Serum IgM testing is needed in all cases of suspected measles

EDITOR,—We agree with Laura Ryall and colleagues that testing for virus specific IgM, in either a saliva specimen or a serum sample, is the appropriate initial method for diagnosing measles.¹ The main advantage of IgM testing, given the current epidemiology of measles in England and Wales, is its high specificity.

Currently measles infections are rare, and less than 1% of notified cases have been confirmed by IgM assay of saliva in the past six months.² In this context, even a test that was 99% specific would be expected to have a positive predictive value of around 50%: for every 1000 suspected cases tested there will be about 10 false positive and 10 true positive results. Since 1995, therefore, the Public Health Laboratory Service Communicable Disease Surveillance Centre has requested additional tests on all cases of laboratory confirmed measles reported in England and Wales. The reporting doctor or laboratory has been asked to refer a serum specimen for IgM assay, either to a local laboratory or to the Public Health Laboratory Service Enteric and Respiratory Virus Laboratory.

Table 1—Cases of measles reported to Communicable Disease Surveillance Centre by method of diagnosis

Initial method of diagnosis	Serum measles IgM result		
	No reported	No tested	No (%) positive
Single high IgG in CFT	46	31	13 (42)
Fourfold rise in IgG in CFT	12	8	3 (38)
Salivary IgM test	38	12	8 (67)
Serum IgM test*	11	8	5 (75)
Total	107	59	29 (49)

CFT = complement fixation test.

*Reports of cases that were positive on IgM testing by ELISA and were retested with an IgM antibody capture radioimmunoassay.

Since the beginning of 1995, 107 confirmed cases have been reported from laboratories in England and Wales, of which only 11 had been confirmed by a serum IgM test before the report. The remaining 96 cases had been diagnosed by the detection of specific salivary IgM or by serum complement fixation tests for IgG (table 1). Additional serum IgM testing was performed with various commercial enzyme linked immunosorbent assay (ELISA) kits (Behring, Sigma, Biostat) or an in house IgM antibody capture radioimmunoassay.³ The proportion of cases that were confirmed as positive by serum IgM testing was not high (table 1), and even some cases reported as positive on IgM testing were not confirmed by a second test. In the three cases with discrepant serum IgM results, specimens were retested with a different ELISA (Denka-Seiken); two gave a negative result and one an equivocal result. This confirms the low positive predictive value of all the diagnostic methods and suggests that many cases diagnosed serologically are false positive cases.

The Public Health Laboratory Service is now following up all confirmed cases of measles to investigate the possible source of infection and to identify remaining pockets of susceptible subjects. For this reason it is important that cases diagnosed by any method (including assay of saliva) are confirmed by one or more specific

serum IgM assays. We are thus asking clinicians and laboratories to submit serum samples from such cases for additional tests.

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- 1 Ryall L, Goodbourn C, Taylor A, Teare L. Laboratories should use serum IgM tests to confirm measles. *BMJ* 1996;312:975-6. (13 April.)
- 2 Ramsay M, Brown D. Measles data are reliable. *BMJ* 1995;311:810.
- 3 Perry KR, Brown DWG, Parry JV, Panday S, Pipkin C, Richards A. The detection of measles, mumps and rubella antibodies in saliva using antibody capture radio-immunoassay. *J Med Virol* 1993;40:235-40.

Psychiatric and psychological aspects of hysterectomy

Authors did not specify type of hysterectomy carried out

EDITOR,—Unfortunately, rather than encourage gynaecologists to adopt new and conservative surgical techniques, David A Alexander and colleagues' study will confirm the opinion of the diehards that hysterectomy is a "good treatment" for women and lead them to discount those who are trying to find new methods of treatment.¹ The fact that the trial presupposed the outcome goes without saying, as the women were preselected and those who had an oophorectomy—the group who experience the most trauma from hysterectomy—were excluded.

It is unfortunate that so many gynaecologists believe that healthy ovaries should be removed at hysterectomy and that a healthy cervix is a non-essential part of a woman's body. The fact that the authors make no mention of whether the hysterectomies were total or subtotal illustrates what I mean. Gynaecologists routinely remove healthy cervixes and never consider that they need to ask the patient her opinion on the subject. One would have expected women who were left with their cervix intact to have fewer psychiatric problems.

I suspect that any study that fails to mention what type of hysterectomy was carried out is deliberately trying to show the operation in a good light. I would like to know what type of hysterectomy was performed and how the 204 subjects in the trial were selected.

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- 1 Alexander DA, Naji AA, Pinion SB, Mollison J, Kitchener HC, Parkin DE, et al. Randomised trial comparing hysterectomy with endometrial ablation for dysfunctional uterine bleeding: psychiatric and psychosocial aspects. *BMJ* 1996;312:280-4. (3 February.)

Study did not reliably exclude possibility of psychological damage

EDITOR,—David A Alexander and colleagues conclude that there is no evidence that hysterectomy leads to postoperative psychiatric illness and that endometrial ablation and hysterectomy have a similar effect on psychiatric outcome.¹ Their conclusion rests heavily on the appropriateness of the main instrument used to explore psychiatric outcome. They used the hospital anxiety and depression scale. This is a useful screening instrument, and it is also a good way of

monitoring change in established depressive illnesses or anxiety states, but it is not a diagnostic tool for discerning psychiatric illness. The authors' attempted validation of the scale is limited. They used the structured clinical interview, which enables psychiatric diagnoses to be made according to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*, and they did this for only 21 of the 204 women, all of whom were classed as being depressed when the hospital anxiety and depression scale was used. Given that most of the women in the study were not designated as depressed when the scale was used, it is difficult to see how this sample could be what the authors describe as a random sample.

It is now well established that one of the most important influences on postoperative psychiatric morbidity is preoperative psychiatric state² but that this does not exclude coexistent negative psychological effects of hysterectomy in some women. Numerous psychological sequelae have been linked to hysterectomy. For example, sexual functioning is improved in at least 30% of women but can be negatively affected in up to 38%.³ Other negative effects include feelings about the loss of womb and childbearing capacity in younger women, adverse effects on women's self image, social disruption due to a long recovery time, a slow return to normal life, and postoperative complications in some women.² Endometrial ablation leaves more choices, has fewer complications,³ and reliably reduces menstrual loss (with an average reduction of more than 90%).⁴

We acknowledge that future studies may redefine the risks of hysterectomy, but in our view Alexander and colleagues' study has not excluded the possibility of psychological damage in some women. Awareness of psychological problems and screening for psychological morbidity remain important elements in the assessment and follow up of women complaining of heavy periods, both in clinical practice and in research.⁵

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- 1 Alexander DA, Naji AA, Pinion SB, Mollison J, Kitchener HC, Parkin DE, et al. Randomised trial comparing hysterectomy with endometrial ablation for dysfunctional uterine bleeding: psychiatric and psychosocial aspects. *BMJ* 1996;312:280-4. (3 February.)
- 2 Wright JB, Gannon MJ, Greenberg M. Psychological aspects of heavy periods: does endometrial ablation provide the answer? *Br J Hosp Med* 1996;55:289-94.
- 3 Gannon MJ, Holt EM, Fairbank J, Fitzgerald M, Milne MA, Crystal AM, et al. A randomised trial comparing endometrial resection and abdominal hysterectomy for the treatment of menorrhagia. *BMJ* 1991;303:1362-4.
- 4 Gannon MJ, Johnson N, O'Donovan P, Hebblethwaite N, Buchan PC, Lilford RJ. Reduction in menstrual loss after loop resection or rollerball ablation for menorrhagia. *Gynaecological Endoscopy* 1994;3(suppl 1):3.
- 5 Wright JB, Greenberg M. Establish severity of blood loss before surgery for dysfunctional uterine bleeding. *BMJ* 1995;310:803.

Results will depend on whether hysterectomy was essential or not

EDITOR,—David A Alexander and colleagues' conclusion that there is no evidence that hysterectomy leads to postoperative psychiatric illness was ensured by the design of their trial.¹ They did not specifically ask the women about their body image before and after operation, they assume that women who are willing to be randomised are typical of all women, and the women were probably carefully counselled.