fifth of the possible women in the fertile age group in his practice by approaching those taking oral contraceptives, despite the fact that only three out of 459 women refused to provide a blood sample. Many women use contraceptive methods which do not require medical supervision. Some use nothing. Some will not be currently at risk of pregnancy, but will be in the future.

Goodman's system⁵ of vaccinating all girls in the practice aged 11-14, identified from the age-sex register, is ideal. However, if GPs rely on vaccination at school (with the current 70% uptake), the back-up facility of offering blood tests to all women in the fertile age group (15-44), with vaccination of seronegatives, needs to be available. This requires an age-sex register and is a major undertaking. Only a few well-organised practices will be able to achieve this. Thus in the long run the school-girl programme is of vital importance in reducing the incidence of congenital rubella and full support must be given to increasing the uptake.

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¹ Dudgeon, J A, *American Journal of Diseases of Children*, 1978, **132**, 748.

² Banatvala, J E, in *Recent Advances in Clinical Virology*, ed A P Waterson, p 173. Edinburgh, Churchill Livingstone, 1977.

³ Clarke, M, et al, *Lancet*, 1979, **1**, 1224.

⁴ Gringras, M, et al, *British Medical Journal*, 1977, **2**, 245.

⁵ Goodman, M, *GP Update*, 1976, **12**, 527.

Value of cytology for detecting endometrial abnormalities

SIR,—We read with concern the original article by Mr J W W Studd and others "Value of cytology for detecting endometrial abnormalities in climacteric women receiving hormone replacement therapy" (31 March, p 846) and feel that this paper should not pass unchallenged. The study appears to us to be ill designed and the interpretation of the results appears misleading.

The value of a pathology report depends on the status and expertise of the pathologist who makes it. In this study no consideration has been given to these important factors. Both consultant histopathologists involved in this study probably have had many years of experience of interpreting endometrial biopsy material. It is unlikely that the same claim can be made by the cytologists. The technique of obtaining endometrial aspirates with the Isaac aspirator is new to this country and criteria for cytological diagnosis of endometrial cell samples have not yet been clearly defined. We have organised a trial of the aspirators at several different centres in the country to try to establish their accuracy for routine cytodiagnosis, based on cytological-histological correlation of over 500 cases, of which an appreciable proportion will have abnormal pathology. We hope to establish a consensus of opinion regarding reliable cytological criteria.

Until a cytologist is experienced in interpreting endometrial aspirates he is in no position to embark on a comparative study of this kind. Thus the conclusion drawn from the study that the Isaacs endometrial cell sampler cannot be advocated for routine use is premature. It is unfortunate that such a statement should appear with so little reliable evidence, especially as the authors themselves claim that cytology was superior in one case.

One of only three adenocarcinomas in the study was detected by cytology and missed by curettage. Surely a new technique deserves a wider trial before being condemned as unsatisfactory, particularly when other studies^{1,2} have shown encouraging results.

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¹ Hutton, J D, et al, *British Medical Journal*, 1978, **1**, 947.

² Isaacs, J H, and Ross, F H, *American Journal of Obstetrics and Gynaecology*, 1978, **131**, 410.

Minor operations in general practice

SIR,—While Dr J S Brown (16 June, p 1609) is to be congratulated on showing how an enthusiastic and suitably experienced general practitioner can perform minor surgery in his practice premises, I must take issue with him over the amount of money he feels that he has saved the area health authority. At no time did Dr Brown question why certain classes of patient were kept in hospital for several days over the period of operation, and yet he could perform the same operation on an outpatient basis from his own surgery. Many hospitals have day theatre facilities and all the operations which he lists could be performed in such facilities without requiring the patient to stay overnight in hospital. Therefore his calculations of the cost of hospital treatment for patients are biased by the average stay of certain classes of patient in hospital. I find it surprising, for instance, that a patient having a wedge resection of nail bed under local anaesthetic would be expected to stay in hospital an average of seven days. It would be almost impossible to justify this length of stay when day theatre facilities are available and it is extremely difficult at times to arrange the admission of patients with acute conditions because of the lack of hospital beds.

Apart from this problem with the data in the article, Dr Brown does not appear to be comparing like with like in that so far as the general practitioner is concerned he has costed only the equipment required, whereas the hospital costs must include an element for staff salary and other facilities which are provided.

It is unfortunate that Dr Brown should have chosen to justify his work by a false costing analysis rather than by the virtue of showing the range of minor surgery that it was possible for a general practitioner to perform outside hospital premises.

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SIR,—I would like to congratulate Dr J S Brown on his article "Minor operations in general practice" (16 June, p 1609), but as an orthopaedic surgeon I feel that I must comment on those operations which he has performed but which are traditionally done by my specialty.

Decompression of carpal tunnel, wedge resection of toenail, excision of synovioma, excision of ganglion, and release of trigger

finger are all operations which are commonly done as day cases. This being so his total should be reduced by £6853. Furthermore, I doubt whether any benefit is ever derived from aspirating a ganglion or a bursa as the contents soon reform. This would therefore reduce his total by a further £65.

I am sure that Dr Brown is saving the hospital budget money but would suggest that this is certainly not more than £8000, and probably less.

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Saving asthmatics

SIR,—I agree very much with Drs I W B Grant and A R Luksa (30 June, p 1791) in their recommendation of easy access to hospital for asthmatic patients or self-admission in emergency. For nearly 20 years asthmatic patients under my care have been given a card which states that they are to be admitted to one of my outpatient clinics without prior appointment if they arrive by 4 pm, or if they present at accident and emergency with asthma they are to be admitted immediately to one of my beds. They also have my secretary's telephone number. There has been no abuse of these facilities—indeed mere possession of the card is said by many to be therapeutic. Sufferers from asthma do not like having to deal with strange doctors because of their extreme sensitivity to domination and rejection, which all too often they court unconsciously; and this factor may lead them to hang on perilously long at home if their own general practitioner is off duty or away on holiday. This is because they are averse to calling one of his partners, whom they may fear will be brusque, or in inner cities submitting to the Russian roulette of the faceless deputising service. Junior staff and accident and emergency departments need to be briefed fairly frequently if the above method is used, because nurses and doctors are always changing and a patient receiving an angry rebuff such as "I have never heard such nonsense" can be tipped even further into status asthmaticus.

I came to the above practice through a gradual understanding of the psychosomatic aspects of asthma and being impressed by the effectiveness of the friendly open-door approach adopted by Hans Heckscher in Copenhagen 30-40 years ago.

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Pathogenesis of pelvic inflammatory disease

SIR,—Your recent leading article on the pathogenesis of pelvic inflammatory disease (16 June, p 1588) highlighted many of the complexities surrounding its aetiology. Secondary infection with anaerobes greatly complicates bacteriological assessment. A contribution to the solution of these difficulties may result from studies using cervical cytology to detect *Actinomyces israelii*.

This potentially pathogenic anaerobe has been identified only in patients with a foreign body in the genital tract, usually an intra-uterine device.¹ Neither symptoms nor clinical evidence of pelvic inflammation are invariable on first detection of the organism.² However,