with exogenous cytomegalovirus DNA. The high sensitivity of the polymerase chain reaction makes exclusion of specimen contamination very difficult.^{8,9} It is thus impossible on the basis of the evidence currently available to say whether the polymerase chain reaction can detect cytomegalovirus DNA in peripheral blood mononuclear cells collected from people with latent infection. If the polymerase chain reaction is adequately sensitive for this purpose it may prove valuable in studying the nature of latent cytomegalovirus infection and screening patients for this infection.

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Twenty four hour care in inner cities

SIR,—We are glad to see that our paper¹ has stimulated a wide ranging discussion, not only on out of hour call rates in many different areas and the method of their collection but also on the general problem posed by the 1990 contract in relation to areas of deprivation and to night work.^{2,3}

Comparison of out of hours work depends on the differing roles of Saturday surgery, the proportion of advice given on the telephone, and whether deputising services are used. Doctors from deputising services visit 97% of all callers⁴ so a meaningful comparison of demand between practices requires the production of a request rate or summing of telephone and visit rates. Thus our request rate for night visiting of 31.8 per 1000 patients per year is comparable with the rate in Bethnal Green of 29.7² and greater than the rate of 24.6 (all deputised) in Plymouth.³ We operate personal lists and, like the doctors in Bethnal Green, find different call rates between different doctors' patients. We believe that this relates mainly to proportions of under 5s and young women, of whom we have many and who make high demand on services. Distance from a casualty department is also a factor. In addition, the increased morbidity of manual workers and their families, and in particular of the unemployed, places a considerable demand on primary care services. Apart from sometimes having inappropriate consultations because of the alienation of urban deprivation, these groups experience more sickness and more severe sickness.

It is clear that the government has not appropriately addressed the problem of how to provide a 24 hour emergency service in general practice. The

1990 contract rests on the plank of increased working hours for general practice principals. It increases the "salaried" aspects of the job—five days of work and 26 hours' patient contact—while retaining the "independent" contractors' 24 hour responsibility. It also reduces the financial viability of practices that wish to offer breadth and quality of care, without placing excessive demands on individuals, by increasing numbers of partners and staff. This is particularly the case in inner London, where costs are higher, but there is no London weighting for general practitioners.

We accept, however, the point made by Drs Main and Main of Bristol⁴ and Dr Gibbons of West Glamorgan⁵ that the variables in the Jarman index, on which the proposed deprivation weighting would be paid, would not reflect the deprivation and morbidity that increase their workload in outer urban areas, and that they, too, need to receive a much needed deprivation allowance. An enhanced night visit fee for non-deputised visits does nothing to reduce the excessive working hours of doctors (although obviously we would appreciate being paid properly for what we do). There are no proposals to tackle the other issues facing doctors who do their own night calls, particularly in deprived areas, such as the fear and danger of violence. Full funding for a local telephone answering service, driver-escort, and mobile telephone would be a start.

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Dietary calcium, physical activity, and risk of hip fracture

SIR,—Dr C A C Wickham and colleagues¹ provide "hard" evidence for the belief in west Africa that dietary calcium may not be an important risk factor for hip fracture. We have been struck by the low prevalence of osteoporosis in the region even though dietary calcium intake is on average lower than that in the United Kingdom and in some rural dwellers is considerably lower than the Food and Agriculture Organisation's recommended daily allowance. In a recent retrospective review of hip fractures seen in our teaching hospital over a one year period we found only 11 patients with such fractures in a catchment population of over one million. This gives a low incidence of hip fracture, even allowing for some underdiagnosis, as this represents all ages and both sexes.

Preliminary studies in the region indicate radial bone densities similar to those of white Europeans. Low calcium intake does not seem to compromise bone mineralisation even among rural west Africans. The belief that Africans have larger and denser bones has previously been disputed in a study on west Africans, albeit using the crude radiological measurement of metacarpal index.²

Similar observations to ours have been documented elsewhere in Africa.³ We believe that the high level of physical activity even among our ever growing geriatric population is the most likely

explanation for the low incidence of osteoporosis in the region. We are currently testing this assertion through longitudinal studies.

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Use of cyanoacrylate tissue adhesive

SIR,—I wish to add two complications of using cyanoacrylate to those mentioned by Dr David P Watson in his timely article.¹

Firstly, when the adhesive is applied to the laceration an exothermic reaction occurs and produces a momentary sharp pricking sensation. This may cause the patient some distress, particularly if no warning was given.

Secondly, additional care needs to be taken for periorbital skin cuts: if the adhesive runs into the eye the eyelid becomes sealed to the cornea. In the few instances in which this has occurred the eye has spontaneously opened in five to seven days, and subsequent ophthalmological referral showed no corneal damage. Reassurance of both parent and child is all that is required.

The glue is a valuable addition to the treatment options for wound care. We have also found it useful in securing skin grafts to their recipient site.

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Looking after a visiting speaker

SIR,—Every organiser of a meeting should keep copies of the excellent article by Dr Patrick Hoyte¹ and an article on the same theme entitled "Nice people with no manners" written by the editor of the *BMJ* some years ago.² Both writers emphasised that as speakers they were usually looked after well but it is the inept organisers whom they remembered. Please permit me to add a few do's and don'ts to Dr Hoyte's useful list for organisers.

- Check all lines of communication. I know of three occasions when the porter at the entrance to a building denied that a meeting was being held there. Advise speakers either to show the porter the programme and insist that he telephones around to find out where the meeting is being held or, failing this, to search the building themselves.

- Educate the chairperson about how to pronounce and remember the speaker's name. Stephen Leacock, humorist and professor of economics at McGill University, described how, during lecture tours, the chairman might have to consult the programme to find the speaker's name or the title of the talk,³ and this still happens. Also it is helpful for the audience to be told something of the speaker's credentials, and a little flattery boosts his or her ego. No need to overdo it. Mark Twain, his biographer wrote,⁴ introduced himself because he had never met anyone who could pay proper tribute to his talents; but no humorist could take himself so seriously, and he no doubt had his tongue in his cheek.

• Look after the speaker's gastronomic needs. The speaker, having spoken, is often delayed by people coming up to him or her or having to collect the slides. He may then have to stand at the end of the queue for coffee and has too little time to drink it, or arrives late for lunch when much of the food has gone. Take the speaker to the front of the queue or have these refreshments put aside.

• A personal touch to the letter of thanks is pleasant. Recently the letter thanking me for a splendid, etc, presentation was given to me just as I had finished the lecture; so it must have been written before I started. Nice that such confidence in my ability was shown; there may have been an alternative toned down letter in case I had been a bore.

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Cardiotocographs at a distance

SIR,—In their recent editorial Professor Philip J Steer and Mr Michael C Carter¹ draw attention to the uncertain clinical value of intrapartum and antenatal fetal heart rate monitoring. Despite this uncertainty cardiotocography is widely and frequently used. This may be explained in part by the lack of any alternative reliable, convenient, and scientific method of surveillance of antenatal fetal wellbeing. Cardiotocographs are often requested in the antenatal period to reassure worried patients and midwives and to treat "obstetrician's distress" in labour. There is little doubt, however, that one of the reasons for the widespread, excessive, and often inappropriate use of antenatal cardiotocography among obstetricians is fear of litigation. Although the value of antenatal and intrapartum fetal heart rate monitoring is unproved, obstetricians have been found negligent for failing to use this form of monitoring in certain circumstances. Fear of litigation will ensure that this type of monitoring will continue to be used at its present rate until the next generation of electronic monitors, which will probably be based on a combination of fetal electrocardiography and heart rate, become available.

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- 1 Steer PJ, Carter MC. Cardiotocographs at a distance. *Br Med J* 1989;299:933-4. (14 October.)

Change in use of asthma as a diagnostic label

SIR,—It may well be the case, as Ms Rosalind Hill and colleagues suggest, that a change in diagnostic labelling is producing an apparent rise in prevalence of asthma.¹ Some caution is needed, however, in interpreting comparisons between two surveys with response rates of 77% and 78%—the 23% who declined to respond in 1985 were not necessarily like the 22% who declined in 1988. Moreover, three years seems rather a short time for a large change in diagnostic fashion to occur. In south Wales we surveyed 12 year old children, 818 in 1973 and 965 in 1988 (with one and no non-responders respectively), and found that the prevalence of "asthma ever" had increased from 5.5% to 12.0% while that of "wheeze ever" had

risen from 17.0% to 22.3%; the prevalence of wheeze not diagnosed as asthma showed little change. Exercise testing suggested that, although some diagnostic shift may have occurred, the true prevalence had risen too.²

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Peripheral vascular disease

SIR,—As Professor E Ernst points out, surgical approaches may be inappropriate in patients with less severe forms of peripheral vascular disease.¹ They may also be unhelpful where peripheral blood flow is reduced by diffuse disease and where there is an important small vessel component. Finally, many patients with peripheral vascular disease have concurrent illness elsewhere in the vascular tree and may be unsuitable for major surgical procedures.

The distribution of emphasis in the article, however, seems to us a little eccentric. An entire paragraph is devoted to immersion of patients in a bath enriched with carbon dioxide, for which, as the author says, clinical proof of effectiveness is still lacking. He is able to refer only to unpublished results of a clinical trial. On the other hand, epidural electrostimulation is dismissed in a single sentence and one reference not yet published. In fact, since Cook *et al* first described pain relief and healing of ulcers in nine patients with vascular insufficiency in the limbs, which in many cases had failed to respond to conventional treatment,² much information has been published supporting the value of epidural stimulation in patients with peripheral vascular disease. Our own study of 10 patients with severe, intractable symptoms of arterial disease reported a more than threefold increase in claudication distance, relief in rest pain in some patients, and small increases in blood flow in skin and muscle.³ There was no clinical response to transcutaneous placebo stimulation in any of these patients. More recently, a much larger series has confirmed the beneficial effects of epidural spinal cord stimulation on peripheral blood flow and both short and long term benefits for patients.⁴

We have been disappointed at the failure of this form of treatment to establish a place in the armoury of surgeons dealing with peripheral vascular disease. This may be because it seems somewhat unorthodox. There are, however, good physiological reasons for the efficacy of this treatment.⁵ We would strongly advocate the setting up of a multicentre trial among vascular units to evaluate further this form of treatment.

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SIR,—We agree with Professor E Ernst that exercise therapy is an effective conservative treatment for patients with intermittent claudication.¹ Few patients with intermittent claudication progress to severe, limb threatening ischaemia; the main justification for treatment is therefore the relief of symptoms. We are at present conducting a prospective randomised study comparing percutaneous transluminal angioplasty with supervised exercise therapy in patients with intermittent claudication who are suitable for treatment by percutaneous transluminal angioplasty. The preliminary results showed a progressive increase in mean maximum walking distance in the group taking exercise, with significant increases of 3.1-fold and 4.0-fold at six and nine months respectively.² This improvement in function was not accompanied by any increase in mean ankle-brachial pressure indices. After percutaneous transluminal angioplasty there was an early peak increase in both mean ankle-brachial pressure indices and maximum walking distance, but from six months onwards mean maximum walking distances were significantly greater in the group taking exercise than in the group treated with percutaneous transluminal angioplasty. These results suggest that in patients with mild or moderate claudication who do not require an immediate therapeutic response, exercise therapy may ultimately produce greater symptomatic improvement than percutaneous transluminal angioplasty.

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Radio-opacity of glass

SIR,—Dr D E Phillips and colleagues present a valuable reminder of the need for caution in managing children with suspected inhalation of foreign bodies, but they perpetuate the myth that "some forms of glass are not radio-opaque."¹ Since 1932 it has been shown that all forms of glass are radio-opaque with respect to soft tissue but not bone.² Glass in common use has a density varying from 2.22 to 2.87 g/cm³, which is over twice that of soft tissue at 1.08 g/cm³.³

As Dr Phillips and colleagues point out, the important point is to obtain the correct projection to enable the glass to be seen clear of radiodense structures. This may mean obtaining an oblique rather than a standard anteroposterior or lateral view.

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Cost effective drug budgets

SIR,—It is perhaps not surprising that there continue to be misunderstandings over indicative drug budgets. A major factor seems to be the