LETTERS TO THE EDITOR

The practice of cardiothoracic surgeons in the perioperative staging of non-small cell lung cancer

The article by Dr G M K Tsang and Mr D C T Watson (January 1992;47:3–5) is a timely reminder that all is far from well in the practice of thoracic surgery in the United Kingdom (and also, according to my information, in Europe). For some time "committed" thoracic surgeons have been concerned not only about its practice but also about training in thoracic surgery. Our present system of training cardiothoracic surgeons is heavily biased in favour of the cardiac component. There is to my knowledge no opportunity for an intending thoracic surgeon to acquire a senior registrar post solely in thoracic surgery or even one in which equal time is devoted to general thoracic (and oesophageal) surgery and to cardiac surgery.

Many of those who practice as cardiothoracic surgeons are in reality cardiac surgeons; in some such units the thoracic surgery is carried out by poorly supervised junior staff or is undertaken as a "quicky thoracotomy" between two cardiac operations. The commitment and work load of such surgeons does not permit the comprehensive preoperative investigation of nodal status and triage, or leave time for the painstaking process of mediastinal exploration and node dissection at operation. The responsibility for this situation, however, does not lie with the surgeon alone. Chest physicians too must accept the blame for some of the shortcomings as they, in many instances, constitute the referral point. Has the time come to abandon the "traditional" cardiothoracic surgeon undertaking all types of surgery of the thorax?

I submit that cardiac and thoracic surgery should be practised in one campus but by different surgeons (as is done in only a few centres in the UK and Europe). Regarding training at registrar level, this should encompass the whole specialty of surgery of the thorax (heart, lung, oesophagus, and mediastinum) but at senior registrar level there should be streaming into thoracic or cardiac surgery, depending on the ultimate interest and goal of the trainee.

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Tuberculosis in the third world

We cannot agree with the view expressed by our good friend Stefan Grzybowski in his editorial (August 1992;46:689–91) that what is now needed is a unit or units, like the Medical Research Council tuberculosis unit, "capable of organising therapeutic trials in the developing countries." Such a limited approach would, in our view, be disastrous. The two MRC tuberculosis units, with the MRC statistics unit, established a team that covered basic laboratory research, the principles and mechanism of drug action, pharmacology, sociological interests, and epidemiological investigations, often under service programme conditions, into, for example, drug resistance, case finding and national surveys of the characteristics of patients presenting, their treatment and response, the trends at intervals (as in Kenya, Tanzania, and Britain), *and* controlled chemotherapy trials.

The multidisciplinary approach, necessary even for chemotherapy studies, as in the 1985 proposal for research on new drugs supported by the World Health Organisation,[1] was also emphasised in the report of a workshop[2] with wide international agency representation from WHO and 31 nations. This stated, "The Group sees a great need for an interdisciplinary approach to the TB problem, an approach that would link basic scientists with clinicians, microbiologists and epidemiologists. One approach to achieving this aim might be to create an international interdisciplinary centre for studying TB . . . ."

We are also surprised at the statements (1) that "casefinding is relatively easy and on the whole functions reasonably well in many developing countries," which is not the case[3]; and (2) that Styblo has dealt successfully with "the problem of poor compliance" by hospitalising patients for an initial two months. This is not the official policy of the International Union Against Tuberculosis and Lung Disease (IUATLD), it ignores competing health priorities, and it is unsupported by clear evidence of success. Finally, the failure to distinguish between primary and initial drug resistance, totally different problems, is confusing.

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1 *Report of a consultative meeting sponsored by the WHO and organised by the MRC's WHO Collaborating Centre in Chemotherapy of Tuberculosis and its Application (London, November 1985).* Geneva: Tuberculosis Programme, Division of Communicable Diseases, WHO, 1986.
2 Summary, conclusions, and recommendations from the international workshop on "Research towards global control and prevention of tuberculosis: with an emphasis on vaccine development." *J Infect Dis* 1988;158: 248–53.
3 Aluoch JA, Swai OB, Edwards EA, *et al.* Studies of case-finding for pulmonary tuberculosis in outpatients at 4 district hospitals in Kenya. *Tubercle* 1985;66:237–49.

AUTHORS REPLY Professor Fox's MRC unit achieved international fame for its chemotherapy trials, conducted mainly in the developing countries. The conduct of such trials requires an interdisciplinary approach with strong statistical, bacteriological, pharmacological, clinical, and other components; these were either developed within this unit or obtained from Professor Mitchison's unit, other MRC units, or other experts and institutions. I thought, obviously erroneously, that in advocating the creation of a unit or units similar to Professor Fox's MRC unit "capable of organising therapeutic trials in the developing countries" I did not need to list these individual components.

Styblo's method in dealing with poor compliance with an initial two months' hospitalisation is used in most if not in all of the dozen or so of the countries assisted by IUATLD. Admittedly, its success could be better documented in accessible medical publications. Competing health priorities for the hospital beds should be assessed.

Primary resistance is resistance of the bacilli with which new patients are infected; initial resistance covers also patients who, fearing rejection, deliberately withhold information about their previous treatment. The fact that in certain countries the distinction between the two is necessary constitutes a terrible indictment of the lack of interest of health authorities in treatment failures, and often of the absence of appropriate drug regimens for such patients.

It is regrettable that I have obviously upset two most eminent authorities on tuberculosis, particularly as one of them is a close personal friend; but I remain unrepentant.

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Cystic fibrosis: current survival and population estimates to the year 2000

Drs J S Elborn and others (December 1991; 46:881–5) estimate that the median survival of babies born in 1990 with cystic fibrosis will be 40 years. They base that estimate on an extrapolation from current survival figures but state that their prediction contains "an element of error that is difficult to estimate." Nevertheless, they suggest using their estimate for counselling purposes and imply that it should be taken into account when future services, such as population screening, are being considered.

They are mistaken on two counts. Firstly, the case for population screening for cystic fibrosis is currently poor because the available tests give too many false positives. An increase in median survival from 20 to 40 or even to 80 years would not affect the issue because the purpose of screening is early detection and treatment, which would presumably still be desirable whatever the projected survival. Secondly, improvements in survival must depend on improvements in the general health of the population from social and environmental factors and advances in medical treatment. Dr Elborn and his colleagues refer to "improved medical care" and "increasing use of heart-lung transplantation." They cannot know what improvements in medical care will occur or what the effect of transplantation will be (currently it seems likely to be small). There is no guarantee that present trends of improvement in survival will continue; the fact that plateauing has not yet occurred cannot be used as evidence that it will not occur and in fact, in the absence of new modes of treatment, it seems likely that it will do so as maximum benefit is reached from present management strategies. On the other hand, if a cure is found—from gene therapy, for instance—then babies born now might have a survival equalling that of the rest of the population.

All we are entitled to say is that the median life expectancy of babies born now is likely to be somewhere between the current 20 years and the normal life expectancy of the population. Other than that we might be more credibly and profitably employed predicting the winner of the next Grand National.

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