These differences emphasise how important it is that research workers studying the mental health of Asian populations in Britain should record details about the populations they study. The study by Cochrane and Stopes-Roe¹ shows this. On the basis of interviews with a carefully drawn population based sample they concluded that "Indian immigrants as a group experience far less psychological disorder than natives," and their introduction suggests that they see the study as having general relevance to British Asians. In their results section, however, they tell us that most of the Asians interviewed were Punjabi Sikhs, a group who on the evidence presented above might be expected to show a relatively low rate of disturbance within the British Asian community.

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- 1 Ineichen B. The mental health of Asians in Britain. *Br Med J* 1990;300:1669-70. (30 June.)
- 2 Nicoll A, Bassett K, Uliaszek SJ. What's in a name: accuracy of using surnames and forenames in ascribing Asian ethnic identity in English populations. *J Epidemiol Community Health* 1986;40:364-8.
- 3 Cochrane R, Stopes-Roe M. Psychological symptom levels in Indian immigrants to England—a comparison with native English. *Psychol Med* 1981;11:319-27.

SIR,—In Dr Bernard Ineichen's review of psychiatric disorders among Asian immigrants to the United Kingdom he points out that none of the alternative explanations for their apparent low uptake of psychiatric services is at present unequivocally superior to the others.¹ Nevertheless, the possibility that cultural barriers may be partly responsible is a matter for some concern.

It is interesting to consider the findings of a recent survey of mental health provision in his own borough of Newham.² This covered the health service, social services, and the voluntary sectors. It showed that in several of the facilities in the health sector Asians were underrepresented relative to the size of the Asian population in Newham.

On the other hand, within the voluntary sector the reverse was sometimes the case. For example, the Newham branch of the National Association of Mental Health (MIND), which offers a specific service to Asian women, reported that 39% of its clients were Asians (compared with an estimated Asian population in the borough of only 13%). Similarly, in the case of the Neighbourhood Care Project for the elderly Asians constituted 22% of those who used the facility; most of the clients referred themselves for social reasons.

In other parts of the voluntary sector where the service was more formal and there was no open referral system ethnic minorities were again underrepresented. The authors suggest that attempts to cater specifically for the needs of the Asian community could be extended from the voluntary to the health service and social services sectors.

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- 1 Ineichen B. The mental health of Asians in Britain. *Br Med J* 1990;300:1669-70. (30 June.)
- 2 Wills J, Martineau F, Denby A, Okine F, Gwyntopher C. A research survey of social services, health service and voluntary sector mental health provision in Newham. London: Newham Health Authority, 1990.

SIR,—The editorial by Dr Bernard Ineichen, with its reference to 34 learned articles on this topic, illustrates how scholarship can be remote from common sense.¹ The writer tortures himself to explain away the cleaner bill of mental health of the ethnic groups originating in the Indian

subcontinent and ends up with sententious advice that Asian patients "need encouragement to express their emotional problems" and that "doctors need to develop a greater sensitivity in recognising them."

The statistics are in line with clinical experience. Southall, with one of the biggest concentrations of Asians in Britain, is next door to St Bernard's psychiatric hospital, where Asians are as conspicuously common among the staff as they are unusual among the patients. Disturbed children were constantly referred from schools to my London child psychiatry clinic, which had liaisons with inner city schools with big ethnic minorities, but over the years few of them were Asian.

The statistics have a commonsense explanation that the writer seems not even to have considered, and they are not obviously an illusion to be explained away. It is simply that secure foundations of mental health are much more commonly laid down in Asian children than in the population generally because they are still being reared, in this Western age of divorce and separation, in cohesive families and by an unbroken parental couple. This is no longer the prevalent experience of children generally and even less is it the experience of children from other ethnic groups with mental health statistics unhappily opposite to the Asian ones.

Dr Ineichen also, incidentally, made no mention of other factors that support the favourable figures for mental health in the Asian ethnic groups and probably have similar causes—their educational and economic upward mobility and their low rate of delinquency.

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- 1 Ineichen B. The mental health of Asians in Britain. *Br Med J* 1990;300:1669-70. (30 June.)

SIR,—Underreporting and lack of appropriate referral are likely to be important causes of the low prevalence of mental illness in British Asians discussed by Dr Bernard Ineichen.¹ Even when there are physical manifestations of disease, prevalence rates can still be low. Huntington's chorea, for example, has long been thought to have a much lower prevalence in Asian populations, but a recent study suggests that the actual prevalence is much higher than previously supposed.² Furthermore, in Bombay the prevalence may be as high as that in the West (M E Barucha, personal communication), yet this is not reflected in the rates of referral of patients and at risk family members to our organisation and to genetics clinics.

In the past four years I have encountered two Asian families. Both were noteworthy for the comparative and remarkable inertia and indifference on the part of almost every agency involved, including medical and nursing staff and housing and social services departments. It was particularly surprising in these two families, which included young children and had problems of domestic violence.

Whence this reluctance to act or refer? Sometimes, I think, from the myth that Asian families are large and self supporting. More often, I fear, from our unwillingness to identify with the sufferings of those with a different language, culture, and colour of skin; this is called racial discrimination.

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- 1 Ineichen B. The mental health of Asians in Britain. *Br Med J* 1990;300:1669-70. (30 June.)
- 2 Shiwak RL, Lindenbaum RH. The prevalence of Huntington's chorea amongst Asian immigrants from the Indian subcontinent. *Br J Psychiatry* (in press).

Management of patients with multiple trauma

SIR,—Your reviewer, having read our audit of major trauma, comes to the conclusion that perhaps Lewisham Hospital should not deal with patients with multiple trauma.¹ We do not disagree entirely with this statement and said so in that paper—but trauma centres must be available first. In the interim it is sensible to use trauma teams in district general hospitals until trauma centres are more readily available in the United Kingdom, and that was the whole point of the audit.

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- 1 Anonymous. News and information. *Br Med J* 1990;300:1569. (16 June.)

Antihypertensive and adverse biochemical effects of bendrofluazide

SIR,—Professor P S Sever's reply to Dr G D Johnston's pertinent question¹ draws attention to the high prevalence of raised serum cholesterol concentrations in hypertensive patients. Professor Sever is concerned that thiazides and perhaps β blockers may worsen this and be responsible for the disappointing impact of antihypertensive treatment on coronary disease.

Collins *et al* recently reviewed the outcome of large trials from this point of view.² The reduction in coronary events with antihypertensive treatment was 14% (95% confidence interval 4 to 22%) compared with a reduction suggested by epidemiological studies of 20-25%. The shortfall in coronary prevention could easily be due to chance,² and even if it is real the small difference in lipid concentrations associated with thiazides was unlikely to account for more than a small part. At a recent meeting of the International Society of Hypertension MacMahon, a coauthor of the review, revealed that he had access to all the data on cholesterol from the Medical Research Council's trial, not just the published data, and that thiazide treatment had no important effect on serum cholesterol concentrations. The dose of bendrofluazide used in the Medical Research Council's trial, 10 mg daily, is now known to be too high, and changes in lipid concentrations are less appreciable in the short term with smaller doses.³ Professor Sever is therefore concerned that a non-existent phenomenon (long term raising of cholesterol concentrations by thiazide) causes a problem that may not exist (a shortfall in coronary prevention) and that if it did exist could not be explained by the non-existent phenomenon.

Professor Sever accepts that views differ as regards replacement of thiazides (and possibly β blockers) as first line drugs, but readers should be clear that his view is very much a minority one. A survey of clinical members of the British Hypertension Society showed that 80% prefer thiazides and β blockers as first and second line treatment.⁴ It seems therefore that the society's members support the policy recommended by the British Hypertension Society Working Party.⁵ Perhaps they, like us, do not accept that newer drugs such as angiotensin converting enzyme inhibitors, calcium antagonists, and α blockers are better tolerated than thiazides and β blockers. The newer drugs have not stood the test of time or examination in large trials to prove their long term safety, and they are, of course, much more expensive than thiazides or β blockers.

We should be thankful that we have new drugs as valuable alternatives or additions to thiazides

and β blockers. But those who favour these drugs for first line treatment because of circumstantial evidence, as Professor Sever does, while disregarding the proved safety and efficacy of the older drugs in long term intervention trials threaten to return us to the dark ages of therapeutics.

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- 1 Correspondence. Antihypertensive and adverse biochemical effects of bendrofluazide. *Br Med J* 1990;301:42-3. (7 July.)
- 2 Collins R, Peto R, MacMahon S, et al. Blood pressure, stroke, and coronary heart disease. 2. Short-term reductions in blood pressure: overview of randomised drug trials in their epidemiological context. *Lancet* 1990;335:827-38.
- 3 Carlsen JE, Kober L, Torp-Pedersen C, Johansen P. Relation between dose of bendrofluazide, antihypertensive effect, and adverse biochemical effects. *Br Med J* 1990;300:975-8. (14 April.)
- 4 Waller PC, McInnes GT, Reid JL. British Hypertension Society members' views on the management of hypertensive patients: results of the 1988 questionnaire. *J Hypertens* 1989;7:931.
- 5 British Hypertension Society Working Party. Treating mild hypertension. *Br Med J* 1989;298:694-8.

Oocyte donation

SIR,—Dr Peter Bromwich made an omission in his editorial on oocyte donation.¹ This form of procreation also greatly appeals to couples who are carriers of autosomal recessive disorders such as cystic fibrosis or thalassaemia. Some couples would not contemplate prenatal diagnosis and termination of pregnancy but are interested in reducing the risk, and one way in which this can be achieved is either by artificial insemination using donor sperm or by oocyte donation. Oocyte donation has greater appeal as the donated oocyte is fertilised by the man's sperm and then implanted into his partner so that the baby belongs to both of them and neither parent feels excluded.

In disorders such as thalassaemia it can be ensured that the donor is not a carrier. For cystic fibrosis the chances of the donor being a carrier can be reduced by testing her for the deletion ΔF_{508} . Couples who have had children with autosomal recessive disorders for which prenatal diagnosis is not available are also interested in oocyte donation because it reduces the risk of having further affected offspring—for example, a couple who have had a child with Werdnig-Hoffman disease would have a one in four chance of having a second child with the disease; oocyte donation would reduce the risk to one in 400, assuming that one in 100 people carry the gene for Werdnig-Hoffman disease.

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- 1 Bromwich P. Oocyte donation. *Br Med J* 1990;300:1671-2. (30 June.)

Human papillomaviruses in anogenital warts in children

SIR,—We wish to add some further observations to the article by Dr A F Padel and colleagues on anogenital warts in children.¹ There are now several methods of showing the presence of human papillomavirus nucleic acids, and these vary in their sensitivity and specificity. We are aware of four studies that have used techniques of Southern blotting and dot blot hybridisation to differentiate between skin and genital types of papillomavirus in anogenital warts of children.²⁻⁵ In these combined series a total of 52 patients were studied, 73% showing papillomavirus type 6 or 11, 10% type 16 or 18, 4% type 2, 2% type 57, and 2% an unclassified type related to types 26 and 57. Dr Padel and colleagues, however, used in situ hy-

bridisation, and their series showed 10 (59%) children with papillomavirus type 6 or 11, none with type 16 or 18, and six (35%) with type 2.

It is commonly assumed that both Southern blotting and in situ hybridisation are 100% accurate. Variation in the results of papillomavirus typing by Southern blotting in different laboratories has been shown.⁶ There have been few studies performed correlating in situ hybridisation with Southern blotting. In a small series of patients with condylomas analysed by both these methods 82% were positive by Southern blotting and 72% by in situ hybridisation.⁷ A reasonable view is that there is still insufficient evidence to assess fully the quality of in situ hybridisation tests against that of Southern blotting.⁸

Cross hybridisation occurs between closely related papillomavirus types even under highly stringent conditions, as was shown by a study in which two specimens hybridised with a papillomavirus type 2 probe in a dot blot assay but did not show the *Pst*I digestion pattern typical of type 2 by Southern blotting. These specimens were subsequently shown to be a type 57 and an unidentified type related to types 26 and 57. Papillomavirus types 2 and 57 have greater than 80% homology in their nucleotide sequences (E M de Villiers, personal communication).

We suggest that further studies using in situ hybridisation on specimens from children with anogenital warts should also use Southern blotting to discriminate fully between skin and genital human papillomavirus types in this important clinical condition.

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- 1 Padel AF, Venning VA, Evans MF, Quantrill AM, Fleming KA. Human papillomaviruses in anogenital warts in children: typing by in situ hybridisation. *Br Med J* 1990;300:1491-4. (9 June.)
- 2 Rock B, Naghashfar Z, Barnett N, Buscema J, Woodruff JD, Shah K. Genital tract papillomavirus infection in children. *Arch Dermatol* 1986;122:1129-32.
- 3 Benton EC, MacKinlay GA, Barr BB, Smith IW. Characterisation of human papillomavirus DNA from genital warts in children. *Br J Dermatol* 1989;121(suppl 34):36.
- 4 Gibson PE, Gardner SD, Best SJ. Human papillomavirus types in ano-genital warts of children. *J Med Virol* 1990;30:142-5.
- 5 Hanson RM, Glasson M, McCrossin I, Rogers M, Rose B, Thompson C. Ano-genital warts in childhood. *Child Abuse Negl* 1989;13:225-33.
- 6 Brandsma J, Burk RD, Lancaster WD, Pfister H, Schiffmann MH. Inter-laboratory variation as an explanation for varying prevalence estimates of human papillomavirus infection. *Int J Cancer* 1989;43:260-2.
- 7 Caussy D, Orr W, Daya AD, Roth P, Reeves W, Rawls W. Evaluation of methods for detecting human papillomavirus deoxyribonucleotide sequences in clinical specimens. *J Clin Microbiol* 1988;26:236-43.
- 8 Lorincz AT. Human papillomavirus detection tests. In: Holmes KK, Mardh PA, Sparling PF, et al, eds. *Sexually transmitted diseases*. New York: McGraw-Hill, 1990:953-9.

AUTHORS' REPLY,—We entirely agree with the comments of Dr C J N Lacey and colleagues that the specificity of dot blot and in situ hybridisation can be much less than that of Southern blot hybridisation and that, indeed, the former methods are notorious for producing false positive results. We also agree that the problem of variation between laboratories in analysing samples is one which needs to be addressed urgently.

It was to try to overcome these potential pitfalls that we rigorously checked the restriction patterns of our probes before use and also rechecked positive restrictions at very high stringency. Using this approach we observed no cross reaction between the usual adult genital and skin types in any of our biopsy specimens. Thus, our conclusion that a proportion of anogenital warts in children

contain human papillomavirus types (including skin types) other than conventional adult genital types agree with recently published data, including those quoted by Lacey *et al*.

The implications of these observations need further study, and though it would be ideal to perform Southern blot hybridisation in all such cases, this special clinical condition often constrains the amount of material that can be obtained. This may necessitate investigation by methods that use less starting tissue than Southern blotting such as in situ hybridisation. If appropriately controlled and interpreted this approach may provide useful information not otherwise available.

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Inspecting the NHS

SIR,—There are unfortunately even more organisations visiting the NHS and local authorities with an inspectorial role than the three Dr Trish Groves's editorial mentions.¹ In addition to the Audit Commission, the Health Advisory Service, and the Social Services Inspectorate there are also accreditation teams from the royal colleges and English National Board for Nursing, Midwifery, and Health Visiting, the National Development Team for Services for People with Learning Difficulties, and the Mental Health Act Commission. Mental health services especially suffer from visiting overload and, while the visiting bodies have specific individual remits, there is inevitably overlap, and regrettably we sometimes make conflicting recommendations.

As services move into the new era of community care, with multiple providers of hospital, residential, and day care across the statutory and independent sectors, there is a danger of fragmentation of planning and delivering services. Monitoring quality standards and ensuring patients' rights is more difficult in a service comprising small isolated units and teams than in traditional large hospitals. Fragmentation of inspection and visiting services can only add to the problem. It may be the right time to consider whether a unified comprehensive national approach to all aspects of mental welfare and care is required, taking into consideration the current functions and duties of the Mental Health Act Commission, Health Advisory Service, Social Services Inspectorate, and national development team.

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- 1 Groves T. Inspecting the NHS. *Br Med J* 1990;300:1601. (23 June.)

Cutaneous leishmaniasis

SIR,—I am only an orthopaedic surgeon, but over the years I have acquired the ability to count (single digits) and to distinguish fingers from toes. The article by Professor P D Marsden shows a three toed, two fingered sloth not, as described, a two toed sloth.¹ I would hesitate to write except that a general surgeon has confirmed my statistical method.

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- 1 Marsden PD. Cutaneous leishmaniasis. *Br Med J* 1990;300:1716-7. (30 June.)

*Sorry!—ED, *BMJ*.