SIR,—Mr M I Alloub and colleagues reported an increased incidence of cervical intraepithelial neoplasia in women with renal allografts.¹ Immunosuppression has been proposed as a high risk factor in the development of cervical dysplasia.^{2,3} This suggestion prompted us to investigate the cervixes of 27 women who attended the sexually transmitted diseases clinic at St Mary's Hospital and were found to be infected by HIV. Examination included cytology, colposcopy, and histology when indicated.

Ten of the 27 women had an abnormal smear, 14 an abnormal colposcopic cervical appearance, and 12 of the 14 who underwent biopsy a histological abnormality (table). Cytological findings did not always correlate with the histological outcome.

Results of cervical investigation of 27 women with HIV infection

	No of patients
Cytology:	
Normal	17
Viral*	3
Dyskaryotic	7
Colposcopy:	
Normal	13
Abnormal	14
Histology:	
Not done	13
Normal	2
Atypical changes	2
Viral*	3
Cervical intraepithelial neoplasia	7

*Evidence of human papillomavirus.

Thus, histology was not performed (since no colposcopic lesion was detected) or the findings were normal in four of the patients with abnormal smears (one contained mildly dyskaryotic cells and three viral changes). Conversely, abnormalities were detected in biopsy specimens from six of the patients whose smears were reported to be normal (one was cervical intraepithelial neoplasia grade 1, two were atypical, and three contained viral changes). Based on all the results a final diagnosis of cervical dysplasia (histologically verified in seven cases) was ascribed to eight of the women, and human papillomavirus infection alone was diagnosed in six. Two patients had atypical changes only. Overall therefore 16 of the 27 women studied had cervical pathological changes.

Two other interesting observations emerged. Firstly, many of the women with cervical pathological changes also had lesions at another site in the lower genital tract. Thus, 11 of the 16 women had human papillomavirus infection (clinical or subclinical) of the vulva, perineum, or vagina. In addition, three of them had concomitant vulval intraepithelial neoplasia and one had perianal intraepithelial neoplasia. Secondly, all the 16 women were clinically well at the time of investigation and had no symptoms or signs suggestive of AIDS or the AIDS related complex. This raises the question whether severe immunosuppression is necessary for the development of genital neoplasia in these women. One woman in the cohort had AIDS but without neoplasia or human papillomavirus infection.

Our data show that both human papillomavirus infection and neoplasia of the lower genital tract are common in women with human papillomavirus infection who have not yet developed AIDS or the AIDS related complex, and we recommend that they should be offered appropriate surveillance. Whether these women are truly at increased risk of acquiring human papillomavirus infection and neoplasia and whether they will have an accelerated rate of progression to invasive genital tract neoplasia remains to be determined by prospective studies, and we are now investigating a cohort of these women, with controls matched for

factors known to be associated with cervical intraepithelial neoplasia.

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- 1 Alloub MI, Barr BBB, McLaren KM, Smith IW, Bunney MH, Smart GE. Human papillomavirus infection and cervical intraepithelial neoplasia in women with renal allografts. *Br Med J* 1989;298:153-6. (21 January.)
- 2 Schneider V, Kay S, Lee HM. Immunosuppression as a high-risk factor in the development of *Condyloma acuminatum* and squamous neoplasia of the cervix. *Acta Cytol* 1983;27:220-4.
- 3 Penn I. Cancer is a complication of severe immunosuppression. *Surg Gynecol Obstet* 1986;162:603-10.

NHS review

SIR,—In their editorial on the NHS review Ms Patricia Day and Professor Rudolf Klein point to a "conspicuous and entirely lamentable failure to give the government's response to the Griffiths report on community care despite the obvious implications for the role of the district health authorities."¹ I endorse that criticism. I have just spent a day at my surgery in central London. At lunchtime the practice partners met with the district nurses and other members of the primary health care team, who are supposed to look after people in their own homes—I had visited four elderly people, three women and one man, and the complaint was always the same—"the community services are just not available." The visits of home helps are minimal, and the visits of nurses to help elderly people with bathing are so infrequent and irregular that some elderly people refuse them when the nurses do call and because of the restrictions they do not call again. The district nurses are each covering the work of two, can only just manage with their workload, and cannot take on a new patient unless another is removed. Only the meals on wheels service gets a universal hooray, although the quality is variable, according to those who take it regularly.

Discussing the problems with the practice team, I found almost universal gloom about the ability of the community services to cope at present, let alone when the hospitals send patients home even earlier to maximise their "throughput and turnover." One of the four patients I had seen clearly could not be adequately looked after at home and had to be admitted to hospital; the others will remain in the community only if the resources are there to maintain them in a warm, humane, and decent environment.

The health authority is unable to achieve its quota of district nurses and is desperately short of health visitors and community psychiatric nurses. The social services do not answer the telephone let alone take a referral of a patient in distress. When they do take a referral a visit may have to wait for a few days because of the pressure of emergency work. The inevitable consequence is that we tend to carry on regardless because we cannot turn away patients' requests for help, and we are forced to admit more people, especially the elderly, to hospital.

Our patients and the team also complain about the ambulance service. Nearly 30% of our elderly patients who have outpatient appointments are not collected because of shortages in the ambulance service, and patients complain also of waiting for hours to return home. One diabetic woman needing regular food intake had to wait until nearly 7 pm before she could be taken home. Another patient, who is partially sighted and unable to walk

far, missed three outpatient appointments for her eyes. When the ambulance had not come on the fourth occasion I felt that I had to take her myself.

The review of the NHS, *Working for Patients*, is irrelevant to most of the needs of elderly patients.² What they require is a caring, compassionate, friendly, and available service, not one that is rushed off its feet, short of staff and facilities, and always facing yet more cutbacks and restrictions.

The drive for cost effectiveness and efficiency should start with caring for people in their own homes and communities, not in buildings and organisations. Unless we get that straight what use is there in screening, early diagnosis, and treatment? Care is what we are there to provide.

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1 Day P, Klein R. NHS review: the broad picture. *Br Med J* 1989;298:339-40. (11 February.)

2 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmd 555.)

SIR,—That the white paper is about keeping costs under control rather than quality of care is shown by the following examples.

Firstly, 100 new consultant posts in the next three years to reduce junior staff workloads is nonsense. That means 33 new posts a year or one new post for every 60 NHS hospitals, of which there are about 2000. Fifty nine out of 60 hospitals will not see even one new consultant. How can that reduce workloads?

Secondly, the white paper claims that it wants a better service. On the other hand, it says that general practitioners should be encouraged to take on more patients. These two ideas are incompatible; more patients mean shorter consultation times and a lowering of standards.

Thirdly, it wants good general practitioners to earn more by attracting more patients. Yet everyone knows that the list size is bound to fall as the population is not growing though the number of general practitioners is. A few general practitioners will manage to get more patients, but on the whole it will not be because they are good but because their area is short of doctors. We will have lost on our basic practice allowance without making up for it from any increase in list size and items of service. In other words, the government's true intention is to reduce gradually the average income of general practitioners.

Fourthly, it says that large practices will be given the opportunity to save money from their budgets, when its real intention is to tighten the budget gradually until there is no more saving to be made. These practices may save money for themselves but only for a short period.

The real aim of the white paper is cost cutting: quality is only secondary.

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SIR,—The outcome of the government's recent review of the NHS will not be clear for some years but there is one particularly alarming section (2.24) concerning a new system for charging for capital in the NHS.¹ Health authorities will be charged for existing and future capital assets: "The charging system will provide a strong incentive for every authority to use its assets efficiently and to invest wisely. It will also place NHS hospitals on a more level footing with private hospitals, which have to meet the cost of capital on a normal commercial basis."

Surely this statement can mean only one thing: after the initiation of the proposals set out in *Working for Patients* and once Mrs Thatcher has established her fourth administration in 1991 NHS hospitals will be instructed to compete directly with private hospitals. I assume by then Mr Clarke

will have changed his job so that his successor will not be bound by the present Secretary of State's protests that there are no privatisation plans. Worse, the authors of the white paper still clearly consider that "the NHS is safe in our hands" as it is at present and more so as a result of the review. The privatisation of water and electricity, unappealing as they are, fade into obscurity by contrast with this plan to undermine the best health service on the globe. For which party do I vote next?

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1 Department of Health. *Working for patients*. London: HMSO, 1989:18.

SIR,—The government's white papers on the future of the NHS, *Promoting Better Health* and *Working for Patients*, sound good.

The first contains a series of fairly minor changes to the NHS which are largely irrelevant to health. Ill health is still mostly caused by poverty, unemployment, bad housing, polluted environments, poor education, smoking, drinking, unsuitable food, accidents, and social isolation. If the government cares about health it could accept the World Health Organisation's recommendations and adopt coherent policies to tackle these things.

The second could perhaps be better named *Working for Profits*. The changes it suggests, though major, are still mainly irrelevant to health. What they will eventually achieve is a much more expensive system with widely differing standards according to the patient's wealth.

If this is what we want—Amen. If not, we should say so loudly now. All who care should write to members of parliament before the proposals are discussed in parliament.

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SIR,—I read Dr Gordon Macpherson's editorial¹ with rising irritation. Perhaps it suffered unduly by following on the intelligent and open minded review by Ms Patricia Day and Professor Rudolf Klein.² I am myself a sceptic who does not believe that the promised land is often entered by the gate of reorganisation, but the manner and matter were peculiarly provoking.

The editorial started badly by saying that the association's leaders are "doubtful that the promise in the white paper's title, *Working for Patients*, will materialise." This was followed by a statement that it would be unwise to make a policy response until the working papers had been analysed and finally that the council and craft committees should have time to consider the proposals. But the policy statement was already implicit in the first sentence quoted; in the simplest terms, "We don't like it and don't think it will work." The generally hostile tone seemed to imply a further statement—"We don't like Mr Clarke," perhaps? Or "We don't like the government"?

The second paragraph seemed to be in danger of coming to grips with reality. The BMA's response is indeed risky in the face of a secretary of state in a hurry. And why does Dr Macpherson believe that neither of the two radical proposals "can be achieved without the cooperation of most NHS doctors." As he himself says, "Kenneth Clarke is a formidable minister who is backed by a Prime Minister with a large parliamentary majority." The NHS will be reorganised and it will be generally on the lines of this review. None of us may like it but carping articles like this can only make matters worse.

He also regrets that the BMA's excellent advice—that any new ideas should be tried out in pilot schemes—are out of time. This is not a moment to be looking over our shoulders at what might have been. The BMA represents most, but not all, of the doctors, who in turn are a small minority of the NHS staff; they are not the government, they have had their say, and they did not persuade. If they cannot come to terms with this they will achieve nothing but harm for their members. A sullen resentment of the government plan as a whole is the worst possible response. The review is published and the political facts are that everyone is stuck with it. The constructive response is to cooperate fully and even enthusiastically; in that way it should be possible to strengthen all that is good and reduce or even eliminate what is dangerous. Politics, like medicine, is the art of the possible. The political situation, like the patient, is a fact; it may be unfortunate that the patient has scabies and it may be unfortunate that the NHS has Kenneth Clarke, but in both cases that is the starting situation so let's be positive and see what we can do about it. In neither case is it useful or prudent to give way to distaste or regret; that can only inhibit effective action.

We have seen this minister in action before on issues like the limited list. Offended dignity and the moral high ground have not proved effective in the past, nor will they now.

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- 1 Macpherson G. BMA's measured response. *Br Med J* 1989;298:340-1. (11 February.)
- 2 Day P, Klein R. NHS review: the broad picture. *Br Med J* 1989;298:339-40. (11 February.)

Diagnosing and treating dementia

SIR,—I hope that Minerva will not be miffed if on her behalf I reply to the letter from Drs R Ramsay and Cornelius L E Katona¹ concerning her comments² on my article.³

Concerning the low incidence of reversible dementias, they commented that "Minerva's conclusions [that patients with dementia should be spared overzealous investigation] are perhaps unduly pessimistic." The whole point of my article was that we do not really know the true incidence of reversible dementias. At most they comprise 11% of all dementias. In fact, only a quarter of those that reverse do so fully, the rest showing various degrees of improvement. Even worse, if followed up for long enough many of the dementias that initially improve are found with time to deteriorate.⁴

Drs Ramsey and Katona mention the multi-infarct dementias. Although I agree that there is some evidence that treating hypertension may halt or perhaps even reverse cognitive decline,⁵ the jury is certainly not yet in on this question. (A small correction: I did not list depression (26.2%) as the commonest cause of reversible dementias but rather medication (28.2%).) Nevertheless, I agree that a careful search for the elements of depression in a patient with apparent dementia is always called for.

I also concur that even if the true incidence of reversible dementias is as low as I found—the true figure is probably even smaller—it is incumbent on doctors to do the necessary investigations. Taking a careful history and performing a physical examination as well as a few selected laboratory tests (complete blood count, biochemical profile, measures of thyroid function and serum B₁₂ concentration) will uncover more than two thirds of the truly (not potentially) reversible causes. Computed tomography should be added for

patients with signs or symptoms of focal neurological deficit, those who are fairly young with dementia of recent onset (<12 months), and those with an atypical presentation. Computed tomography may also be considered for a patient (or family, or both) who cannot reasonably be reassured without it.

I sympathise with the view of having computed tomography and other investigations "to exclude even the remotest chance of discovery of a treatable condition. . . ." This is not supported, however, from the cost-benefit point of view. The whole practice of medicine depends on skilled weighing of information gleaned from a careful history, complete physical examination, and basic laboratory tests. Drs Ramsey and Katona would doubtless agree that all patients do not require all tests all of the time; the problem is to know how and when to choose them and which ones to choose—the case for dementia is no different.

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Effect of uterine contractions in a pregnant woman with mitral stenosis

SIR,—The case report of Dr Peter Jakobi and others raises some interesting points, but their final proposals for the management of women with mitral valve disease are contentious.¹ The observation of a significant association between an increase in left atrial pressure and coincident uterine contractions and the hypothesis that this may precipitate acute heart failure "of unknown origin" in women with mitral valve stenosis are interesting and merit further consideration. The authors go on to suggest, however, based on their observations in this single case, that in pregnant women with known mitral valve stenosis the contractions associated with premature labour and the physiological uterine activity known as Braxton Hicks contractions should be "treated immediately and aggressively and considered among possible trigger mechanisms for heart failure." We think that the reasoning behind this suggestion is inherently unsound.

In rheumatic heart disease in pregnancy the most common lesion is mitral stenosis.² Although maternal deaths are most likely when abnormalities prevent increases in pulmonary blood flow, deaths due to rheumatic heart disease are rare. In the event of the patient's condition deteriorating during pregnancy we agree that uterine contractions should be considered among the possible causes of acute heart failure, but aggressive treatment with tocolytics is unlikely to be helpful for a number of reasons. Currently available β_2 sympathomimetics may temporarily suppress spontaneous uterine activity but long term use is unlikely to result in abolition of Braxton Hicks contractions and will not suppress established labour. Indeed, the resultant increase in heart rate and cardiac output may further exacerbate cardiac failure, and long term intra-