life table rate per 100 woman-years, in which this problem of interpretation does not arise.

(3) The risk factors which predispose to ectopic pregnancy vary from population to population and may vary between users of different contraceptive methods. Unless this variability is taken into account bias may be introduced. Future studies should be designed to ensure that such bias is excluded.

(4) All published studies of ectopic pregnancy rates have, so far as can be determined, failed to state the criteria for the diagnosis of ectopic pregnancy, leading perhaps to an overestimate of its incidence. If ectopic pregnancy is thought to have occurred in test or control patients in any clinical trial of an IUD all material removed from the peritoneal cavity should be examined. Fluid, blood clots, and curettings, if taken, should be studied macroscopically. Clots should be sieved or fixed and sliced for gross examination and all suspicious areas examined microscopically. The aim of the verification of the diagnosis of ectopic pregnancy is to improve the accuracy of incidence data in IUD studies. For this purpose it is considered essential for the diagnosis that fetal parts (identified grossly or microscopically) and/or trophoblast are identified. Decidual reaction and/or blood in the Fallopian tube is not sufficient to establish the diagnosis. This definition does not preclude a presumptive diagnosis made for clinical purposes, based for example on tubal disruption, decidual change in Fallopian tube or endometrium, gross blood in the peritoneal cavity, or other suggestive operative findings.

(5) Because of the limited data available and the difficulties of comparisons between studies it is not possible to state that the Progestasert IUD users are at higher risk of ectopic pregnancy than other IUD users. Ectopic pregnancy rates for Lippes Loop and copper-carrying IUD users quoted by Dr Snowden, 0.06 and 0.05/100 woman-years respectively, are much lower than those cited by Vessey *et al.*,² 0.121/100 woman-years for a variety of IUDs. Dr Snowden compares UK data with world-wide data for the Progestasert IUD, a comparison which is felt to be invalid.

At the present time it is not possible to make a valid comparison of the ectopic pregnancy rates for different IUDs.

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¹ Tatum, H J, and Schmidt, F H, *Fertility and Sterility*, 1977, **28**, 407.

² Vessey, M P, *et al*, *Journal of Biosocial Science*, 1976, Suppl 11.

How not to apply for an appointment

SIR,—Among the large number of applications received in response to a recent advertisement in the *BMJ* for a vacancy in this department many were from overseas graduates. Most were handwritten and several were scarcely legible. One spelt the addressee's name incorrectly. In other cases the carbon copy of a standard letter of application was sent with amendments and additional information in ballpoint. Typed curricula vitae, when these were sent, were generally set out badly and often contained spelling mistakes. One applicant requested the return of his curriculum vitae after "we had finished with it."

The immediate reaction on receiving applications such as these is to dismiss them as being so carelessly prepared that they indicate little real desire to be considered seriously for the vacancy. However, having

made the effort to read each of them, it became clear that several of the applicants were of high quality. It is regrettable, therefore, that partly out of a poor knowledge of English and partly out of ignorance of the high value (perhaps much too high a value) placed in our culture upon neatness and etiquette in matters of this kind many doctors do not do themselves justice and risk repeated disappointments over not being short-listed.

I would like to suggest that those whom overseas graduates request to be a referee might offer their help over composing letters of application and curricula vitae. Since nearly all overseas graduates spend some time in hospital appointments, should not the consultants for whom they work make sure that their protégés have mastered the rules of this procedure, which is one of such importance to them in their future career?

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"Baby and Child"

SIR,—When I read Dr Penelope Leach's letter (25 February, p 506) I felt some initial anxiety lest I had misread certain sections of her book. However, your readers will find if they will refer to the book that I have nowhere misquoted it.

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Stiff-neck syndrome

SIR,—I was most interested to read the letter from Dr J Shafar describing a stiff-neck syndrome (25 February, p 511). About four years ago I witnessed a similar incident. Three nurses working in the theatres at one hospital where I worked and one auxiliary working in the theatres of another all complained of stiff neck at about the same time. I was also affected as was my sister with whom I lived.

Although I was not concerned with treating any of the nursing staff, the clinical picture relating to my sister and myself was as described by Dr Shafar. The close association of cases in time seemed to be more than coincidence and an infective origin the most likely explanation.

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Plasma urate changes in pre-eclampsia

SIR,—Dr C W G Redman and his colleagues (25 February, p 467) are to be commended for attempting to establish the sequence of events leading to pre-eclampsia. However, in using plasma urate concentration to define incipient pre-eclampsia they may have underestimated the variations which occur in normal pregnancy.

Previous publications^{1,2} from Oxford have made use of a critical value (350 $\mu\text{mol/l}$ (6 mg/100 ml)) above which patients might be classified as having significant pre-eclampsia. The justification for such a classification is to be found in an epidemiological study³ in which the same authors demonstrated

a significant increase in perinatal mortality in hypertensive patients with a plasma urate concentration above this value. Their recent paper, however, makes use of incremental changes in plasma urate concentration without reference to this critical value. We are not shown the epidemiological justification for this new method of defining disease severity.

Our own data would suggest that the rise of 30 $\mu\text{mol/l}$ (0.5 mg/100 ml) used by the authors to categorise "borderline" pre-eclampsia may be physiological in normotensive pregnancy, during which a gradual increase in plasma urate concentration is to be anticipated.⁴ We have found that (1) between 16 and 36 weeks' gestation in normal pregnancy an increase in plasma urate concentration of 30 $\mu\text{mol/l}$ or more occurred in 13 out of 24 healthy patients,⁵ while eight patients in fact showed a rise of more than 60 $\mu\text{mol/l}$ (1 mg/100 ml); and (2) throughout the course of a single 24-h period in the third trimester of normal pregnancy a diurnal variation of 30 $\mu\text{mol/l}$ or more occurred in 10 out of 14 healthy patients.⁶ (One subject showed a maximum variation of 61 $\mu\text{mol/l}$.)

In the recent study by Dr Redman and his colleagues, the groups of patients showing a "borderline increase" and "no increase" in plasma urate did not differ appreciably in terms of mean blood pressure, proteinuria, gestational age at delivery, mean birth weight, and perinatal mortality. This seems to strengthen our suggestion that an increase in plasma urate concentration of 30 $\mu\text{mol/l}$ should not be regarded as abnormal.

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¹ Redman, C W G, *et al*, *British Journal of Obstetrics and Gynaecology*, 1977, **84**, 904.

² Redman, C W G, *et al*, *Lancet*, 1977, **2**, 1249.

³ Redman, C W G, *et al*, *Lancet*, 1976, **1**, 1370.

⁴ Boyle, J A, *et al*, *Journal of Clinical Pathology*, 1966, **19**, 501.

⁵ Dunlop, W, and Davison, J M, *British Journal of Obstetrics and Gynaecology*, 1977, **84**, 13.

⁶ Hill, L M, Furness, C, and Dunlop, W, *British Medical Journal*, 1977, **2**, 1520.

Osteoporosis and osteomalacia

SIR,—Dr T C B Stamp (25 February, p 511), discussing a paper by Dr R G Long and others on the treatment of hepatic osteomalacia (14 January, p 75), comments that the x-rays in the latter study "indicated osteoporosis and not osteomalacia." Apart from numerous fractures the radiological skeletal survey in all four patients showed bone thinning but no evidence of osteitis fibrosa cystica or periosteal reactions.

In 56 consecutive cases of thinning of the upper cortex of the clavicle in adults aged 42-91 idiopathic osteoporosis was present in 44, but osteomalacia was present in 4.¹ In elderly patients it is uncertain whether cortical thinning is due to osteomalacia, as there may be a concomitant osteoporosis due to aging. For this reason I followed up all cases of clavicular cortical thinning (1.5 mm or less) in adults over 45. There were 18 such patients in a 10-year period. Chronic renal failure accounted for eight, coeliac disease seven, steroid therapy two, and Cushing's syndrome one. All the patients with coeliac disease had biochemical osteomalacia. Pseudofractures were common but were absent in one case,