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LETTERS

SEX LIVES OF OLDER PEOPLE

Self reported sexual activity in Australian sexagenarians

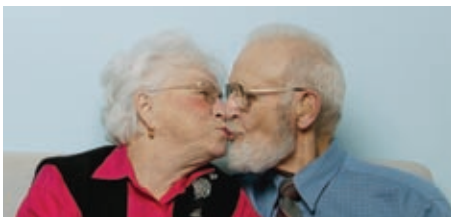
Partner status and sexual activity during previous year and frequency of sex in previous four weeks in men and women aged 60-64. Values are numbers (percentages) unless stated otherwise

Sexual activity	Women (n=298)		Men (n=337)	
	With regular partner (n=223; 75%)	Without regular partner (n=75; 25%)	With regular partner (n=288; 85%)	Without regular partner (n=49; 15%)
Sex during past year	203 (91)	4 (6)	278 (97)	15 (31)
Average No of times in previous month	3.0	0	3.2	0.1

We compare the self reported sexual activity and satisfaction in Swedish 70 year olds¹ with recent data from the Australian longitudinal study of health and relationships (ALSHR)—a nationally representative random sample of men and women aged 16 to 64 who completed a computer assisted telephone interview.² The sample had 635 sexagenarians (60-64), most (80%) with a regular partner, almost all of them married and living with their partner. A quarter of women and 15% of men were not in a regular relationship. Regular sexual activity was the norm for those with a regular partner, both women and men reporting an average of three sexual experiences a month (table).

Among the attitudinal statements presented to respondents was: "An active sex life is important for one's sense of wellbeing"; 78% of women 91% of men agreed with this statement. On a four point scale (not at all, slightly, moderately, and very), respondents in relationships were asked to indicate the degree of physical pleasure in sex with the partner, satisfaction with the sexual relationship, and emotional satisfaction with the relationship. Although women were less likely than men to say that sex was "very" pleasurable (56% v 81%), satisfaction with the sexual relationship differed less (65% women and 72% men reported being very satisfied). Men (86%) were more likely than women (72%) to say that they found the relationship "very" emotionally satisfying.

These data and those of Beckman et al are a timely reminder for health providers



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that older people are still sexually active and enjoying sexual activity. Given the importance of pleasurable sexual activity for these older people, it is important that clinicians consider sexuality as an important aspect of all patients' wellbeing regardless of their age.

Competing interests: None declared.

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- 1 Beckman N, Waern M, Gustafson G, Skoog I. Secular trends in self reported sexual activity and satisfaction in Swedish 70 year olds: cross sectional survey of four populations, 1971-2001. *BMJ* 2008;337:a279. (8 July.)
- 2 Smith AM, Pitts MK, Shelley JM, Richters J, Ferris J. The Australian longitudinal study of health and relationships. *BMC Public Health* 2007;7:139.

Cite this as: *BMJ* 2008;337:a1250

SEROPROTECTION AND MENINGITIS C

Meningococcal C booster not recommended by evidence

Snape et al recommend that a booster dose of meningococcal group C glycoconjugate vaccine (MenC) be administered to children entering adolescence in the UK in the next five years.¹ However, their study did not look for, or provide, any evidence of increasing nasopharyngeal carriage in pre-adolescents, and underestimates the protective effect of herd immunity on those vaccinated in early childhood between 2000 and 2005 who may have lower levels of seroprotection.

MenC vaccination reduces the prevalence of nasopharyngeal carriage of serogroup C meningococci,² as well as disease incidence in the unvaccinated population.³ Post-licensure

surveillance of meningococcal group C disease in England has not found evidence of reduced effectiveness of the vaccine with time, apart from in infants, who are now given a booster dose at one year.⁴ In 2007-8 (July to June), only 28 laboratory confirmed cases were identified in England and Wales, compared with over 900 cases in the year preceding the introduction of vaccination.

Mathematical modelling predicts that high rates of indirect protection against meningococcal group C disease are likely to persist, even if the vaccine only provides three years' protection against carriage.⁵ The most recent surveillance data are consistent with model predictions of a continued decline in disease incidence (figure available on request) and suggest that protection against carriage lasts somewhere between three and 10 years, with the impact on herd immunity likely to persist for much longer.

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 Competing interests: None declared.

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Cite this as: *BMJ* 2008;337:a1139

FUNDING CANCER TREATMENTS

Ethics of PCT decision making on funding cancer treatments

We recently co-chaired the Cancer Agenda 2008 meeting with leading cancer clinicians. One theme that emerged was the high level of concern about the ethics of primary care trusts' decision making on funding cancer treatments.

Increasingly, clinicians feel tension between their obligations to individual patients and

society.^{1,2} They are trained to provide best care for patients but recognise that this conflicts with the NHS's ability to provide optimal care to all patients with all conditions in a just and equitable way in an economically limited system. Societal responsibility for these decisions is expressed through the National Institute for Health and Clinical Excellence (NICE), the Scottish Medicines Consortium, and similar bodies.

NICE's judgments allow for non-approved treatments in "exceptional cases." The principle of natural justice supports equity of treatment for all. This is being undermined by different interpretations of exceptionality; the decision to argue for exceptionality can put the responsibility—but neither the decision making nor the funding—back in the clinician's court. We urge that national guidance be provided to define "exceptional cases."

Professional bodies, and the *BMJ*, should challenge primary care trusts to show they have adopted a coherent, cogent, and transparent approach to making decisions about funding treatments.

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Competing interests: Cancer Agenda is supported by an unconditional education grant from Pfizer Oncology. To the best of our knowledge, Pfizer Pharmaceuticals, which provided this grant, will not benefit financially in any way from the publication of our letter summarising the concerns which arose at the 2008 meeting.

- 1 Godlee F. The world is watching the English experiment. *BMJ* 2008;337:a953. (23 July.)
- 2 Beach MC, Meredith LS, Halpern J, Ford D. Physician conceptions of responsibility to individual patients and distributive justice in health care. *Ann Fam Med* 2005;3:53-9.

Cite this as: *BMJ* 2008;337:a1243

NEW PROSTATE CANCER DRUG

Prostate cancer's day in the sun

Recently we and others have studied different anti-cancer drugs in patients with castration resistant prostate cancer (CRPC).^{1,2} In none of these trials have we observed anything like the biochemical, radiological, and, importantly, symptomatic benefit reported with abiraterone acetate.

The results of our phase I study have been confirmed by a second phase I study in North America and four phase II studies run by our team and several North American investigators. These studies were recently presented at the American Society of Clinical Oncology annual meeting held in Chicago³⁻⁵ and will be published over the next year. The results remain preliminary and require confirmation in an ongoing 1180 patient phase III study, but they are very encouraging and



anticipate that further therapeutic targeting of the androgen receptor signalling axis in CRPC can achieve disease control in a sizeable proportion of CRPC patients whose prostate cancer has progressed through all currently available hormonal treatments.

Nevertheless, although these treatments should not be heralded as a cure for metastatic CRPC, our research is leading us closer to an increased understanding of the biology of this disease, which, in turn, increases the likelihood of our achieving better long term control of it. Abiraterone now needs to be further evaluated in the adjuvant setting in high risk patients to determine whether it can reduce the risk of recurrence.

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Competing interests: Abiraterone acetate was discovered at the Institute of Cancer Research, which therefore has a commercial interest in its development. JSDeB is a paid employee of the Institute of Cancer Research and has served as an unpaid consultant for Cougar Biotechnology. The authors are employees of the Section of Medicine, which is supported by a Cancer Research UK programme grant and an Experimental Cancer Medical Centre (ECMC) grant from Cancer Research UK and the Department of Health. The authors were also supported by the Medical Research Council, the Prostate Cancer Research Foundation, and the Royal Marsden Hospital General Research Council Fund.

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- 2 Attard G, Sarker D, Reid A, Mollife R, Parker C, de Bono JS. Improving the outcome of patients with castration-resistant prostate cancer through rational drug development. *Br J Cancer* 2006;95:767-74.
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- 4 Ryan CS, Smith MR, Rosenberg JE, Lin AM, Taplin M, Kantoff PW, et al. Impact of prior ketoconazole therapy on response proportion to abiraterone acetate, a 17-alpha hydroxylase C17,20-lyase inhibitor in castration resistant prostate cancer (CRPC). *J Clin Oncol* 2008;26(May 20 suppl:abstr 5018).

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Cite this as: *BMJ* 2008;337:a1249

COMPETING INTERESTS

Any affiliation can lead to bias

Lenzer and Brownlee rightly draw attention to the problem of undeclared commercial interests that conflict with the public interest and influence media reporting of medical advances, but there is a danger that their diagnosis and proposed solution ignore the underlying causes.¹

Any affiliation, not just a link to a commercial enterprise, can lead to bias, and almost everybody has some sort of affiliation, so few people are truly independent. However, the absence or presence of such affiliations does not prove or disprove bias. The actual, rather than potential, independence of a commentator depends on qualities that are difficult to measure such as personal integrity and expertise, rather than proxies such as declarations of "no commercial interest."

More importantly, while efforts to identify conflicts of interest are important, there is an unhealthy trend towards the demonisation of everybody who is associated with the commercial sector. Commercial interests are not always corrupting, and much high quality, honest work is carried on outside universities and other supposedly independent research institutions.

But a very major contributor to the current problem is the time pressure under which journalists have to operate. It is always dangerous for any journalist to rely on just one commentator for opinion, even if they do appear on an "approved list of independent experts," but it can often be difficult to get experts on the phone to express an interesting and coherent opinion. Ideally, journalists should be able to gain a range of expert views, allowing them to identify and detect any outlying opinions that seem to have been influenced by bias, lack of expertise, etc. It would be far better to encourage more experts to make themselves available for comment, than to come up with lists of approved sources.

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Competing interests: TLB and BW have acted as experts in the media on various issues. The views expressed are their own and do not represent their organisations.

- 1 Lenzer J, Brownlee S. Naming names: is there an (unbiased) doctor in the house? *BMJ* 2008; 337: a930. (23 July.)

Cite this as: *BMJ* 2008;337:a1256