she continued on prednisolone 4 mg/day but was breathless doing housework. Her diffusing capacity was 70% predicted.

We consider that she had a forme fruste of the eosinophilia myalgia syndrome. She had no myalgia, but American cases have highlighted pulmonary disease and pulmonary hypertension.² The main differential diagnosis of a Churg-Strauss vasculitis is weakened by the normal erythrocyte sedimentation rate and the absence of asthma. There was no evidence to support a diagnosis of either tropical eosinophilia or allergic bronchopulmonary aspergillosis. The profound hyponatraemia, previously unreported in the eosinophilia myalgia syndrome, may have resulted from inappropriate antidiuretic hormone secretion.

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1 van Garssse LGMM, Boeykens PPH. Two patients with eosinophilia myalgia syndrome associated with tryptophan. *Br Med J* 1990;301:21. (7 July.)

2 Medsger TA. Tryptophan-induced eosinophilia-myalgia syndrome. *N Engl J Med* 1990;322:926-8.

Chief inspector criticises prison medical service

SIR,—The news report by Dr Richard Smith quoted criticisms of the prison medical service in the recently published annual report of Her Majesty's Chief Inspector of Prisons and comments made to the *Guardian* by the medical inspector Mr Grant Williams. The chief inspector's report was for the first time published in advance of the government's response, which will be made when parliament resumes. I hope you will give the response equal publicity in due course.

In the mean time there is one point that I would like to make now. I have discussed with Mr Grant Williams the remark attributed to him that "A number of doctors in full time [prison] medical service would not be able to maintain a job outside" and have ascertained that none of the people he had in mind are now working in the service.

I trust you will make this known in fairness to the 120 full time doctors who care for 130 000 prisoners each year and who rise to the challenge presented by this unique group of patients.

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1 Smith R. Chief inspector criticises prison medical services. *Br Med J* 1990;301:253. (4 August.)

Human papillomaviruses in anogenital warts in children

SIR,—We were concerned by the lack of detail given about the screening procedures used to exclude sexual abuse in the children studied by Dr A F Padel and colleagues.¹ Department of Health guidelines recommend that such children should be referred to a team experienced in the management of sexual abuse,² whereas opinions expressed in this paper were drawn from several different agencies, including general practitioners and health visitors.

While we accept that the absence of physical signs does not preclude sexual abuse,² nowhere was there any indication that these were specifically looked for. Although vertical transmission is accepted in young children, it must not be forgotten that such children may also be sexually abused.³ We were concerned that failure to isolate venereal pathogens seemed to be used as an indicator that

sexual abuse had not occurred. We would seek clarification as to which sexually transmitted diseases were screened for and what tests were used.

The techniques used in transporting biopsy specimens from anogenital warts before processing differed from those used in other recent studies.^{3,4} We are uncertain whether this would influence overall results but would argue for the standardisation of procedures adopted in such cases.

In two recent studies 40 children with anogenital warts were evaluated.^{3,4} The route of transmission was determined in 30, of whom 16 had been sexually abused. This result supports the statement made by the American Academy of Dermatology task force on paediatric dermatology⁵ before human papillomavirus typing became available that over half of children with anogenital warts aged less than 12 had been sexually abused.

In the light of current knowledge, we agree with the recommendation that the "high incidence of sexual abuse in children with anogenital warts makes . . . referral to agencies equipped to assess the possibility of sexual abuse mandatory."⁵ Further studies of larger numbers of children and their families are necessary, however, before definite conclusions can be drawn about modes of transmission and the importance of the different types of human papillomaviruses.

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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 Standing Medical Advisory Committee for the Secretaries of State for Social Services and Wales. *Diagnosis of child sexual abuse: guidelines for doctors*. London: HMSO, 1988.

3 Hanson RM, Glasson M, McCrossin I, Rogers M, Rose B, Thompson C. Anogenital warts in childhood. *Child Abuse Negl* 1989;13:225-33.

4 Gibson PE, Gardner SD, Best SJ. Human papillomavirus types in anogenital warts of children. *J Med Virol* 1990;30:142-5.

5 American Academy of Dermatology Task Force on Pediatric Dermatology. Genital warts and sexual abuse in children. *J Am Acad Dermatol* 1984;11:529-30.

AUTHOR'S REPLY,—The letter by Dr Greta E Forster and colleagues raises an extremely pertinent point regarding the diagnosis of sexual abuse in children—that is, that we have no definitive diagnostic test. In this study we attempted as far as possible to exclude that abuse had occurred in the children seen by establishing that there were no physical signs of acute or chronic trauma to the genitalia (or elsewhere), no evidence of other sexually transmitted diseases, and no suspicion of abuse having occurred in the opinion of health staff with a knowledge of the family and after an interview with the child and parents by a paediatrician. We accept, however, that none of these tests can be regarded as conclusive evidence of the absence of abuse, and this we make clear in our paper. Routine referral to further agencies was not made as all but two of the children in the study were seen before publication of the Department of Health guidelines in 1988, and teams experienced in the management of sexual abuse were non-existent at the time.

The specific venereal pathogens excluded were *Neisseria gonorrhoeae* (microscopy and culture of vaginal, rectal, and throat swabs), chlamydia (specific enzyme linked immunosorbent assay (ELISA) of a vaginal rather than a cervical swab), and trichomonas (culture). The vaginal swabs were taken blind and probably approximated to the mid to high vagina. For obvious reasons a speculum examination was not performed and endocervical swabs were not taken.

Dr Forster and colleagues make the final point that there are apparent discrepancies in the rate of

suspected sexual abuse in our study compared with some of the earlier studies quoted. At least some of this discrepancy may relate to the differences in the routes of referral used for recruiting children to these studies. The composite figure of a 50% incidence of sexual abuse in children with genital warts quoted by the task force on paediatric dermatology relates largely to studies of children presenting to paediatric departments and other referring agencies.¹ In several cases genital warts were an incidental finding, the primary reason for referral having been a variety of symptoms, including vaginal or rectal bleeding or behavioural disturbances.^{2,3} At least one study related specifically to children with known sexual abuse.⁴ It is to be expected that such studies would show a bias towards sexual transmission as opposed to other routes. By contrast, in our study all the children but one were recruited with genital warts as the primary reason for referral so it is likely that if anything the reverse bias is present, and this may well account for the discrepancy.

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1 American Academy of Dermatology Task Force on Pediatric Dermatology. Genital warts and sexual abuse in children. *J Am Acad Dermatol* 1984;11:529-30.

2 De Jong AR, Weiss JC, Brent RL. Condylomata acuminata in children. *Am J Dis Child* 1982;136:704-6.

3 Seidel J, Zonana J, Totten E. Condylomata acuminata as a sign of sexual abuse in children. *J Pediatr* 1979;95:553-4.

4 White ST, Loda FA, Ingram DL, Pearson A. Sexually transmitted diseases in sexually abused children. *Pediatrics* 1983;72:16-21.

Consanguineous marriage

SIR,—Dr Bernadette Modell criticised the discussion of consanguineous marriage among the British Asian community in *East*.¹

She wrote, "conditions in the photographs [used in the programme] were not recessively inherited." We were careful to ensure that the photographs were real examples of babies who had autosomal recessive disorders and were born of consanguineous marriages. The photographs came from Dr Dian Donnai, a dysmorphologist of the regional genetic service in Manchester.

Dr Sarah Bunday, a clinical geneticist at Birmingham Maternity Hospital, is misquoted as stating that "a lot of Pakistani babies are dying." Dr Bunday never made this statement. The only part of the programme that this might refer to is that when Dr Bunday said, "the random risk that any couple has for having a child with a severe problem is 1 in 40. And if first cousins marry their risk of having a child with a severe problem is 1 in 20." Following on from this, Dr Bunday suggested that "Pakistani mothers have quite a high risk of having a baby with severe congenital malformation, so I think they should probably be screened with extra care during pregnancy." We showed a counselling session with the words "services already exist in several languages" and at the end of the programme gave advice for couples seeking genetic counselling. Yet Dr Modell states, "The possibilities of genetic counselling and of carrier and prenatal diagnosis were not discussed."

We have a long list of such quibbles but Dr Modell's main objection to the programme seems to be her subjective judgment that consanguineous marriage has social advantages for the people concerned that outweigh the slender risk of an autosomal recessive disorder. It is on subjects like this that programmes such as *East*—made by the Asian community for the Asian community—can make forthright statements; the cultural relativism of some of the medical profession and the media may fear to criticise well established but politically sensitive practices of the Asian community.

It is naturally sad for us if anyone who has given up valuable time is unhappy with the finished product, particularly so if they are as critical as Dr