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.

G A VERNHAM

Department of Otolaryngology and Head and Neck Surgery,
Victoria Infirmary NHS Trust,
Glasgow G42 9TY

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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.

GEOFFREY CHAMBERLAIN

Royal College of Obstetricians and Gynaecologists,
London NW1 4RG

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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.

C HAWLEY

Queen Elizabeth II Hospital,
Welwyn Garden City AL7 4HQ

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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.

R V MILLARD

Reading,
Berkshire RG1 5SB

- 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.

PETER ORMEROD

Chest Clinic,
Blackburn Royal Infirmary,
Blackburn,
Lancashire BB2 3LR

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Using ovarian tissue from fetuses

EDITOR,—S R Brennan writes that the BMA's medical ethics committee has rushed to support the idea of donation of ovarian tissue by fetuses.¹ The committee began its discussions on this issue last September, when a presentation was made by Dr Roger Gosden, a leading researcher into the use of fetal ovarian tissue; all the issues were carefully explored. At its meeting on 10 February the committee discussed at length the use of fetal ovarian tissue for treatment purposes and the other issues raised in the Human Fertilisation and Embryology Authority's consultation document on donated ovarian tissue in embryo research and assisted conception. Contrary to press reports earlier this year, the committee concluded that use of ovarian tissue from fetuses for treatment purposes was unethical, although it accepted use of such tissue in research. Concern was expressed about the safety of the techniques and the long term effects on children who found out about their genetic origins. The difficulties of obtaining ethically acceptable consent were also highlighted.

These conclusions and the BMA's response to the Human Fertilisation and Embryology Authority's consultation will be debated fully by the BMA's council in May, when the views of other committees in the BMA are known. Any policy decision taken by the council will also require ratification by the representative body at the BMA's annual representative meeting in the summer.

J STUART HORNER

Medical Ethics Committee,
BMA,
London WC1H 9JP

- 1 Brennan SR. Medical ethics and human reproduction. *BMJ* 1994;308:536. (19 February.)

Management of preterm labour

Safety of hormone treatment unproved

EDITOR,—Gerald J Clesham reports a case in which antenatal corticosteroids and thyrotrophin releasing hormone were used in an attempt to accelerate fetal lung maturity in a twin pregnancy with imminent preterm delivery.¹ Randomised controlled trials have shown that corticosteroids given to mothers before preterm delivery can reduce the odds of neonatal death by about 40% and of periventricular haemorrhage and the respiratory distress syndrome by half, with no known side effects.² Analysis of the trials should be based on "intention to treat." This is especially important in preterm labour as our experience shows that as many as half of pregnancies judged to be at sufficient risk of preterm delivery to warrant a course of corticosteroids will continue for at least 10 days after the course is completed. Evidence from randomised controlled trials based on intention to treat analysis and long term follow up studies is reassuring, indicating that antenatal corticosteroids are safe not just for those babies born within 10 days but also for babies in pregnancies that continue.

Although the methodological safeguards described above have been followed in the trials of corticosteroids,² they have not been in the trials of a combination of corticosteroids and thyrotrophin

releasing hormone. Although the data from the five small randomised controlled trials suggest potential benefits (particularly for the respiratory distress syndrome) from such combined treatment, the effects are still far from certain.³ Only two of the trials used an intention to treat analysis. In the others the outcome for babies resulting from pregnancies that continued for more than 10 days after administration of thyrotrophin releasing hormone is not known.

Current scarcity of reassuring evidence that thyrotrophin releasing hormone is safe cannot be disregarded, particularly when evidence of effectiveness is weak. There are certainly maternal side effects, and thyrotrophin releasing hormone might conceivably be harmful to a fetus with compromised placental supply.

We believe that the temptation to try new treatments outside properly designed trials should be resisted, particularly in fetal medicine, until clear evidence emerges. We hope that the publication of two recently completed trials, from New Zealand and Australia, will help in this respect.^{4,5}

ZARKO ALFIREVIC
JAMES P NEILSON

Department of Obstetrics and Gynaecology,
University of Liverpool,
PO Box 147,
Liverpool L69 3BX

DIANA ELBOURNE
ADRIAN GRANT

Perinatal Trials Service,
National Perinatal Epidemiology Unit,
Radcliffe Infirmary,
Oxford OX2 6HE

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Avoid ergometrine in the third stage

EDITOR,—As Gerald J Clesham mentions,¹ fluid overload is generally accepted as being probably the most important factor in the development of pulmonary oedema associated with the use of β agonists in the treatment of preterm labour. Every step, therefore, should be taken to reduce the risk of fluid overload. This includes giving the drug in small volumes of 5% dextrose with a syringe pump.¹

Another step, which is often ignored, is the choice of oxytocic drug used in the active management of the third stage of labour in these patients.² The two most widely used oxytocic agents are oxytocin and ergometrine-oxytocin (Syntometrine). Ergometrine has both α and β adrenergic properties, causing widespread peripheral vasoconstriction and leading to a sudden diminution of the vascular compartment.³ The pulmonary vessels, on the other hand, seem to be less susceptible to adrenergic stimulation and are controlled mainly by a metabolic autoregulatory mechanism.⁴ Intense adrenergic activity (for example, the effect of ergometrine) causes widespread constriction of the peripheral vessels and shifts a relatively large volume of blood to the pulmonary circulation, thus creating a local pul-

monary fluid overload.^{4,5} This effect, coupled with the normal increase in the circulating blood volume due to the autotransfusion that follows uterine contraction after delivery,⁶ can further contribute to the development of pulmonary oedema.²

When there are other risk factors, such as multiple pregnancy (with increased plasma volume) and the use of steroids (with their fluid retaining mineralocorticoid activity), it is worth considering using oxytocin instead of ergometrine-oxytocin in the management of the third stage in patients who have recently received β agonists.

K SHARIF

Department of Obstetrics and Gynaecology,
St James's University Hospital,
Leeds LS9 7TF

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Antimalarial prophylaxis

Manufacturers recommend more stringent guidelines for halofantrine

EDITOR,—Current advice on prophylaxis against malaria for travellers from the United Kingdom was published in the *BMJ*.¹ Halofantrine hydrochloride was among the drugs recommended if standby treatment of malaria is necessary—that is, to be carried by travellers to malarious areas who will be out of reach of prompt medical advice for self treatment only in an emergency. The British position on this was consistent with that of the World Health Organisation.

In the light of further experience of cardiac adverse effects, the manufacturers have recommended more stringent guidelines for use of halofantrine. These have been endorsed by the World Health Organisation, and the British recommendations have therefore been modified. In particular, halofantrine should be used only for emergency self treatment by people who have a normal QTc interval (one not exceeding 0.44 s). The drug should be taken on an empty stomach. It is unsuitable for those with a family history of congenital QT prolongation, for those with electrolyte imbalance or cardiac disorders, or in combination with drugs that prolong the QT interval. The dose should not exceed the recommended 1500 mg given as 500 mg (two tablets) three times every six hours for adults, or 24 mg/kg given as 8 mg/kg three times every six hours for children. Halofantrine should also not be given as a standby antimalarial to those taking mefloquine prophylaxis.

DAVID J BRADLEY

Public Health Laboratory Service
Malaria Reference Laboratory,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

- 1 Bradley D on behalf of a meeting convened by the Malaria Reference Laboratory and the Ross Institute. Prophylaxis against malaria for travellers from the United Kingdom. *BMJ* 1993;306:1247-52.

Mefloquine not first choice in aircrew

EDITOR,—N J White's editorial on mefloquine¹ quotes a recommendation by Bradley that for all British people except pregnant women mefloquine is the drug of choice for short term antimalarial prophylaxis in resistant areas.² White omits the other exclusion group mentioned in Bradley's article—namely, aircrew. Until more is known about the risk of serious side effects, mefloquine is