in Britain, many of the difficult decisions would not have been necessary.

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Counselling will be needed when embryos are donated as well as when they are stored

EDITOR,—We agree with Alan Trounson and Karen Dawson that the ability to cryopreserve embryos has presented both opportunities and dilemmas.¹ The authors suggest that consent be obtained at the time of storage, and this may have organisational advantages. Nevertheless, we have misgivings about this suggestion because many units may not have screened couples for HIV infection, cystic fibrosis, and hepatitis B. It is also possible that, in future, additional screening may be deemed necessary. We suggest that couples who consent to the storage of embryos for donation should be told that at the time the embryos are donated they will need to be further counselled and screened and will need to give their consent again. Our present experience is that couples do not wish to return to the unit for further screening, possibly because we did not counsel them about this at the time that their initial consent was obtained.

If a couple who wish to donate frozen embryos return for screening and are found to be positive for HIV or hepatitis B virus then another potential problem arises: there is currently some concern that cross contamination is possible between tissues held in liquid nitrogen storage.²

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Postmenopausal cystitis

Bladder cancer may be a cause, but interstitial cystitis is an unusual differential diagnosis

EDITOR,—Linda Cardozo is right to draw attention to the problem of postmenopausal cystitis and the use of topical oestrogens in its treatment.¹ Topical oestrogens are almost certainly underused in this condition. From the urological perspective, however, certain important points should be emphasised.

Firstly, ultrasonography is probably preferable to intravenous urography for imaging. Ultrasonography will quantify residual urine and detects renal and bladder calculi better than plain radiography. Ureteric stones (which ultrasonography will probably miss) are virtually never the isolated cause of recurrent infections.

Ultrasonography spares the patient irradiation and the finite risk of a reaction to contrast medium.

Secondly, bladder cancer is an important consideration in postmenopausal women who present with irritative voiding symptoms. There can be few urologists who have not seen patients referred late with bladder tumours after inappropriate management for other presumed causes of lower urinary tract symptoms. In all patients whose urine is not free of cells after treatment of a confirmed urinary tract infection, repeat cytological examination of urine and flexible cystoscopy should be carried out. Cytological examination will detect those patients with carcinoma in situ whose bladder looks normal cystoscopically.

Thirdly, interstitial cystitis is an unusual differential diagnosis in this group of patients. We accept that it creates considerable controversy both in its diagnosis and in its treatment. The putative role of mast cells in this condition is debated; some studies have reported greater numbers of these cells in the detrusor muscle of patients with interstitial cystitis than in normal detrusor muscle, though the value of counting mast cells for diagnostic purposes is still doubted.² Indeed, overlapping values are found when the control group includes patients with other types of chronic cystitis³; differences are at the statistical, rather than the individual, level. The issue is further confused by the fact that mast cell counts that are related to the surface area of the detrusor muscle will be affected by the state of contraction or distension of the bladder wall and the procedures for tissue fixation and processing. For these reasons, many uropathologists would not routinely count mast cells when presented with a biopsy specimen in this clinical condition⁴; the main value of the biopsy is to exclude neoplasia.

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Should be managed in urological units

EDITOR,—We take issue with several points in Linda Cardozo's editorial on postmenopausal cystitis.¹ The comment that "for those women in whom oestrogen therapy is ineffective or inappropriate, it is important to exclude underlying pathology" is misleading as it implies that oestrogen should be given before adequate assessment and investigation. The author should have mentioned that urothelial carcinoma should be excluded by microscopical examination of urine for red cells, followed if indicated by cytological examination of urine and flexible cystourethroscopy, before oestrogen is started after antibiotic treatment for bacterial cystitis.²

The coexistence of vaginal and urethral stenosis with atrophic vaginitis is well known and is best treated with a combination of urethral dilatation and intravaginal oestrogen for long term success.³

Bacterial cystitis can be difficult to distinguish from bladder carcinoma, especially carcinoma in situ. Interstitial cystitis has clearly defined diagnostic criteria,⁴ including a particular symptom complex, a systemic response to endoscopic cystodistension, and specific histological appearances on biopsy. The suggested treatment options for interstitial cystitis are incomplete. The therapeutic effects of cystodistension and cystodiathermy are not mentioned; nor is the role of intravesical instillation of silver nitrate, dimethyl sulphoxide, or newer agents such as hyaluronic acid.

This editorial emphasises that postmenopausal cystitis is best investigated and managed in urological units.

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Sensitivity testing for *Helicobacter pylori* should be more widely available

EDITOR,—Greg Rubin and Richard Stevens are right to ask for the wider availability of non-invasive diagnostic tests for managing *Helicobacter pylori* infection in primary care.¹ We believe that the implementation of management guidelines for peptic ulcer disease also requires the wider availability of tests to determine the sensitivity of *H pylori*, because increased prescribing of antimicrobial drugs to treat the infection may be associated with increased drug resistance. Furthermore, our data indicate that if the global eradication of *H pylori* is deemed desirable then simpler and more effective regimens need to be developed for infected patients.

Table 1 (see overleaf) gives details of seven patients with gastric or duodenal ulcer who received at least three different courses of eradication treatment, including the most commonly used drugs, in an attempt to eradicate *H pylori*. In all cases we used either histological examination (Giemsa staining) plus the rapid urease test or breath testing to evaluate the patients' *H pylori* status at least six weeks after the completion of the treatments. All the patients were fully informed and complied with the treatments.

Failure of treatment may be due to the different antibiotic susceptibilities of the various strains of *H pylori*; phenotypically and genotypically different strains of *H pylori* can be present in the stomach at the same time.² We do not yet know whether, in an individual patient, drug resistance occurs through the selection of resistant strains within a mixed population (that is, primary resistance) or through previously sensitive strains becoming resistant (that is, secondary resistance). Because we found that a patient might have to be treated three or more times for *H pylori* to be eradicated, both mechanisms may act in the same patient. In some cases, after the selection of organisms that are primarily resistant to certain antibiotics, secondary resistance to other drugs might develop.

Before treating patients with *H pylori* infection it is thus always important to consider the results of culture and sensitivity tests.³ The problem is that at present the tests are unavailable in most centres. In addition, the routine isolation of

Table 1—*H pylori* status of seven patients after three courses of eradication treatment

Case No	First treatment		Second treatment		Third treatment		<i>H pylori</i> status after third treatment	Duration of follow up (months)
	Drug	No of days	Drug	No of days	Drug	No of days		
1	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Positive	9
2	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Tinidazole 500 mg twice daily	14	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily	14	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Negative	11
3	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Metronidazole 250 mg four times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Positive	13
4	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Bismuth 120 mg four times daily Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily	7	Positive	9
5	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Negative	15
6	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Positive	12
7	Omeprazole 20 mg daily Amoxycillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxycillin 1 g twice daily Metronidazole 250 mg six times daily	7	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Positive	11

H pylori is difficult,⁴ and the need to culture the bacterium from several gastric sites in a single patient because of the possible coexistence of several strains compounds this difficulty.

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Complementary medicine

Most private medical insurers will pay for certain forms of complementary medicine

EDITOR,—The news article about the use of complementary medicine in various countries raises several points of interest, such as the variability in the recognition of, and in the attitudes towards, complementary medicine among the public and the medical profession.¹ Little is

known about private medical insurers' reimbursement policies for complementary medicine. The findings of a survey that a colleague and I recently carried out may be of interest.² We sent a modified questionnaire³ to a random sample of 100 rheumatologists across Britain. We also sent a questionnaire to the 20 main private medical insurers, asking about company policy towards reimbursement for complementary treatment.

Seventy one rheumatologists responded. Acupuncture was the most popular discipline (n = 42), followed by osteopathy (n = 24) and the Alexander technique (n = 18). A third (23) of the rheumatologists thought that osteopathy should be available on the NHS, and over half (40) thought the same for acupuncture; other treatments were regarded as less desirable. Rheumatologists generally supported the suggestion that certain disciplines, such as acupuncture, should be taught to medical students and physiotherapists, though they were less supportive of this for other disciplines.

Rheumatologists generally considered osteopathy, acupuncture, and chiropractic to be more effective in treating rheumatic complaints than other complementary treatments. Patients were usually referred to these disciplines after conventional treatment and rarely at their initial consultation. Only a quarter of the respondents were aware that private medical insurers paid for certain forms of complementary medicine.

Of the 20 companies to which we sent questionnaires, 17 responded. Most of the companies paid for chiropractic, osteopathy, homoeopathy, acupuncture, and the Alexander technique. Other treatments were paid for less commonly. In certain disciplines, such as acupuncture, homoeopathy, and the Alexander technique, only consultant referrals were paid for. Some disciplines, such as herbal medicine, naturopathy, reflexology, and aromatherapy, were not paid for even on consultant referral.

Despite much controversy, complementary

medicine is popular with the general public. In the new consumer conscious NHS, trusts must take into account the attitudes of the public as well as of various specialists when planning or purchasing such treatments.

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Norwegian ministry of health is discussing whether to authorise various treatments

EDITOR,—In the article about the use of complementary medicine in various countries, Norway is one of those discussed.¹ We would like to point out an error and to give some more information.

Firstly, it is incorrect to state that no state funding is available for research into complementary medicine. Each year since 1993 the Norwegian Ministry of Health and Social Affairs has given 1.5m Norwegian kroner (£151 500; \$227 250) for research into complementary medicine.

Secondly, the article does not mention chiropractic. Chiropractic is relatively widely practised in Norway, and chiropractors became authorised a few years ago, in 1988. The cost of chiropractic treatment is partly reimbursed.

Finally, we would point out that alternative medicine is still under discussion in the Norwegian Ministry of Health and Social Affairs. One of the questions being discussed is