FcεRI-β polymorphisms unlikely to contribute substantially to genetic risk of allergic disease

EDITOR,—M R Hill and colleagues report the association between a variant of the gene for the β chain of the high affinity receptor for IgE (FcεRI-β) with the *Leu 181/Leu 183* polymorphism and atopy in an Australian population.¹ They suggest that polymorphism in FcεRI-β is one factor that can be used to assign genetic risk of atopy. This group has previously suggested that *Leu 181* may be associated with atopy in the British population.²

As part of a study examining the relation between β₂ adrenoceptor polymorphisms and airway reactivity³ we recently screened a population of asthmatic patients for FcεRI-β polymorphisms. Polymerase chain reaction based on the amplification refractory mutation system failed to identify any subjects with either the *Leu 181* or the *Leu 181/Leu 183* polymorphism. We therefore proceeded to direct sequencing of this region of FcεRI-β to ensure that our ability to detect the *Leu 181* polymorphism was not due to problems with the method. None of our 65 asthmatic subjects, however, had either the *Leu 181* or the *Leu 183* substitution on direct sequencing. Of these 65 subjects, 41 fulfilled Hill and colleagues' criteria for atopy, although all had a 20% fall in forced expiratory volume in one second after challenge with methacholine.

These results suggest that, while FcεRI-β polymorphisms may contribute to the atopic phenotype in defined populations, they are unlikely to contribute substantially to the genetic risk of allergic disease in the population at large.

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Training of overseas qualified doctors in Britain

Views of overseas doctors training in obstetrics and gynaecology

EDITOR,—Chris Holcombe and David K Watters's editorial about the training of overseas qualified doctors expresses the views of many people, but no one has asked the trainees their views.¹ Between February and April 1994 a working party of the Royal College of Obstetricians and Gynaecologists carried out a survey of 100 doctors from the overseas doctors training scheme who were working in Britain and 100 doctors on the scheme who were

awaiting placement. Altogether 110 doctors from 18 countries replied.

Most of the doctors wished to take the examination for membership of the Royal College of Obstetricians and Gynaecologists (the MRCOG) to obtain a better post in their own country (including private practice) or to have an international qualification that would allow them to work abroad. Few considered the future training of doctors in their own country. While British graduates usually take the MRCOG after working for three years in the specialty, the doctors on the overseas doctors training scheme had spent at least twice as long in training before coming to Britain.

The perceived weaknesses in overseas training were in endoscopic surgery and the four subspecialties of oncology, reproductive medicine, fetal medicine, and urogynaecology. Almost all doctors on the scheme's waiting list thought that time spent in Britain would correct the weaknesses in their training. Two thirds of those working in Britain found that this was not the case, mainly because they were working in junior posts in which they did not get enough experience and got no teaching. Despite the often inappropriate training available in Britain both the doctors working in Britain and those on the waiting list considered that training in Britain should be compulsory for anyone taking the MRCOG examination and that the ideal time should be about one year. Few doctors kept a logbook of training in their own country before coming to Britain.

If this scheme is to continue, the specific training needs of each overseas trainee should be established before his or her arrival in Britain and the objectives of training in the given post should be discussed at the time of appointment. Regular formative assessment is essential for overseas as well as British trainees. Many overseas doctors are anxious for subspecialty training. The opportunities for this are limited, and therefore overseas doctors are at a disadvantage when competing with British trainees for a limited number of posts. It is important that this is made clear at the outset to all overseas doctors so as to avoid disappointment.

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Training programmes in countries overseas should be supported

EDITOR,—We welcome the supplementary Calman report on the training of overseas qualified doctors in Britain.¹ As Chris Holcombe and David K Watters point out, many trainees in Britain come from the developing world, where they will practise under very different circumstances.² For this reason we believe that support should be given to the training of overseas doctors in the environment where they will practise. A period of training in Britain may be an important component of that training, particularly for those doctors who will return to become teachers, trainers, and researchers in their own countries. Hence it is necessary to integrate overseas doctors into British training programmes as part of an overall planned training, tailored to their own needs, in their own country and in Britain.

The International Health Consortium has representatives from a wide range of professional associations and disciplines who believe that the first priority is the support of indigenous training programmes in countries overseas. This can be done effectively if visiting teachers supplement

such programmes in areas or subjects that are weak in people or skill. Short intensive visits, well planned beforehand, are proving most valuable. The consortium has had considerable success in responding to requests for help from Uganda, Tanzania, and Ghana across many specialties. Ideally, these visits are planned so that they lead to long term commitment and support. The visits are also particularly important in overseas medical schools not recognised by the General Medical Council, whose graduates are unable to do any clinical training in Britain.

Longer visits are difficult to arrange, and, although many NHS trusts now recognise the value of sabbatical leave, they are reluctant to provide funds for locums, so that a period of absence may jeopardise performance targets and put unfair burdens on colleagues. The British government could greatly help training in poorer countries if it made available funds to support short term teaching visits for defined needs in indigenous training programmes.

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Publicity about certain aspects of meningococcal disease is still needed

EDITOR,—There has been widespread media coverage of the seasonal increase in the incidence of meningitis, which consequently has caused much public concern.¹ Unfortunately, reports in the media have not always emphasised the most relevant symptoms and signs of meningitis and meningococcal septicaemia.² We interviewed 180 parents and carers of children attending playgroups throughout London to assess their knowledge of meningitis and meningococcal septicaemia.

Overall, awareness was good, with 173 of the respondents having seen or heard publicity about meningitis. When asked to identify eight symptoms of meningitis (from a list of 14) 122 respondents correctly chose six or more. Among the most poorly recognised symptoms were rash and photophobia (not recognised by 45 and 47 respondents respectively). Eighty three respondents said that if they found a purple rash that did not fade when pressure was applied they would not seek medical help immediately, while 20 said that they would not seek medical help until the next day. Other points of potential concern were highlighted—for example, a considerable number of respondents did not realise that teenagers and elderly people are at risk of meningitis (52 and 97 respectively). Thirty four respondents did not know that meningitis is transmissible. Because most people obtained their information about meningitis from television

or radio (162) and newspapers (119) we believe that these are important vehicles for increasing public awareness of this disease.

In the light of our findings we suggest that future publicity should emphasise that meningitis is not a threat only to babies and young children and that teenagers and elderly people are also particularly at risk. The importance of a petechial or purpuric rash that does not fade when pressure is applied and the need for immediate action when such a rash is found should also be highlighted.

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Neonatal screening in New Zealand

EDITOR,—Alison Streetly and colleagues describe the neonatal screening programmes in the United Kingdom.¹ Screening for phenylketonuria and congenital hypothyroidism is almost universal, but other conditions have been added to meet regional needs (or regional skills and interests). The authors comment that not all programmes have been assessed against the criteria that determine whether a screening programme is suitable.²

In New Zealand seven conditions are screened for (table 1), with roughly 95% coverage of about 60 000 births annually. Some of the tests may not meet the commonly cited criteria for a screening test; many people involved in neonatal screening acknowledge, however, that it may not be necessary to meet all the criteria—that the criteria should be considered and that a rational decision to screen can be made if not all the criteria are met. It has also been suggested that the criteria, now 27 years old, should be reconsidered and, for instance, that the requirement for a “treatment to be available” should be replaced by “scope for action to be available.”

Recommendations for neonatal screening tests for New Zealand and Australia are made by a joint subcommittee of the Human Genetics Society of Australasia and the Australian College of Paediatrics. The subcommittee recommends unequivocally screening for phenylketonuria and congenital hypothyroidism and also recommends screening for cystic fibrosis, galactosaemia, and congenital adrenal hyperplasia.

The additional screening tests in New Zealand are justified on the basis of our scattered population and the fact that standards of diagnosis of metabolic disease in sick children differ in different parts of the country. In the four cases of maple syrup urine disease diagnosed most recently by the screening programme no metabolic tests had been requested on the infants before the likely diagnosis was reported by the screening programme, although all

the infants had symptoms suggestive of metabolic disease. The marginal cost of adding screening for biotinidase deficiency and maple syrup urine disease to screening for the five other conditions is less than \$NZ1 (43p) per infant screened.

The efficacy of screening is constantly reviewed, and screening for homocystinuria was stopped in 1986. This was because the decrease in the use of cows' milk as infant food plus the fact that the screening test was being done increasingly early meant that the protein intake of infants with homocystinuria was insufficient to result in pathological values of methionine at the time the sample is taken.

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Breast feeding should be promoted as a public health measure

EDITOR,—C Worth and Howard Barnes draw attention to the serious public health implications of the water shortage in West Yorkshire and the proposal that 24 hour cuts in the water supply might be made on a “one day on, one day off” basis.¹ A topic not specifically mentioned is the particular difficulties that interruptions in the water supply pose for mothers who feed their babies with artificial milks. Worth and Barnes note the increased general risk of gastrointestinal infection that would result from any interruptions in the water supply. Inevitably, the risk of severe disease will be particularly high among artificially fed babies.²

One immediate measure to reduce the numbers susceptible would be vigorously to promote breast feeding in hospitals and the community. Breast feeding is of proved benefit in protecting infants against gastrointestinal infection even when the water supply is constant and safe.³ If the water supply was interrupted mothers who were breast feeding would be saved one major concern over their babies' health when other, practical concerns would be paramount. The most recent national data indicate that the north of England has a low and declining rate of breast feeding: in 1990 only 50-60% of mothers started breast feeding, and by 6 weeks of age the proportion continuing was under a third.³ Breast feeding is often successfully promoted in the developing world.⁴ Preliminary data from the World Health Organisation and Unicef's “baby friendly initiative” indicate that breast feeding rates can also be increased in Britain by local professional initiatives. In Sheffield the Jessop Hospital for Women has adopted both the recommendations made in the baby friendly initiative and the Department of Health's guidance on promoting breast feeding and has increased its breast feeding rates accordingly (S Ashmore, personal communication).

Such an intervention would be a simple public health measure that, even if further interruptions in the water supply did not occur, would result in health gains. For example, it has been estimated that costs to the health services in England and Wales would be reduced by about £0.5m a year (mostly through the prevention of gastrointestinal

infections) for every percentage point increase in breast feeding rates.⁵

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Treatment of toenail tinea infection

True cure seems unlikely

EDITOR,—In the report of their study comparing terbinafine and itraconazole in toenail tinea infection M Bräutigam and colleagues state that “because the disappearance of the hyphae from the nail plate took more time than fungal viability, the mycological cure rate increased more slowly.”¹ As the authors point out, this probably reflects the incorporation of the drug into the nail and the resultant inhibitory effects. Thus the persistence of hyphae long after the results of cultures became negative may reflect only the time taken by the nail with the incorporated antifungal to reach the terminal nail plate, which is sampled for culture and microscopy. Given that only 49% of the group given terbinafine and 36% of the group given itraconazole showed clinical cure at one year (authors' table I), it would be interesting to see the results of follow up at two years. Additionally, true cure seems unlikely, given that the length of unaffected nail reached a plateau at 8 mm. If a true cure had been attained the progression would have continued until all of the nail was unaffected.

The true cure rate of onychomycosis has been low when studied beyond the period of the drug's direct action. Despite adverse effects being common (occurring in about 40% of cases) it may be worth treating the condition with oral antifungals, but only if they are truly curative. But if the benefit is only temporary, as some authors suggest,^{2,3} then perhaps future studies should incorporate in their outcome measures patients' subjective assessment of their symptoms. This would help determine whether the short term benefits outweigh the adverse effects.

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Authors' reply

EDITOR,—David S Buck suggests that in some patients one year may be too short for a final assessment of therapeutic efficacy in toenail tinea infection. We agree that our figure and the

Table 1—Diseases screened for in New Zealand neonatal screening programme and their incidence

Condition	Incidence
Cystic fibrosis	1 in 3 900
Congenital hypothyroidism	1 in 5 300
Phenylketonuria	1 in 20 100
Congenital adrenal hyperplasia	1 in 21 800
Biotinidase deficiency	1 in 58 800
Galactosaemia	1 in 123 400
Maple syrup urine disease	1 in 168 100