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Book Review

Musculoskeletal Oncology
Edited by Michael M. Lewis.
Philadelphia, W.B. Saunders Company, 1992. ISBN 0-7216-5771-0.
$95.00

THIS BOOK has 27 chapters written by 54 co-authors and aims to give a moderately comprehensive account of the main areas of musculo-skeletal oncology. There are many competitors—mostly considerably larger. The chapters tend to be reviews of topics rather than guides about what to do with a patient. In this respect the book is wholly different from say, Campanacci's *Bone and Soft Tissue Tumours* or the much larger text of Mirra *et al.* Like all reviews, the chapters are heavily referenced (who needs 15 references to the age and sex incidence of Ewing's sarcoma?) The clinical and radiological descriptions are, for the most part, clear. The paper is an off-white art paper which doesn't take the black and white histology very well or, for that matter, some of the X-rays. I have used the book in clinical practice for a few weeks and found it informative but not innovative. It contains a good solid descripton of bone tumours, but no new insights.

The balance of content is unsatisfactory. There is a whole chapter on allografts and bone banking, but endo-prosthetic replacement (which is much more widely practised) is tucked into a general chapter on reconstructive surgery. There is very little indeed on soft tissue sarcomas and 90% of the book is about bone tumours—I don't know how such an imbalance can have been overlooked. The pathology of soft tissue tumours is almost non-existent, and there is no mention of the recent and potential future developments in molecular biology of bone and soft tissue sarcomas. Elsewhere, important diseases have been under-represented, appearing in bits and pieces in several chapters. For example, there is only a brief pathological description of eosinophilic granuloma in chapter 2 which doesn't adequately discuss the cell of origin of the tumour or its natural history; fragments of information are then scattered in other chapters (site-related tumours) but there is no authoritative or helpful description of the management of this group of puzzling variable conditions.

What is here, is a solid selection of chapters where the authors survey some of what is known about major diseases and try to give a balanced account of the pathology, radiology and treatment. There are useful chapters on rehabilitation, nursing and counselling. The book is useful for trainees interested in this field and, for the most part, gives reliable information concisely. In the next edition the authors might ask the question if I had a patient, say, with mesenchymal chondrosarcoma or retroperitoneal liposarcoma, would this book help me decide what to do? The editorial task would then become clearer.

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News

G.P. Role in Cancer Care

The European School of Oncology funded several multinational courses in 1991 to look at the role of the general practitioner in primary, secondary and tertiary prevention in cancer care in Europe. We report on the French language course at which 20 delegates represented Spain, Germany, Holland, Belgium, Portugal, Italy, Greece, Ireland and Great Britain. Specialist and generalist input, as a formal lecture on each area of prevention, were followed by discussion in small mixed nationality groups, at which the difficulties of the G.P. were freely and openly addressed.

The different health care systems in Europe vary widely, as do the undergraduate and postgraduate medical training programmes.

Primary prevention

In the political forum and in the public perception, primary prevention often has a low status. It is not taught in medical schools or as part of postgraduate training and many doctors demonstrate their own scepticism of primary prevention by continuing to smoke, thereby giving conflicting messages to patients.

The fear of losing 'customers' (patients) makes those in countries without fixed patient lists particularly reluctant to /t ear to criticise their patients' lifestyles. Conflicting opinions over some aspects of prevention can jeopardise the G.P.'s credibility.

A prevention protocol throughout Europe could be used as a basis for health promotion teaching to doctors and medical

students as well as the lay public. A specific protocol should be developed for general practitioners; they are ideally suited to undertaking primary prevention because:

— the G.P. has contact with the family before any illness occurs and during disease-free intervals
— the G.P. is a known and respected member of the local community
— the G.P. clinical record shows the life pattern of the patient, allowing a holistic approach to prevention, unlike the specialist record which tends to be confined to one system or disease
— the consultation in general practice provides the ideal opportunity for primary prevention, especially when acts of secondary prevention such as cervical smears are being undertaken or when giving contraceptive advice.

Data on age, sex, smoking and dietary habits, environmental and industrial exposure to carcinogens, genetic factors and advice given, should all be included in the protocol. Primary prevention should be taught in schools by teachers working with local G.P.s and school doctors. The schools programme should be coordinated with public campaigns on health.

Secondary prevention

Although delegates all agreed that cervical and mammographic screening are of proven value, the screening programmes fail for several reasons.

Some women, fearful of a cancer being found or shy of a male doctor, decline to attend. The national press in some countries does nothing to promote secondary prevention programmes and women's health has a low priority in some countries, where the financial implications of saving years of life are poorly appreciated.

Identification of the population to be screened fails when age–sex registers do not exist. Duplication of tests by generalist and specialist is wasteful of resources. Poor technique in taking smears and poor laboratory technique result in inaccuracies; these quality control issues are often not fed back to the G.P. concerned, whilst few laboratories publish an audit of their results.

Even where screening is well established, the management of the high-risk case is managed idiosyncratically. The medical act of screening is frequently undervalued; the consultation should include a pelvic examination and an opportunity for other aspects of health promotion.

Screening protocols should be written by specialist and generalist working together, to ensure efficient use of resources with frequent evaluation and updating. The programme should define education of the doctors in screening technique, coordination between doctor and laboratory, and aftercare of detected cases requiring further diagnosis and treatment by specialists.

Tertiary prevention

The topic of tertiary prevention involves the palliative and terminal care of the patient with advanced cancer. Home care of patients can be extremely difficult in those countries where domiciliary nursing help and financial assistance is not available. In northern Europe the number of elderly people living alone is increasing.

In Latin countries a death phobia exists, preventing the doctor from addressing the needs of the patient. Sometimes religion bars discussion of other related issues such as contraception or abortion.

Communication skills and palliation are not yet routinely taught to medical students and in postgraduate medical training, leaving doctors ignorant of ways to improve patient care.

The largest problem in several countries remains archaic and restrictive prescribing regulations for opiates. Restrictions on the total daily dose of opiate (e.g. Italy) or the need to obtain a permit for each prescription (e.g. Spain), deny patients adequate pain control.

Changes in these regulations, accompanied by medical education in all aspects of palliative and terminal care, are urgently required. Education should address communication skills, ethics and the theory and practice of techniques for symptom control. The provision of financial assistance and trained community paramedical services would allow many patients to remain at home during their last illness.

The need for changes in medical education

Controls are needed on the numbers of students entering clinical training to ensure classes are of a manageable size. G.P.s are a teaching resource, inadequately used throughout Europe, who can teach on primary, secondary and tertiary prevention, ethics, communication skills and family dynamics. Development of trained G.P. teachers requires a Department of General Practice in each medical school.

Vocational training for general practice is already mandatory for all those wishing to enter practice after 1995. Sadly, several countries in the EEC have used a derogation to avoid establishing proper training programmes which involve hospital and G.P. posts. A higher organisation is required to bring all countries in line with Holland, Denmark, Ireland and the UK, who have already met the minimum training criteria.

Teaching for general practice should be undertaken in small groups, using G.P. tutors with specialist advisors. Both teachers and trainees should be adequately paid. Specific accreditation in general practice is an essential development.

Specialist training for all branches of medicine should ideally contain some experience of general practice to increase understanding of individual patient and family needs, improve understanding between specialist and generalist and encourage joint writing of the proposed treatment protocols.

Continuing medical education should become a statutory requirement of all doctors in Europe. A minimum standard would ensure updating on epidemiology, treatment options, ethics and communication skills. Audit should be used as a standard educational tool to improve patient care.

Overall, all delegates concluded that changes are required in undergraduate, postgraduate and continuing medical education. The regulations governing opiate prescribing need to be brought into line with scientific advances to improve patient care.

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