The issue of compensation is much more difficult. Sikora's suggestion would be seen as no fault compensation by the back door, and such an argument would doubtless be extended to all medical accidents. I expect that the calculation has been made that the present "negligence lottery," with a few relatively large pay outs, will be much cheaper than a large number of smaller no fault payments.

All cancer treatment necessitates compromise as we juggle with the response rate, quality of life, and survival versus toxicity, inconvenience, and risk. Eventually it may well be shown that the six week treatment advocated by Sikora and his American colleagues is excessive and wastes resources.

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Self referral service is unique

EDITOR,—The well woman centre at the United Elizabeth Garrett Anderson Hospital provides a self referral preventive health care service including, if indicated, mammography and ultrasonography of the breast. Nurse practitioners and doctors work together to provide a "woman for woman" service.

I believe that the centre provides the sort of service that Lesley Elliott is calling for.¹ It is free; is part of the NHS; and is, unfortunately, so far as we are aware, unique. Women need easy access to breast examination and screening. The Forrest programme meets the needs of women over 50, but younger women often have to fight to get their concerns taken seriously. I recently did a survey of mammography facilities, other than those of the Forrest programme, provided by surrounding health districts. Of 15 districts that responded, two offered mammography for women referred by their general practitioner. None, other than ours, offered self referral.

Many of the women we see are young women anxious about changes in their breasts. Often they have family histories of breast cancer; sometimes they do not. Sometimes they have breast cancer. Women may have a breast biopsy done by a radiologist or may be referred direct to a breast surgeon. We also work closely with local general practitioners and are about to launch a quick response breast clinic, whereby general practitioners who are worried about breast pathology can arrange for the woman to have an examination, mammography, or ultrasonography within two or three days.

The propaganda of private medicine would have women believe that if they value their health they should seek private preventive health care. Why should they have to? Top quality services to prevent breast cancer can and should be widely available on the NHS. Women, as taxpayers, have paid for them. They deserve them. Perhaps the newly formed all party committee on breast cancer will not only talk but act.

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1 Elliott L. Breast cancer: a fighting chance. *BMJ* 1994;308:210. (15 January.)

Understand women's preconceptions

EDITOR,—In their review of familial breast cancer D G R Evans and colleagues clearly define criteria for referral to a family breast cancer clinic.¹ Several studies are examining women's experiences of these clinics. Our study, which concerns family

beliefs and communication about genetic disease,² has meant attending clinics for women with a family history of breast and ovarian cancer and interviewing women before and after their consultations. Though our work is preliminary, it has raised several issues related to counselling.

Women come with prior beliefs (for example, about interactions with lifestyle, cancer skipping generations, males being unable to inherit the gene, and a concept of proneness³) which may be incompatible with a mendelian explanation. We suggest that an understanding of the prior beliefs that women hold about the ways in which cancer occurs in their families is necessary for effective counselling. The roles of men in passing a gene associated with female diseases may cause particular difficulty and lead to misunderstandings about which family members are at risk.

Our observations suggest that women come to these clinics primarily to gain access to screening and to discuss ways of reducing risk. Providing numerical estimates of risk is not always helpful. Their meaning and implications are often misunderstood, as is their calculation on the basis of disparate factors (for example, the penetrance of the gene). Many women probably adopt appropriate strategies on the much simpler basis of their own perceived raised susceptibility in relation to that of other women.

The BRCA1 gene is associated with both breast and ovarian cancer, as has been widely discussed in the media. Some women who have been counselled about only one cancer have subsequently become concerned about the other. This raises questions about the extent to which both cancers should be discussed in counselling and emphasises that family members are likely to hear about ovarian and breast cancer in the media. Media coverage may also serve to produce unrealistic hopes of the relevance and usefulness of testing for BRCA1 (when it arrives) for many women.

In common with others in Britain, we have not seen the reluctance to seek screening that has been reported in some American studies and has been attributed to high levels of anxiety and stress.⁴ This may be because women generally refer themselves in Britain, but this could change in the future.

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Chlamydia trachomatis infection

Prevalence varies in general practice

EDITOR,—More is known about the prevalence of *Chlamydia trachomatis* infections in women in primary care than David Taylor-Robinson mentions.¹ Analysis of studies in general practice has raised several more specific problems and hence some more specific solutions. These studies have shown variations both over time and among practices in the prevalence of cervical chlamydial infections, ranging from 0.5% to 10.7%.^{2,3} The variations in prevalence can be attributed to the different tests used to detect *C trachomatis*; the site of the practice (inner city or suburban); whether the patients were symptomatic; and changes in the prevalence of the organism itself. Information on the changing prevalence of *C trachomatis* in

primary care is not routinely available to general practitioners, although such information is available to genitourinary medicine clinics. General practitioners require this information if they are to make rational decisions on investigating and treating patients.

I suggest that this information could be provided for general practitioners by the use of "spotter" practices. A small number of selected practices from various inner city, suburban, and rural sites would be funded to enable them to investigate all women presenting with lower genital tract symptoms, collate the results, and issue regular reports on the prevalence of all gynaecological infections. This information should be integrated with the figures from genitourinary medicine clinics to allow a more complete assessment of progress in meeting the targets of the *Health of the Nation* than is currently possible from use of information from secondary care alone.

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Screening associated with reduced infection rates

EDITOR,—David Taylor-Robinson emphasises the need for a comprehensive programme of widespread screening, contact tracing, and treatment to reduce genital chlamydial infection and the consequent morbidity in the community.¹ We have been pursuing such a policy in our genitourinary medicine clinic since 1989. There has been a significant decline in the incidence of *Chlamydia trachomatis* infection in women attending our clinic (χ^2 for trend = 79.68, $P < 0.00001$; table).

C trachomatis primarily causes asymptomatic infection in women. In men it causes 30-50% of cases of acute non-gonococcal urethritis, yet studies in genitourinary medicine clinics indicate that 4-4.6-6% of men may carry this infection without signs or symptoms of non-gonococcal urethritis.^{2,4} Little is known about the incidence of asymptomatic infection in men in settings other than genitourinary medicine clinics.

In 1989 we began screening both male and female patients attending our clinic with a new problem. *C trachomatis* was detected with an enzyme immunoassay (Dako) and specimens were confirmed as being positive for chlamydia by direct immunofluorescence (Syva). In our clinic 42-46% of male patients with non-gonococcal urethritis are positive for *C trachomatis*.^{3,4} All were interviewed by a health adviser to establish names and addresses of

Proportion of women attending genitourinary medicine clinic in 1988-93 who were positive for chlamydia

Year of diagnosis	Proportion (%) of women positive for chlamydia
1988-9	600/4943 (12.1)
1989-90	436/4461 (9.8)
1990-1	390/4553 (8.6)
1991-2	431/4915 (8.8)
1992-3	286/4302 (6.6)

recent sexual partners. Patients were informed that their confidentiality would be preserved. This is important as many patients would not otherwise give details of their contacts. This is protected by law in the genitourinary medicine clinic. Patients were advised to tell their contacts of their diagnosis and to encourage their attendance at a genitourinary medicine clinic.

Male and female patients found to be positive for chlamydia and who had not received treatment at presentation were recalled, treated, and interviewed by the health adviser. All identified partners were then actively sought by the health adviser, when necessary by a home visit. Those who were traced were offered screening and treatment.

Our experience shows that a programme such as that described by Taylor-Robinson is effective in a genitourinary medicine clinic and suggests that results similar to those in Sweden would be achievable if applied to the community as a whole. We believe that a comprehensive screening programme should include testing of both men and women and that contacts need to be actively pursued by people skilled in preserving confidentiality. The use of a non-invasive first catch urine sample, as we originally described,³ would greatly facilitate widespread screening of sexually active male patients and would identify asymptomatic infections.

Sexually transmitted diseases, including *C trachomatis* infection, are cofactors in the heterosexual transmission of HIV infection.⁵ The need for active intervention in the community cannot therefore be overemphasised.

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Depot medroxyprogesterone acetate and osteoporosis

Monitor serum oestradiol concentration in users

EDITOR,—T Cundy and colleagues again report the theoretical risk of oestrogen deficiency and osteoporosis in long term users of depot medroxyprogesterone acetate.¹ Their previous study² was criticised on methodological grounds,³ and the issue has not yet been resolved. As before, their small study is cross sectional rather than prospective. Once again, we do not know the bone densities of the women before they used depot medroxyprogesterone acetate. In addition, we are not given any details of the oestradiol concentrations during or after use of the contraceptive.

As in the previous study, the bone densities of the women using the contraceptive were not such as to place them at current risk of a fracture. Since 1991, however, we have suggested that serum oestradiol concentrations should be measured in

long term users of depot medroxyprogesterone acetate. For any women found to be oestrogen deficient there is a good alternative to stopping the method: this is to add natural oestrogens, just as if the women were using hormone replacement therapy, with the depot medroxyprogesterone providing the progesterone component. Depot medroxyprogesterone acetate gives a fivefold protective effect against endometrial cancer.⁴ A prospective study of bone density (including measurements of oestradiol concentrations) will start shortly and, we hope, resolve the controversy.

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Smoking may explain findings

EDITOR,—T Cundy and colleagues' paper on bone density in women who stop using depot medroxyprogesterone acetate raises certain questions.¹ There was a considerable difference in the percentage of smokers (22% v 6%) between the women who stopped using the drug and those who have never used it; this could have been responsible for the difference in results between the two groups. Smoking increases the incidence of osteoporosis, and stopping smoking has been recommended as a preventive measure for osteoporosis.²

The hypothesis that medroxyprogesterone acetate reduces bone density contrasts with that of Prior, who has considered the potential role of progesterone in bone formation.³ Prior *et al* have reported the presence of progesterone receptors on osteoblasts in vitro, citing this as evidence that progesterone acts as a bone trophic hormone.⁴

Cundy and colleagues did not find any significant difference in the bone density in the femoral neck, which can be measured accurately; measurements of bone density in the spine are less accurate. Measurement of bone density at the wrist might have yielded more reliable results.

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Palliative care in severe heart failure

EDITOR,—I wish to draw attention to Henry J Dargie and J J V McMurray's comments about the malignant nature of severe heart failure,¹ and the need for discussion about quality rather than quantity of life in this condition. Palliative medicine is the "study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus for care is quality of life."² It addresses not the diagnosis but

the need for care in the final stages of life. Patients with cancer are not the only patients with this need.

Palliative medicine has revolutionised the management of pain and other symptoms of cancer, including dyspnoea. End stage heart failure has several features in common with cancer, such as dyspnoea, tiredness, and cachexia. The role of opioids in acute pulmonary oedema is undisputed. Little information exists, however, on the effects of oral or nebulised morphine for dyspnoea in end stage heart failure. Research on this is badly needed and should be possible with cooperation between palliative and other physicians.

Deciding when a patient with heart failure has reached a stage when palliative care is appropriate is not easy. Doctors treating patients with heart disease are often obsessed with resuscitation even when this is inappropriate, and dying patients may be subjected to intensive treatment because no one has said stop. If the quality of life of patients with terminal heart disease is to be improved we need to lose more of our preconceptions.

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Catatonic stupor after "ecstasy"

EDITOR,—D L Maxwell and colleagues report two cases of catatonic stupor in patients who had taken 3,4-methylenedioxymethamphetamine ("ecstasy").¹ I doubt whether the patients exhibited sufficient features to justify the diagnosis of catatonic stupor.

Catatonia is a behavioural neurological syndrome characterised by abnormal motor behaviour and periods of extreme hyperactivity and hypoactivity.² Mutism and stupor are common, but alone they are not pathognomonic. Several organic conditions associated with catatonia have been reported, but the catatonias were often not diagnosed according to strict criteria.³

To aid research and communication a consensus definition of diagnostic criteria for the catatonic syndrome is desirable. According to diagnostic guidelines in the *International Classification of Diseases*, tenth revision, organic catatonic stupor is a state (of assumed organic aetiology) of diminution or absence of spontaneous movement with partial or complete mutism, negativism, and rigid posturing; the presence of other catatonic phenomena such as stereotypies or waxy flexibility increases confidence in the diagnosis.⁴ Interestingly, specific operational criteria for catatonia, as a separate category, have also been suggested for the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition.⁵

The first patient reported on by the authors was drowsy and could be roused but was uncommunicative. She responded appropriately to pain but not to command. She intermittently opened her eyes but did not respond to or recognise anyone. This is a picture of organic (neurological) stupor, which may be associated with the absence of verbal response—mutism, when the subject aroused is incapable of normal alertness and interaction. There were no catatonic features other than stupor and mutism. The second patient became restless and uncommunicative after taking 3,4-methylenedioxymethamphetamine. She was apparently conscious. She did not speak. At times she sat up and moved about spontaneously with a "wild eyed" look. She was not stuporous in the neurological or psychiatric sense. In psychiatric practice stupor is regarded as a syndrome whose central feature is a reduction in or absence of relational