vasodilatation induced by prostaglandin, just as readily as it fits with the use of trimethoprim. Once the patient was well again, non-steroidal anti-inflammatory drugs would not be expected to cause problems, and thus rechallenge with the drug would be of no discriminatory value in this case. It seems unnecessary to propose an unusual effect of trimethoprim when the case is readily explained by the known and commonly observed effects of non-steroidal anti-inflammatory drugs,

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New roles for general practitioners

GPs frustrated by restricted access to investigations

EDITOR,—Stuart Handysides's article on new roles for general practitioners states what is reasonable but obvious to most practising general practitioners.¹ The limitation on medical responsibility in general practice is not so much general practitioners' ability to do the work but the limitation imposed by hospital investigative departments which will carry out certain tests only when the request is in the name of a staff consultant. This is all very well, but probably most of these requests are issued by junior doctors, generally on their own initiative and generally correctly. There is nothing more frustrating than to leave a post as a senior house officer or registrar and to enter general practice and be told that you cannot request a barium enema or endoscopy, let alone computed tomography or magnetic resonance imaging, other than through a hospital outpatient clinic.

Much of this policy is traditional rather than based on the results of audit. Schemes in which open access exist, and "supervised" review of referrals for specific investigations, work well and are popular with specialists, general practitioners, and patients as they save them all time. Additionally, there is a saving to the hospital as general practitioners are inevitably more experienced than the clinics' senior house officers and request only specifically required tests, requesting a batch of secondary investigations only when positive results are obtained. Becoming a "general practitioner physician" is well within the capability of all but a few general practitioners, particularly if initiatives were set up locally.

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- 1 Handysides S. New roles for general practitioners. *BMJ* 1994;308:513-6. (19 February.)

General physicians not a thing of the past

EDITOR,—Stuart Handysides states that "the general physician in hospital practice is a thing of the past,"¹ quoting a speculative article written some 10 years ago. Neither the statement nor the speculation is correct. Most posts advertised for consultant physicians, even though a specialty is specified, require the appointee to attend general medical outpatients and to look after patients admitted as medical emergencies. Despite the

caption of the photograph in Handysides's article it would be difficult to see how general practitioners can "take on the role of hospital general physicians" in charge of such conditions as upper gastrointestinal bleeding, myocardial infarction, overdoses, and diabetic ketoacidosis. To do so would add an impossible burden to their already heavy clinical load. Moreover, acquiring the necessary knowledge additional to that already required by a general practitioner would tax even the most agile and retentive brain. Furthermore, it is difficult to envisage a general practitioner, working predominantly in the community, teaching medicine as practised in a hospital.

Although Handysides is right to be concerned about the dangers of the "Calman recommendations" squeezing out general medicine, negotiations to enable most trainees to be certificated in both general internal medicine and another specialty without unrealistic prolongation of the period of training are well advanced.

While the welfare of the patient is best secured if care is shared between the physician and the general practitioner, standards would be unlikely to be maintained if general practitioners took on the role of hospital general physician.

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Capture-recapture as a tool for programme evaluation

EDITOR,—The capture-recapture technique described by Ronald LaPorte¹ may be particularly useful in studying marginalised or inaccessible groups to assess the size and characteristics of the target population and the proportion in contact with services. For example, Fisher *et al* used a capture-recapture analysis of individual patterns of contact with homeless agencies in north east Westminster to estimate the total number of homeless people.² They also used the data to determine use of services and concluded that, during the study, almost two thirds of the homeless people in the area did not contact the statutory or voluntary agencies involved in the study.

We recently used capture-recapture analysis to estimate the numbers of sex workers meeting clients at bars in Mutare, Zimbabwe, and to assess their levels of contact with the Mutare HIV Prevention Programme (D Wilson *et al*, VIIIth International Conference on AIDS and STDs, Amsterdam, 1993). This programme was founded in 1991 and is run jointly by Mutare City Health Department and Family AIDS Caring Trust with technical support from the University of Zimbabwe. The study was conducted over four nights on two weekends at a weighted random sample of bars in the city. On each night programme workers held structured interviews with women reporting involvement in commercial sex. Because prostitution is illegal and stigmatised we did not try to use names to distinguish individuals. Instead, each night different gifts were given to each woman interviewed. We used information collected about items received on previous nights to assess on which nights sex workers had been contacted during the survey. To assess programme coverage, 204 sex workers were also interviewed about their contact with the programme.

Each night, 600-800 sex workers were interviewed. A preliminary capture-recapture analysis of the patterns of contact indicated that about 1600-2000 women were selling sex from bars over the two weekends. A more accurate estimate that accounts for different work patterns and move-

ment in and out of the population is being determined. Programme coverage was found to be extremely high, with almost all sex workers reporting contact with the prevention programme, 83% reporting seeing an AIDS lecture that month, and 93% reporting obtaining condoms from the programme.

These examples illustrate the potential uses of the capture-recapture technique as a tool for programme evaluation. Such information can be used to assess local needs and help guide programme planning and management.

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Management of cutaneous T cell lymphoma

EDITOR,—We agree with Paul A Bunn that multi-centre prospective randomised trials in patients with properly staged cutaneous T cell lymphoma are urgently needed to define the optimal topical or systemic treatment.¹ We also agree with his comments regarding the combination of psoralens and ultraviolet A treatment and interferon, which may produce a higher complete response rate than either agent used singly; we have useful experience of this.

We have successfully managed an 89 year old woman with tumour stage cutaneous T cell lymphoma with this combination. She presented with cutaneous plaques and ulcerated nodular lesions, which had relapsed after treatment with localised kilovoltage radiotherapy. There was no evidence of systemic disease on clinical examination or investigation. Cutaneous T cell lymphoma was confirmed on skin biopsy. Treatment was started with 3 million units of interferon alfa-2a subcutaneously three times a week and psoralens and ultraviolet A treatment twice a week, initially as an inpatient as she lived a considerable distance from our hospital. Within four weeks of the start of treatment there was a partial response (greater than 50% clearance of cutaneous lesions), which continued over the next month, when she was treated as an outpatient.

Psoralens and ultraviolet A treatment was then stopped at the patient's request because she found travelling difficult. Although treatment with interferon was continued, there was evidence of progression of disease at review a month later. The superiority of combination treatment was confirmed on two occasions over the next six months, with clearance of cutaneous lesions during inpatient treatment with both interferon and psoralens and ultraviolet A and gradual relapse during outpatient treatment with interferon alone.

Three studies have highlighted the combination of interferon and psoralens and ultraviolet A as a promising new treatment.^{2,4} The combined data from the 31 patients treated in these studies give a complete remission rate of 71% (22 patients) and a partial remission rate of 26% (eight patients). Patients with all stages of disease and those extensively pretreated with other modalities have

responded, with durations of response of up to 17 months so far. This remission rate is higher than that reported in patients with all stages of disease for either interferon or psoralens and ultraviolet A alone.⁵ Psoralens and ultraviolet A are usually well tolerated, although interferon is limited by side effects related to the dose.² Like Mostow *et al*,⁴ however, we found that a regimen of low dose interferon was extremely well tolerated, even by an 89 year old woman. In view of the age range of patients with cutaneous T cell lymphoma this is particularly relevant.

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Bone cancer in Wales overestimated

EDITOR,—Chris Busby, of the Wales Green party, reports an excess of cases of bone cancer in Wales since 1975.¹ Considerable care is needed in drawing conclusions from comparisons of the published data for England and Wales.

The Welsh Cancer Registry collates data from four main sources: hospital episode databases, death certificates, radiotherapy departments, and regional registries in England. Over 90% of the data arise directly from case records coded at the hospital for the inpatient or day case dataset. The completeness and accuracy of the data in the registry thus depend on appropriate and accurate coding at hospital level. This is particularly relevant with regard to data on bone cancer as we suspect that the figures may have been inflated by the inclusion of secondary cancers.

The Welsh Cancer Registry is reviewing all cases of bone cancer recorded in the registry for 1974-90 by reference to the case notes, with the cooperation of the clinicians concerned. The limitations of the published data have been openly acknowledged in the past, not least in correspondence with the Wales Green party.

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Friday the 13th

EDITOR,—C D O'Brien states that "actuarial investigation has shown that the 13th of a month is more likely to be a Friday than any other day."¹ This is not correct. The sequence of weekdays repeats every 28 years. Over such periods the 13th of a month will have occurred 48 times on each weekday. Over 400 years, which is 14 cycles plus eight consecutive years, the total number of times that the 13th of a month occurs on each weekday is as shown in the table. There are no calendrical reasons for assuming that Friday the 13th is

Number of times Friday the 13th falls on each weekday in 400 years

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
14 cycles of 28 years	672	672	672	672	672	672	672
8 years	13	14	14	13	15	13	14
Total	685	686	686	685	687	685	686

"unlucky" if the summation extends over one or more complete cycles of 28 years.

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- 1 O'Brien CD. Friday the 13th. *BMJ* 1994;308:473. (12 February.)

European directive on confidential data

EDITOR,—Elsebeth Lynge's editorial on the European directive on confidential data draws attention to a major threat to epidemiological research.¹ I have participated in a series of studies of a population originally identified in Aberdeen in 1964 as being wheezy schoolchildren.² Recent studies have included a comparison of the current prevalence of asthma, hay fever, and eczema with the prevalence in 1964³ and follow up studies of outcome with respect to social factors⁴ and symptoms and pulmonary function in people originally studied in 1964.⁵

These studies, which have yielded important information on the natural course of wheezing in childhood, would not have been possible had the European Union's directive been in force in 1964 as the original records would have been destroyed. The high participation rate that has been achieved (80% after 25 years) and the fact that the subjects expressed willingness to continue to participate in such studies indicate that the subjects support this type of research. It would be unfortunate if such opportunities were denied to future generations of researchers and their patients.

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Think before donating medical supplies

EDITOR,—I would urge that donations of medical supplies to Third World countries should be chosen just as carefully as those to the former Yugoslavia.¹ In Zimbabwe I worked at a mission hospital where some of the donations we received included lorazepam, drops for infant colic, and decongestant nasal sprays. In most developing countries, including Zimbabwe, the main health problems are infectious diseases and nutritional deficiencies. Donations of items like these do not meet priority needs and are counterproductive. Local health workers may prescribe particular items because they are available rather than for

clinical need. Furthermore, although the drugs themselves may cost nothing, considerable resources are devoted to storing and transporting them.

Many donations we received in Zimbabwe, in addition to being non-essential, were of expired or nearly expired items. Although most drugs are said to be safe and effective well beyond their expiry dates, there is no guarantee of this, especially if storage conditions have been hot and humid. Local health workers may perceive donations of drugs that cannot be used in the country of origin as reflecting double standards.

All drug donations to developing countries should reflect health care priorities. The World Health Organisation has developed an admirable essential drug list, and this, supplemented with specific requests from the country in question, should be used as a basis for drawing up orders. Items on the WHO's list are available in bulk at low cost through several channels.

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Women consultants

EDITOR,—Geoffrey Chamberlain writes about the need for flexibility in employment practices for senior medical appointments in order to retain women doctors in the NHS.¹ I share his concerns, as women doctors invest considerable effort in their careers and the NHS considerable resources in training them. I am also anxious that, whenever possible, patients should have access to the most appropriate professional for their needs. This is particularly true in obstetrics and gynaecology,² where the availability of a female consultant is especially important for many women.

The recent proposal for a part time consultant scheme, which makes it easier for women doctors to stay in the NHS, proved extremely popular and generated over 550 bids from units and trusts. Several appointments have already been made, and I await with interest the decisions of the remaining appointments committees. The scheme encourages NHS managers to consider the business advantages of part time appointments and provides an incentive for employers to be innovative. I hope that a further tranche of bids may be stimulated shortly on the same basis.

I welcome the royal colleges' encouragement of alternative ways to work and their lead in appointing an adviser on part time working. The Department of Health is currently preparing a good practice guide, which will outline examples of successful, imaginative arrangements. Several registers already exist for doctors interested in job sharing, and I believe that these will become increasingly important as more women complete their undergraduate training and choose careers in hospital specialties.

I am certain that the quality of care will be enhanced where men and women complement each other in leading the profession. Earlier appointment to consultant posts, which will follow the changes in postgraduate training that we are introducing, will also demand increasing flexibility in work patterns, for both men and women, as interests and commitments change over the working lifetime.

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