explains the increased sensitivity of whole cell inclusion immunofluorescence, which detects genus specific and species specific antibody.¹ Antigenic diversity within species has also led to a serious failure of microimmunofluorescence to detect many *C psittaci* infections. The specificity of microimmunofluorescence has been questioned owing to reports of cross reactivity between species⁴ and the demonstration of both species specific and genus specific epitopes being expressed on elementary bodies.

Serological approaches are used variably by some clinicians investigating respiratory infections, highlighting the need for non-invasive diagnostic alternatives. The value of routinely used commercial enzyme linked immunoassays to detect chlamydia in sputum has been shown in laboratory diagnosis provided that reactive samples are confirmed with direct immunofluorescence.⁵ Genome detection of chlamydia in sputum, although promising, is currently unsuitable for hospital laboratories. Undoubtedly, future techniques will focus on molecular approaches.

It would be foolhardy to be overwhelmed by the hyperbole surrounding *C pneumoniae* and to ignore, within our current knowledge, the clinically more important respiratory pathogen—*C psittaci*.

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Author's reply

EDITOR,—Margaret Sillis and colleagues provide useful data on their experience of diagnostic tests for chlamydial respiratory infections. Laboratory diagnosis of *Chlamydia pneumoniae* infection poses a major problem, and the limitations of serological tests are apparent.¹ Techniques that use monoclonal antibodies or the polymerase chain reaction² may prove useful but are unlikely to be widely available as standard diagnostic tests.

Treatment of respiratory tract infections, however, is often pragmatic, based on a knowledge of the likely pathogens and their antibiotic sensitivities rather than on detailed investigation of individual patients. Although it will be difficult for laboratories to provide a routine diagnostic service for *C pneumoniae* infection, further research studies of newer microbiological techniques are likely to provide useful guidance for doctors and thereby improve patients' management. Initial serological studies from Europe and North America suggest that *C pneumoniae* accounts for about 10-15% of cases of community acquired pneumonia.^{3,4} Grayston *et al* provided strong evidence of the pathogenicity of *C pneumoniae* and of the usefulness of microimmunofluorescence serological tests in research studies by isolating the organism from patients with respiratory symptoms and serological evidence of infection.⁴

Doctors are familiar with *C psittaci* as a relatively

rare, potentially life threatening infection, and there is no reason why further studies of *C pneumoniae* should detract from the established role of *C psittaci*. Such studies should not be confined to patients in hospital since the initial evidence suggests that *C pneumoniae* infection is usually mild and likely to be treated in the community. Tetracycline or macrolide antibiotics are effective against both *C psittaci* and *C pneumoniae*, but doctors need to be aware that current standard complement fixation tests detect only a minority of cases of *C pneumoniae* infection.

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Positive discrimination in India's medical schools

EDITOR,—While reacting to Guru Nandan's news item on private medical colleges in India,¹ M K Sridhar, E S Krishnamoorthy and C S Sanjay have made assumptions that are not substantiated by scientific theory.² We are disappointed that the *BMJ* has published such partisan views.³

The authors insinuate that positive discrimination always leads to a real decline in standards, but they fail to provide any evidence to justify this. The concept of positive discrimination in society is found even in developed countries, and so far its negative impact on standards has not been documented in social science.³

Positive discrimination does not extend to exams. Students irrespective of caste must pass final examinations. Against a background of caste prejudice students from backward communities will have a tough time from their examiners.⁴

The authors' conclusion that "many deserving students find themselves denied a seat owing to the sheer accident of having been born into a particular caste" is neither logical nor factual.

The authors have shown their disregard for the Medical Council of India and its principled stand against private medical colleges. Dr Pai, a leading educationist, who is head of Krishnamoorthy's own medical college, stated that "private bodies all over the country began to clamour for government sanction to open professional colleges. Unscrupulous managements out to make quick money grabbed sanctions and there was soon a mushrooming of such institutions."⁵ Those who are rather emphatic about standards of private medical schools should note Dr Pai's observation that "all decent norms were cast aside and seats were sold to the highest bidders. No attempt was made to provide minimal infrastructure." If not the Supreme Court of India then this information should make the authors review their blanket support for commercialisation of medical education in India.

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Tuberculosis is increasing in England and Wales

EDITOR,—I wonder if I could make a qualification to Fiona Godlee's statement that "as yet there is no increase in the number of cases [of tuberculosis] in Britain."¹ This statement hides the fact that since 1987 the number of cases in England and Wales has increased (figure), though data for 1991 and 1992 are uncorrected. Notifications for the first four months of 1993 show a 7% increase on the equivalent period in 1992.

Notifications of tuberculosis in England and Wales from 1980 to 1992. Exponential decline from 1980 to 1985 is continued to emphasise divergence between actual and expected cases

There seems to be a tendency to play down this apparent increase,² and some authors imply that services for controlling tuberculosis could be reduced further.^{3,4}

I believe that these statements are sending the wrong messages to health care workers and managers at a time when tuberculosis is almost certainly increasing globally, is undoubtedly increasing in many developed nations, and is apparently increasing in England and Wales.

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Epidural analgesia during childbirth

Minimising headache after dural puncture

EDITOR,—I agree with Michael Jordan that for epidural siting the Tuohy needle should be inserted with the hole facing cephalad so that it need not be rotated while in the epidural space.¹ It is indeed more important to minimise accidental dural puncture than to minimise the headache resulting from it. Anaesthetists have access to plenty of information on this topic, and to expound fully all the aspects of a technique designed to avoid dural