 2000 new cancers diagnosed each year in the United Kingdom in people aged 15 to 25 years. If patients "graduating" from paediatric oncology services are added this number would be considerably larger. In the light of specific recommendations of the Calman report on cancer services,<sup>1</sup> the time is right for purchasers to recognise the needs of these patients and for interested professionals within the United Kingdom Children Cancer Study Group and the Joint

Council of Clinical Oncology to develop a national strategy for adolescent cancer units linked to major cancer centres.

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- 1 Department of Health. *A policy framework for commissioning cancer services*. London: DoH, 1995.

## Pneumococcal vaccine for HIV patients

Patients with HIV infection should be immunised . . .

EDITOR,—We were dismayed by the article of A Jain and colleagues, which was published just as we were about to start a pneumococcal vaccine campaign in Tameside. We do not agree with the conclusions of Jain and colleagues, and we do not see how they arrived at them from the evidence they cite.

We agree that the Department of Health's policy is not being well implemented, but this is not specific to HIV infection. Failure to vaccinate has many causes, including lack of ownership of responsibility for implementing the policy, the low status and difficulty in identifying the target groups, and, until recently, limited supplies of the vaccine in the United Kingdom.

Jain and colleagues first suggest that a policy of early vaccination in HIV infection is reasonable. Later, they advise that vaccinating some or all HIV positive patients is illogical. Which piece of advice do they wish us to follow?

They seem to call for a (randomised controlled?) large clinical trial of vaccine efficacy in HIV positive patients. At this stage a more ethical (and cheaper) approach would be to carry out a retrospective cohort analysis.

They also suggest that "data from trials suggest that the vaccine works in healthy but not immunocompromised people."<sup>1</sup> The vaccine works less well in immunocompromised people, but it does offer some protection.<sup>2,3</sup> Their comment that those who will benefit the least are being vaccinated is illogical. The desired end point of immunisation is prevention of infections, not good antibody values. There is more health gain in providing partial protection to patients whose risk of infection may be up to 600 times increased<sup>4</sup> than there is in providing good protection to someone at low risk of infection.

The vaccine has not been shown to perform worse than the very low efficacy and shortened duration at which Rose *et al* estimated that it was still cost effective.<sup>5</sup> We will continue to advise

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