disease must be considered. I became aware of an association between adult epiglottitis and malignancy when treating a patient with acute epiglottitis due to infection with *Branhamella catarrhalis* who was subsequently diagnosed as having acute myeloid leukaemia.² There have been other reports of acute epiglottitis in patients with leukaemia,³ and Lederman *et al* described seven cases of pneumococcal epiglottitis, six of which were associated with some form of malignancy.⁴

Thus an underlying malignancy or other immunosuppressive disease⁵ should be suspected in cases of adult epiglottitis. This association may simply represent opportunistic infection occurring in immunocompromised patients and need not indicate a specific link. Assessment of the whole patient is, however, vitally important, even when the presenting symptoms and signs seem to be localised.

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Women consultants

EDITOR,—John Stark and Heather Demery state that although fewer women than men apply for consultant posts in the East Anglian region, a greater proportion of women are both shortlisted and appointed.¹ They put some of the low application rate down to the problems that the women's partners might have in finding suitable posts in small towns, in which most East Anglian hospitals are found.

This is a nationwide problem in obstetrics and gynaecology. At the Royal College of Obstetricians and Gynaecologists we have details of 54 of the 60 consultant appointments made in the specialty in Britain last year. Of the 558 applicants, 397 (71%) were male and 73 (13%) were female; sex was not recorded for 88. There was no female applicant for 21 of the 54 posts. Forty seven (32%) of the 148 applicants shortlisted for the 33 other posts were female; when a woman was among the applicants a woman was appointed in 45% of cases. Thus when women apply they have a 19% chance of being appointed while men have an 11.5% chance.

These proportions are not dissimilar from the proportions for East Anglia and show that the shortfall of female consultants in obstetrics and gynaecology owes much to women not applying for posts rather than to them not being shortlisted or being unsuccessful at interview. To address this waste of womanpower perhaps a less rigid approach to consultants' hours is needed, with more part time consultant posts being available than at present. Although flexible training, job sharing, and part time posts are found at registrar and senior registrar levels in obstetrics and gynaecology, it seems to be assumed that when a woman reaches consultancy level all her reasons for wanting a part time job have disappeared and she will be able to work full time.

The solution lies in many more part time (six session) posts being funded centrally. In addition, job sharing could be encouraged between two consultants, perhaps one having been appointed recently and the other being in the latter years of his or her career. In our training grades 32% of

senior registrars and 40% of registrars are women; 52% of female senior registrars are in part time employment and will be considered for consultant appointments in the next few years. We cannot afford to waste this intellectual potential.

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Personality disorder or recurrent brief depression?

EDITOR,—Di Gordon's moving account of having a personality disorder is full of insight.¹ Clearly, her doctors have tried hard to treat her with the best available pharmacological and psychological techniques. I wonder, however, whether her diagnosis should be reconsidered and she in fact has recurrent brief depression; certainly, her description of her disorder would fit with this diagnosis.

Recurrent brief depression is a disorder in which symptoms of depression occur suddenly but last only a few days; the brief depressions occur unpredictably but frequently. An average of two attacks a month is typical. Although the episodes are brief, symptoms are severe. Intense suicidal ideation is common. The disorder does not appear in current diagnostic manuals but will be included in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition and the *International Classification of Diseases*, tenth revision.

There is no known treatment for recurrent brief depression, but having an explanation of the diagnosis and prognosis seems to help patients. A managed multiprofessional approach can provide support during attacks and combat the negative stereotyping that these patients often attract. The greatest hope for sufferers is a pharmacological strategy that could prevent attacks or reduce their severity. Clinical trials are in progress at this centre and at St Mary's Hospital, London.

Recurrent brief depression is serious and often life threatening. Clinicians should consider it as a differential diagnosis of personality disorder if mood symptoms are prominent.

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Intrapartum monitoring in rural Africa

EDITOR,—K Mahomed and colleagues conclude that ultrasound monitoring during labour can improve neonatal outcome.¹ Seventeen cases of ischaemic encephalopathy occurred in the low technology group (monitoring with a Pinard stethoscope and routine monitoring combined) compared with three cases in the high technology group (electronic monitoring and ultrasound scanning combined). But to achieve this the caesarean section rate was almost double in the high technology group, with 87 excess caesarean sections. This is a serious consideration in a hospital that has limited theatre time and where overstretched doctors are often unavailable; the study shows that in 3-5% of cases caesarean section was delayed, often because of inadequate resources.

I recently spent a year working at Jane Furse Memorial Hospital in rural South Africa, where we delivered almost all the high risk cases locally; transfer to a teaching hospital was difficult and took a long time. The overall caesarean section rate was 12% and accounted for much of the heavy on call workload. Caesarean section for fetal distress was usually done only when there was also an abnormal pattern of labour. Poor outcome was sometimes caused by doctors or midwives failing to use the partogram correctly, so in that hospital further training to use existing technology might be more useful than the introduction of new technology.

The risks of subsequent pregnancies after caesarean section must also be considered. Some of our patients attempted a trial of scar at home. Such cases are difficult both to monitor during a trial of labour and to operate on.

Most caesarean sections in Africa are not performed in teaching centres, so I hope that further research will evaluate the overall effect of using ultrasonography in rural hospitals. Otherwise the false perception that such monitoring is good because it is used in large hospitals will soon take hold, and the new method will then be implemented piecemeal in rural hospitals with unknown consequences.

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- 1 Mahomed K, Nyoni R, Mulambo T, Kasule J, Jacobus E. Randomised controlled trial of intrapartum fetal heart rate monitoring. *BMJ* 1994;308:497-500. (19 February.)

Screening immigrants at risk of tuberculosis

EDITOR,—Surinder Bakhshi¹ seems to have missed the main points of R M Hardie and J M Watson's paper, which looked mainly at the efficiency of the current systems of identifying immigrants at risk of tuberculosis so that screening and prevention can be carried out.² Although only a small number of cases of active disease are found, 30% of new immigrants yield negative results on tuberculin testing on entry to Britain and would hence benefit from BCG vaccination and 13% of children yield strongly positive results and so require chemoprophylaxis.³ The screening is therefore directed much more at identifying infected subjects who may require chemoprophylaxis and uninfected people who may require BCG vaccination than at detecting clinically active disease, as Bakhshi suggests.

The advice to carry out such screening as part of an integrated policy on tuberculosis was confirmed by the joint tuberculosis committee of the British Thoracic Society in 1990.⁴ Comprehensive screening of new immigrants for tuberculosis has been an important part of the policy of my district health authority (Blackburn, Hyndburn and Ribbles Valley) since 1981, with the full support of local ethnic minority organisations. These organisations are well aware of the health benefit such screening provides and help us to obtain a high attendance rate. This has contributed to a 65% reduction in notified cases of tuberculosis in adults and a 95% reduction in notified cases in children from 1981 to 1993.

Bakhshi's confusion between the objectives of such screening and the organisational difficulties surrounding it should not deter us from continuing this important part of preventing tuberculosis.

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