

Matters arising

Performance indicators

I am sure all haematologists are in agreement with Dr Cavill's article on the complexities of measuring pathology workload.¹ As the article indicates these workload measurements are currently used to draw up performance indicators (PI).

The basic PI in pathology is the cost/workload defined as the annual revenue expenditure on a branch of pathology in a district health authority, divided by the annual number of unweighted requests in that discipline. As with the definition of "request," addressed in Dr Cavill's article, the measurement of the expenditure element is also far from satisfactory. The DHSS guidelines on which items should be included in expenditure are far from comprehensive and even allow some non-pay items to be costed under "miscellaneous".

A questionnaire was circulated to all haematology laboratories within district general hospitals in this region asking about the inclusion or exclusion of certain items in their budget. The results are shown in the table. This shows a wide variance between districts in the inclusion of certain items in the haematology budget. It is hardly surprising that district A has a far better PI than district J.

These PIs are ranked by the region to give an idea of relative levels of activity. PIs were introduced through the publication of *HN(83)25, Health Services Management Performance Indicators*² which states that, "rankings and averages must not be used as norms or as targets," but this does happen when "league tables" are published. PIs can be of value, but it is important that like is compared with like. Personnel in charge of pathology laboratories rather than hospital administrators know what items directly involved in the provision of results should be costed. It is important that more comprehensive guidelines for PIs are produced, hopefully by the profession itself through the Joint Royal College of Pathologists and Association of Clinical Pathologists' Working Party on Performance Indicators before the PIs already published are accepted as meaningful.

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Prospects for cure in acute leukaemia

JM Goldman states that there "is no evidence that adding additional anti-leukaemic agents, such as etoposide, increases the incidence of remission" in acute non-lymphocytic leukaemia (ANLL).¹

The Australian Leukaemia Study Group has reported a randomised study of standard 7-3 (cytosine arabinoside and daunorubicin) v the same drugs with etoposide added (7-3-7) in 264 previously untreated patients with ANLL.² JM Goldman's statement is strictly correct as the complete response rate is not increased with etoposide, but the statement is misleading as etoposide results in significantly prolonged remission, and in younger patients aged < 55, significantly prolonged remission and survival.

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References

- 1 Cavill I. Measurement of pathology workload in the United Kingdom. *J Clin Pathol* 1988;41:817-19.
- 2 DHSS. *HN(83)25, Health services management performance indicators*. London: DHSS, 1984.

References

- 1 Goldman JM. Prospects of cure in leukaemia. *J Clin Pathol* 1987;40:985-94.
- 2 Bishop J, Lowenthal R, Joshua D, et al. A randomized trial of remission induction therapy intensified with VP16 for acute non-lymphocytic leukemia. *Blood* 1987;70(Suppl 1):233a.

Table

Item of Expenditure	District									
	A	B	C	D	E	F	G	H	I	J
On-call payments to MLSSO's	cost included	cost included			cost included	cost included	cost included		cost included	cost included
Service contracts on machinery		cost included		cost included			cost included			cost included
Equipment purchased (value £500-£2000)				cost included				cost included	cost included	cost included
Commercial blood products					cost included	cost included		cost included	cost included	cost included
Specialist blood product charges from NBTS					cost included		cost included	cost included		
PI cost/workload	1.9	2.0	2.1	2.6	2.6	2.7	2.8	3.4	3.6	3.8

Mean PI—Region 2.7, England 2.9.

Dr Goldman comments:

I stand firmly by my statement that the rate of complete remission in AML is not increased by addition of extra drugs, such as etoposide. The Australian Leukaemia Study Group data are entirely consistent with this statement. Moreover, the concept that the drugs used to induce remission influence the duration of remission or survival may well be true for AML (as in ALL), but it is not generally accepted. What is accepted is that early consolidation may prolong remission in AML, and the Hammersmith programme incorporates a variety of drugs for consolidation that were not used to induce remission. It is not therefore surprising that the Australian patients who received the combination including etoposide for consolidation fared slightly better than those who received only the two drug combination.