taken.¹ They also, however, noted a rise in the number of cases of homosexually acquired gonorrhoea in 1990, with a rate of rectal infection of 6-9%.

In the three genitourinary medicine clinics in Riverside Health Authority 59 episodes of confirmed anorectal gonococcal infection occurred in 57 homosexual or bisexual men attending between 30 March and 8 October this year. Of these 57 men, 17 were known to be HIV seropositive and 19 HIV seronegative and 21 were untested for HIV antibodies. Thus while the rate of detection of rectal gonorrhoea in homosexual and bisexual men attending genitourinary medicine departments in this area is much lower than in the era before AIDS, there are no grounds for complacency as these men, regardless of their HIV status, are presumably continuing to have unprotected anal sex or failure of barrier methods.

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EDITOR,—D J Jones and B P Goorney's article on sexually transmitted diseases and anal papillomas contains many inaccuracies.¹

The incidence of sexually transmitted diseases affecting the anorectal region is not increasing in Britain^{2,3} or the United States.⁴ The authors state that "about one quarter of homosexual men attending screening clinics have anorectal gonorrhoea." A recent countrywide survey by the British Co-operative Clinical Group found between 3-4% and 2-7% of homosexual men had gonorrhoea (site unspecified).⁵ Our own (unpublished) data suggest that just over one third of these infections will be rectal, giving a prevalence of anorectal gonorrhoea among gay men attending a sexually transmitted disease clinic of not 25% but 1%.

The inguinal adenopathy in both primary and secondary syphilis is painless. The first serological test to yield a positive result in syphilis is the fluorescent treponemal antibody absorption test⁶ and not, as implied, the Venereal Disease Research Laboratory test. Condylomata lata, as manifestations of secondary (systemic) syphilis, are independent of the site of the primary chancre and may therefore represent infection acquired heterosexually, a more common occurrence in Britain today.⁷ A foul discharge is not characteristic of condylomata lata.

The authors confuse the clinical manifestations of the oculogenital strains of *Chlamydia trachomatis* (serotypes D to K, and commonly found in non-gonococcal urethritis) and those of the tropical disease lymphogranuloma venereum (serotypes L1 to L3). Lymphadenopathy (which may be painful) is associated only with lymphogranuloma venereum. It is not true that many people who practise anoreceptive intercourse harbour sub-clinical infections. Non-lymphogranuloma venereum *C trachomatis* was isolated from the rectums of only six of 150 homosexual men in one study,⁸ none of whom had any symptoms referable to the disease. Rectal stricture is a late complication of lymphogranuloma venereum, found predominantly in women and homosexual men. It is extremely rare in Britain.

Herpes simplex virus infection is an important complication, rather than manifestation, of HIV infection. Chronic mucocutaneous herpes simplex virus infection is not diagnostic of AIDS. Herpetic ulcers, with definitive identification of the virus,

persisting for at least one month in someone with a positive HIV antibody test result or evidence of immune deficiency (in the absence of any other cause) is an AIDS defining illness.⁹ The picture used shows herpes simplex virus infection of the buttock, not the anus. Diagnosing herpes simplex virus by cytological examination lacks sensitivity; culture of the virus is the usual method of diagnosis.¹⁰ The authors' description of an ulcerating proctitis is not characteristic of herpes simplex virus infection in immunocompetent patients, pronounced erythema being typical.

Cryptosporidiosis causes a profuse and watery (secretory) diarrhoea, which is not haemorrhagic.¹¹ Although oocytes may be found in rectal biopsy specimens, diagnosis is usually made by examination of the stool. Centers for Disease Control stage III refers to persistent generalised lymphadenopathy, patients being otherwise asymptomatic and well—we see no reason why they should be denied anorectal surgery.

Condylomata acuminata (viral warts) are caused by human papillomavirus. Proctoscopy may show lesions not only within the anal canal but also in the distal rectum. Polyps outside the anal canal may respond to application of podophyllin only if they are of viral aetiology. Cryotherapy and use of a laser, both useful methods of treatment, are not mentioned. Finally, it is surprising that there is no discussion of anal intraepithelial neoplasia and malignant change.

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- 1 Jones DJ, Goorney BP. Sexually transmitted diseases and anal papillomas. *BMJ* 1992;305:820-3. (3 October.)
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AUTHOR'S REPLY,—Our article was intended to raise clinicians' awareness of the sexually transmitted diseases and anal papillomas that may present in the colorectal and anal region. We were unable to elaborate on such details as lymphogranuloma venereum causing rectal strictures as opposed to oculogenital strains of *Chlamydia trachomatis*. But several of the points raised by J Sherrard and colleagues deserve clarification.

Firstly, regarding the prevalence of rectal gonorrhoea in Britain, we meant to say that one quarter of homosexual men with gonorrhoea have rectal disease. We do not disagree with Sherrard and colleagues' data concerning gonorrhoea in homosexuals.

In the section on syphilis and the serological

tests used the Venereal Disease Research Laboratory test was discussed first in the context of patients presenting with a clinical lesion suggestive of early syphilis. We were not suggesting that it is the first test to show seroconversion after the acquisition of syphilis, which is the fluorescent treponemal antibody absorption test.

In the section on herpes the opening sentence mentions the infection in association with HIV infection; the assumption that we were referring to chronic mucocutaneous herpes simplex in an immunocompetent person is incorrect. Persistent or continuous mucocutaneous herpes with positive culture of the virus, particularly the aggressive and ulcerative variety, in a person with HIV infection (and in the absence of other cellular immunodeficiency) does indicate advanced HIV disease and, if of more than a month's duration, is an AIDS indicator diagnosis.¹

Although cryptosporidiosis and isosporiasis mainly cause a secretory diarrhoea, a haemorrhagic colitis has been described,² which responds promptly to cotrimoxazole.

We did not imply that otherwise well patients with Centers for Disease Control stage III disease, persistent generalised lymphadenopathy, should be denied anorectal surgery. The presence of important constitutional symptoms such as fever and weight loss also needs to be considered. As with any operation, the final decision to operate has to be based on the person's disease and condition.

Finally, with regard to anal warts and pre-malignant change, I would refer Sherrard and colleagues to the article on anal cancer in the ABC series.

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- 1 Wexner SD. Sexually transmitted disease of the colon, rectum and anus. *Dis Colon Rectum* 1990;33:1048-62.

Health checks for people over 75

EDITOR,—Like Andrew Barker and colleagues¹ I am disappointed that so many general practitioners fail to take the opportunity that the annual health check for people over 75 provides to assess dementia. In March 1990 the Alzheimer's Disease Society circulated all 35 000 general practitioners in the United Kingdom with an information pack containing a copy of the abbreviated mental test score.² The society would be pleased to supply, free of charge, a copy of the test to any general practitioner who did not receive one or has mislaid it. The society will also make available its publication on managing dementia.³

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- 1 Barker A, Betmouni S, Harrison M, Jones R. Health checks for people over 75. *BMJ* 1992;305:1098. (31 October.)
- 2 Qureshi AN, Hodkinson HM. Evaluation of a ten question mental test in the institutionalised elderly. *Age Ageing* 1974;3: 152-7.
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EDITOR,—Few people doubt the utility of mental test scores when used as clinical instruments or research tools. Andrew Harris¹ and Andrew Barker and colleagues² suggest that community screening for cognitive impairment in older people with these scores may be useful; this seems optimistic in the light of problems with interpreting the results.³ The Folstein mini-mental state examination was recently selected as one of two questionnaires with the most robust scientific background.⁴ Its positive predictive value for organic brain disease in community screening was, however, only 55% at the

usual cut off of $\leq 23/30$. Nearly one eighth of those scoring $\leq 23/30$ were suffering from functional illnesses.¹

The lack of national guidance on this matter is probably due to an understanding that the methodology of cognitive screening in the community is neither sufficiently sophisticated nor proved to be effective, as well as of the difficulties of diagnosing early dementia.⁵ The abbreviated mental test score proposed by the Alzheimer's Disease Society works well in hospital settings. Two problems detract from its use in community screening. One is that all short tests (about 10 questions) suffer from a more pronounced "ceiling effect" than longer scores (such as the mini-mental state examination), whereby many patients with mild cognitive impairment may score no errors.⁶ The second problem is that the abbreviated mental test asks the patient to recognise two people—a question of limited utility in the homes of the many older people living alone. The recognition of organic brain disease in elderly patients by general practitioners virtually quadrupled from 15% in 1964 to 58% in 1988.⁵ This occurred in the absence of community screening. It is worth waiting for more research on the topic before recommending any particular mental test score for community screening for cognitive impairment.

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- 2 Barker A, Betmouni S, Harrison M, Jones R. Health checks for people over 75. *BMJ* 1992;305:1098-9. (31 October.)
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EDITOR,—Simon Winner and Simon Plint emphasise the importance of coordinating medical and social services assessments in the light of the NHS and Community Care Act.¹ We agree with this in principle, but not all general practitioners share this view.

General practitioners' terms of service require them to determine whether a client needs to be offered general medical services. Some general practitioners hold the view (expressed by the General Medical Services Committee in its recent discussions with the Department of Health) that extra work undertaken in helping clients to get community care needs to be separately identified and costed. It is against this background that we are developing our approach to the health check for those over 75.

Locally we are working to ensure sharing of intelligence and compatibility between the assessment of those over 75 and community care assessments by making representations to the multi-disciplinary groups developing referral and assessment instruments. Both we and our local authority colleagues are aware of the need for cross matching to avoid duplications.

In our experience the assessment of those over 75 rarely provides the first indication that community care services might be required. In view of this we have asked social services to provide clear information on pathways to services for use in everyday practice rather than concentrating solely on following up on the health check. Like Winner and Plint, we have been impressed by the OxCASSE health check schedule, but we believe that a less cumbersome and more sensitive tool may be more appropriate locally.

We have a strong commitment to an oppor-

tunistic approach and interest in improving uptake of services in areas of unmet need, such as dental, audiological, psychological, and continence services. Socioeconomic deprivation is considerable in the boroughs we serve. This leads many clients to have a low expectation of services, which in turn leads to underexpressed need: contacts with social services in particular tend to be limited to crisis intervention.

To break this cycle we need to adopt a surveillance schedule that will show unexpressed need and indicate where minor interventions will lead to substantial improvement. The latter kind of intelligence will not be generated on, for example, mobility by applying the Barthel scale. Another deficiency lies in the possible iatrogenic effects of using an abbreviated mental test score.

For these reasons we are looking at a range of assessment tools that combine sensitivity and acceptability to practices and elderly people. We want to discover whether the patient is a carer, whether there are needs specific to ethnic minorities, and whether we can prevent accidents by identifying environmental risks at home. We believe that the OxCASSE check is too complex and insufficiently focused on the needs of an inner city population.

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- 1 Winner S, Plint S. Health checks for people over 75. *BMJ* 1992;305:1227. (14 November.)

Mild cervical cytological abnormalities

EDITOR,—Mahmood I Shafi and colleagues' editorial on mild cervical cytological abnormalities attempts to reassure clinicians that cytological surveillance is adequate management.¹ Indeed, this seems a definitive statement. We agree with it in so far as it applies to cooperative patients in the general population, with a fail safe system of follow up. In the high risk group who attend genitourinary clinics with genital warts, however, this philosophy may not be adequate.

We offer colposcopic assessment of the cervix to patients seen in our department with genital warts. Altogether 428 patients (mean age 22) with negative results of cervical smear tests had colposcopy and punch biopsy. One hundred and forty six had cervical intraepithelial neoplasia, of whom 72 had grade I disease, 62 grade II, and 12 grade III or worse. Five patients had invasive carcinoma of the cervix. Three of them had a normal looking cervix on routine examination and would have been missed in the early stage if colposcopy had not been done. A further 56 patients with mild cytological abnormality had colposcopy; 17 had grade I cervical intraepithelial neoplasia, 18 grade II, and nine grade III or microinvasive carcinoma; 12 showed no cervical intraepithelial neoplasia.

If we had relied on cervical smear testing alone we would have missed a third of the cases of cervical intraepithelial neoplasia in our group. In fact, 74 of these patients had grade II or worse disease. It is well recognised that asymptomatic disease is more likely to be small volume. Thus the morbidity and mortality will be much lower. In patients with mild cytological abnormality almost half had grade II or worse disease. As we do not yet know the natural progression of the disease, colposcopic assessment in this group is more pressing.

We believe that the high risk, highly mobile patients mainly below the age of 25 with mild cytological abnormalities merit colposcopic examination of the cervix. We also believe that

patients with genital warts should be offered colposcopy. As most genitourinary departments now have the facility and skill for this investigation this group should not be a drain on the available resources.

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Euthanasia

EDITOR,—We have followed with interest the case of Dr Nigel Cox and the subsequent debate and correspondence on euthanasia in the lay and medical press.^{1,2} Physicians, anaesthetists, general practitioners, and many others have felt moved to comment, but psychological and psychiatric perspectives seem to have been neglected. Many patients with chronic pain also become concurrently depressed, and severe depression may intensify the experience of pain, making life not worth living.

Evidence of psychiatric assessment was not provided in this case. As Eric Wilkes points out (17 October), there are many complex reasons for requesting euthanasia. Nevertheless, without adequate psychiatric assessment or consultation with other experts in disciplines such as palliative care and anaesthetics (and appropriate intervention within these areas), we believe it hard to defend the actions of a doctor from only one discipline making a euthanasia decision. Euthanasia may appear the only humane option to a family faced with the apparent hopelessness of the patient's position and unaware that other forms of care, support, and treatment might be of considerable benefit.

The Mental Health Act was in part devised to protect the rights of patients in a suicidal state. The act requires that assessments of the patient are made by two doctors and a social worker, to protect the patient against the potentially unrepresentative views of some doctors and also distraught relatives. Here the purpose is to save life against the wishes of the patient. An act should be even more rigorous if life is to be terminated.

Although this is an oversimplified view of the multidisciplinary requirements of the Mental Health Act, our point is that other independent professionals should be involved in the consideration of euthanasia (which, unlike sectioning is irreversible). If the moral argument for euthanasia is won and the law is changed, the opinion of just one doctor and the relatives could potentially be inappropriate.

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- 1 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)
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Oestrogen replacement therapy after hysterectomy

EDITOR,—Tony Seeley reports a study to identify women who might benefit from oestrogen replacement after hysterectomy.¹ I have conducted a similar study, whose results reinforce his findings.

I aimed to inform women who had undergone hysterectomy with preservation of the ovaries of