leprosy. I referred him to the panel of leprosy opinion, which is a panel of experts appointed by the Department of Health to give advice on the clinical management of leprosy.

More importantly, Crawford referred to a meeting between the parliamentary secretary for health and the Thalidomide Action Group. At that meeting Baroness Cumberlege undertook to make known to the medical profession the fact that guidelines on the use of thalidomide are available. Guidance on thalidomide was published in the May issue of *Current Problems*,² which is distributed to most doctors. This guidance note advises all doctors considering using thalidomide to follow a guideline for the clinical use and distribution of thalidomide,³ which is available from Dr Richard Powell, Clinical Immunology Unit, Queen's Medical Centre, University Hospital, Nottingham NG7 2UH. This guideline discusses the use of electrophysiological tests for detecting peripheral neuropathy in patients treated with thalidomide.

WILLIAM ASSCHER
Principal

St George's Hospital Medical School,
London SW17 0RE

1 Crawford CL. Safety of thalidomide. *BMJ* 1994;308:1437-8. (28 May.)

2 CSM/MCA. Guidance on thalidomide. *Current Problems in Pharmacovigilance* 1994;20:8.

3 Powell RJ, Gardner-Medwin JMM. Guideline for the clinical use and distribution of thalidomide. *Postgrad Med J* (in press).

When to do orchidopexy

EDITOR,—It is unfortunate that the paper from the United Kingdom Testicular Cancer Study Group reporting a study completed on 1 January 1987 was not published until this year.¹ Many urologists will be startled at some of the statements in the paper.

Of the 794 men with testicular germ cell tumour studied, 165 were aged under 24. In the early 1960s, when they would have been diagnosed as having undescended testes, the current policy of early orchidopexy was not widely accepted. The paper dwells on orchidopexies done after the age of 10, implying that orchidopexy at an early age is not necessary. That may be true from the point of view of diminishing the risk of malignancy, but from the point of view of fertility it is disastrous to do orchidopexies as late as 10. If testes have not descended into the scrotum by about the age of 2 they will not do so and orchidopexy might as well be done then.

GRANT WILLIAMS
Consultant urological surgeon

Nephrourology Unit,
Harley Street Clinic,
London W1M 7AB

1 United Kingdom Testicular Cancer Study Group. Aetiology of testicular cancer: association with congenital abnormalities, age at puberty, infertility, and exercise. *BMJ* 1994;308:1393-9. (28 May.)

Postmarketing surveillance

EDITOR,—The need to monitor the safety of medicines as they are used in clinical practice is well recognised and based on the Committee on the Safety of Medicines' yellow card system. Further evidence of drug safety is provided by the Drug Safety Research Unit's prescription event monitoring system¹ and postmarketing surveillance performed by pharmaceutical companies or by independent research companies employed by them.

Although most postmarketing surveillance studies are conducted within the framework of guidelines produced by the BMA, the Committee on the Safety of Medicines, and the Royal College of General Practitioners, the link between pharma-

ceutical companies and the so called independent research companies is not always made clear, leading doctors to believe that these research companies are carrying out independent research. We share the concerns of medical and pharmaceutical advisers in this region that some companies are using this route not to assess safety but as a covert way of promoting their products.

We are also concerned that the apparently non-promotional payment made to general practitioners for the time they spend completing the relevant paperwork may encourage them to prescribe the drug being monitored. The doctors and health authorities involved with the studies may not be fully aware of the potential effect on prescribing costs. The clinical decision to prescribe newer, more expensive drugs may be influenced by the financial gain to the prescriber, and we wonder whether patients would be willing to take these drugs if they knew that the doctor was effectively being paid for having prescribed them.

All those involved in any way with postmarketing surveillance studies should be made aware of any links between independent research organisations and the pharmaceutical industry and of the potential financial reward to any doctors who may participate. Guidelines on postmarketing surveillance should take account of these points.

SIMON VOSS
Primary care medical adviser

Southampton and South West Hampshire Health Commission,
Southampton SO16 4GX

FIONA HARRIS
Pharmaceutical adviser

North and Mid Hampshire Health Commission,
Basingstoke RG24 9NB

1 Inman W, Pearce G. Prescriber profile and post marketing surveillance. *Lancet* 1993;342:658-61.

Antenatal screening for syphilis

Is not justified

EDITOR,—In these heady days of cost effective health care, priority setting, and market forces, I felt as though I was back in the 1970s while reading Angus Nicoll and Clare Moisley's editorial on antenatal screening for syphilis.¹ They describe a routine test that is extensively carried out to prevent a condition whose true incidence is unknown. It is all very well applauding new surveillance initiatives, but isn't it surprising that these were not started some years ago? There is no mention at all of the costs of the tests in Britain, let alone whether the tests are cost effective. Screening for some conditions—for example, cholesterol testing—has moved focus recently from general screening to the targeting of high risk populations. If we accept that congenital syphilis may increase in Britain (as it has done in the United States) has any consideration been given to offering antenatal testing for women at higher risk?

The authors conclude that universal screening should continue because no accurate data are available for reappraisal. I fail to see how they can justify this conclusion. Surely it would be equally acceptable to stop universal antenatal screening until new data suggest that it is worthwhile.

NEIL SNOWISE
General practitioner

Bath BA2 5BG

1 Nicoll A, Moisley C. Antenatal screening for syphilis. *BMJ* 1994;308:1253-4. (14 May.)

Should continue

EDITOR,—We agree with Angus Nicoll and Clare Moisley that universal antenatal screening for syphilis should continue until more data are

available.¹ In our unit over the 12 months to 31 March this year 16 patients were referred from the antenatal clinic because serological tests for treponemes yielded positive results. Two of these patients had secondary syphilis, and 14 were classified as having late latent infection, of whom six had had documented treatment in the past. Both early infections had been acquired abroad. On routine screening for other sexually transmitted diseases additional infections with *Trichomonas vaginalis* and *Chlamydia trachomatis* were diagnosed in two of the 16 patients. Contact tracing was arranged for all these patients.

Interpretation of positive results of serological tests may be a problem, not, usually, because of concurrent HIV infection but because false positive reactions may occur in pregnancy. Biological false positive reactions occur in 0.3-0.9% of all serum samples examined by non-specific cardiolipin antigen tests.² In pregnancy they may be associated with an adverse outcome.³ Syphilis cannot be differentiated from non-venereal treponematoses, such as yaws, by serological methods. False negative reactions also occur and are more common in people with HIV infection.

Nicoll and Moisley are incorrect to state that the Jarisch-Herxheimer reaction is rare. It is common in both pregnant and non-pregnant patients after treatment for early syphilis, and in pregnant women it may give rise to uterine contractions, decreased fetal movements, and even fetal death.⁴

Finally, whether pregnant women in whom serological tests give a positive result and who have a documented history of adequately treated infection should be treated again is controversial. Retreatment is based on the premise that treponemes may persist even after full treatment and that pregnancy is a natural immunosuppressive state. If there is doubt about the adequacy of treatment of syphilis in pregnancy or if suboptimal treatment—for example, erythromycin—is used the baby must be treated at birth; doctors should not wait for signs of congenital syphilis to occur.⁵

JOHN SWEENEY
Senior registrar

GRETA FORSTER
Consultant in genitourinary medicine
BENG TIN GOH
Consultant in genitourinary medicine

Ambrose King Centre,
Royal Hospitals NHS Trust,
London E1 1BB

1 Nicoll A, Moisley C. Antenatal screening for syphilis. *BMJ* 1994;308:1253-4. (14 May.)

2 Young H. Syphilis: new diagnostic directions. *International Journal of STD and AIDS* 1992;3:391-413.

3 Thornton JG, Foote GA, Page CE, Clayden AD, Tovey LAD, Scott JS. False positive results of tests for syphilis and outcome of pregnancy: a retrospective case-control study. *BMJ* 1987; 295:355-6.

4 Klein VR, Cox SM, Mitchell MD, Wendell GD. The Jarisch-Herxheimer reaction complicating syphilotherapy in pregnancy. *Obstet Gynaecol* 1990;75:375-80.

5 Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines. *MMWR* 1993;42(RR-14): 27-44.

Screening for toxoplasmosis

EDITOR,—Health education probably plays a major part in the prevention of toxoplasma infection in pregnancy.¹ The current consensus on antenatal screening in Britain is summed up by a report by a working party of the Royal College of Obstetricians and Gynaecologists, which concluded that nationwide screening is not appropriate at present.²

Last year the Toxoplasmosis Trust surveyed policy and practice concerning toxoplasmosis in antenatal clinics across Britain to obtain insight into current practice. Two hundred and thirty (89%) of 259 hospital antenatal clinics responded to a questionnaire administered over the telephone to the senior midwife on duty. The table gives the main findings in terms of information and

	No of clinics
Advice and information given:	
On listeriaiosis and salmonellosis	198
On toxoplasmosis	136
Policies:	
Existing policy on screening	32
Change of approach in past year	108
Issue of screening raised	97
Women screened:	
Routinely	5
On request	219
If cat owners	51
When flu-like symptoms reported	104

advice, policies (written or unwritten), and screening for toxoplasmosis. These indicate that toxoplasmosis is actively considered in antenatal clinics but that practice varies widely and that consumer led, ad hoc screening occurs.

The survey sought information about senior midwives' knowledge of further diagnosis, treatment, and follow up of women with toxoplasma infection during pregnancy or during the baby's first year. Altogether 110 respondents did not know whether action would be taken in the event of the infection being diagnosed; 113 did not know what action would be taken. Only 110 were aware that babies born to women with a current infection would warrant investigation and follow up. One hundred and fifty two were satisfied with advice given concerning toxoplasmosis.

This survey indicates the lack of a coherent clinical approach to toxoplasmosis in pregnancy. It highlights potential gaps in the knowledge of an important group of health professionals (midwives). The Toxoplasmosis Trust considers that this matter should be addressed urgently by the production of guidelines recommending best practice. Finally, the findings highlight the ad hoc nature of current screening policy and the need for a multicentre study on the incidence of toxoplasmosis in pregnancy to obtain the data necessary to unify clinics' approach.

I thank PPP Medical Trust for supporting this project.

CHRISTINE ASBURY
Director

Toxoplasmosis Trust,
London N1 9BE

1 Ho-Yen DO, Chatterton JMW. Congenital toxoplasmosis—why and how to screen. *Reviews in Medical Microbiology* 1990;1: 229-35.

2 Royal College of Obstetricians and Gynaecologists. *Prenatal screening for toxoplasmosis in the UK. Report of a multidisciplinary working group.* London: RCOG, 1992.

Screening for cervical intraepithelial neoplasia

EDITOR,—J Elizabeth Macgregor and colleagues show that the incidence of invasive cervical cancer fell sharply in women aged 40-69 who had been well screened and had had the opportunity of repeat screening.¹ Screening was associated with a tendency to present at an earlier stage. Though their evidence clearly shows that treatment of cervical intraepithelial neoplasia influences the course of the disease, their attribution of the changes in the population incidence and mortality due to cervical cancer to the screening oversimplifies the matter.

They acknowledge that, as has been recognised for some time,² cohort effects are seen in the incidence of cervical cancer. Data from the Yorkshire Cancer Registry suggest that women who were aged 40-60 during 1968-79 were members of a cohort with a high incidence.³ Women who are currently aged 40-60 include members of a cohort with a lower incidence. A rising incidence of

invasive cervical cancer in women under 40 is also seen in the Yorkshire data and suggests that a new cohort of women with a higher incidence is coming through.

The difference in incidence between cohorts probably reflects the sexual behaviour of these women in their late teens and 20s. Popular history describes a freer pattern of sexual behaviour during the second world war. This is corroborated objectively by a doubling in the proportion of children born outside marriage during that period.⁴ Behaviour then reverted to a more restricted pattern, and the proportion of births outside marriage fell. Women whose early adulthood occurred in this period are members of the cohort with a lower incidence. The changes in behaviour from the 1960s onwards are, as Macgregor and colleagues point out, associated with an increased incidence of cervical cancer. That statistics on births outside marriage indicate behaviour associated with a relatively high incidence of cervical cancer is supported by the international comparative data in the table.

International data on births outside marriage and incidence of cervical cancer

Country	Births outside marriage, 1970 (%)	Incidence of cervical cancer 1979-82 (cases/100 000 population)
United Kingdom	8.0	13.5
Denmark	11.0	18.5
France	6.9	14.3*
West Germany	7.2	13.9
Netherlands	2.1	7.6
Spain	1.4	5.9*

Data from references 3 and 4.
Spearman correlation coefficient 0.8857, $P=0.05$.

*Mean of figures from two cancer registries.

Macgregor and colleagues refer to "a concomitant rise in preinvasive disease," but they provide no data on its age distribution. The data from Yorkshire region show a slightly skewed distribution, with a model age at 30.³ If this pattern is reflected in north east Scotland then the increase in the incidence of invasive disease in younger women seems to be occurring despite the increase in the detection of preinvasive disease. The contribution of screening programmes to the epidemiology of cervical cancer at the present level of service provision and uptake still remains uncertain.

S M CRAWFORD
Director

Cancer Medicine Research Unit,
University of Bradford,
Bradford BD7 1DP

- Macgregor JE, Campbell MK, Mann EMF, Sanson KY. Screening for cervical intraepithelial neoplasia in north east Scotland shows fall in incidence and mortality from invasive cancer with concomitant rise in preinvasive disease. *BMJ* 1994;308:1407-11. (28 May.)
- Mould RF. *Cancer statistics.* Bristol: Hilger, 1983.
- Yorkshire Cancer Registry. *Report 1991 including cancer statistics from 1984-1988.* Leeds: Yorkshire Regional Cancer Organisation, 1992.
- Central Statistical Office. *Social trends 24.* London: HMSO, 1994.

Schizophrenia among residents of hostels for homeless people

EDITOR,—Jim Connelly and Rhys Williams suggest that our finding of a lower prevalence of schizophrenia among homeless people resident in hostels in 1992 than in 1966 is explained by selection bias.^{1,2} As we explained in our paper, the aim of sampling in 1992, as in 1966, was to produce a representative sample of people living in hostels for the homeless in Edinburgh. The provision of hostels has changed over the past three decades, with a considerable reduction in the number of

places in direct access hostels.³ We thought it possible that the prevalence of schizophrenia would differ according to the type of hostel, and we therefore classified hostels into two types according to whether they were most like or least like the hostels in 1966. Connelly and Williams seem to assume not only that it was invalid for us to include some hostels in our survey but also that the prevalence of schizophrenia differed substantially between the two types of hostel. The prevalence of schizophrenia in our study was similar in the two types of hostel (7/72 (10%) in the most comparable and 5/64 (8%) in the least comparable).

We reported our findings as objectively and cautiously as possible, and, as Connelly and Williams concede, we discussed the study's shortcomings. We could have emphasised the lower prevalence of schizophrenia much more in our discussion, but we chose to err on the side of caution. Connelly and Williams worry that our findings may be misrepresented. We hope that policymakers will be able to discern the strengths and weaknesses of the study themselves.

We are grateful to Connelly and Williams for finding an error in the table of our paper. Ninety seven (49%) of the 198 people in the sample studied in 1992 were resident in the most comparable hostels, and diagnostic assessments were performed on 72 of these subjects. This error does not affect any of the analyses or conclusions.

JOHN GEDDES

Senior registrar

SHEENA BAILEY

Research associate

GILL YOUNG

Research associate

CHRIS FREEMAN

Consultant psychotherapist

Royal Edinburgh Hospital,
Edinburgh EH10 5HF

RICHARD NEWTON
Psychiatrist

Inner North Community Mental Health Services,
Carlton,
Melbourne,
Australia

ROBIN PRIEST
Professor

Academic Department of Psychiatry,
St Mary's Hospital,
London W2 1NY

- Connelly J, Williams R. Schizophrenia among residents of hostels for homeless people. *BMJ* 1994;308:1572. (11 June.)
- Geddes J, Newton R, Bailey S, Young G, Freeman C, Priest R. Comparison of prevalence of schizophrenia among residents of hostels for homeless people in 1966 and 1992. *BMJ* 1994;308: 816-9. (26 March.)
- Craig T, Timms PW. Out of the wards and onto the streets? Deinstitutionalisation and homelessness in Britain. *Journal of Mental Health* 1992;1:265-75.

Skill mix in primary care

EDITOR,—Iona Heath emphasises that decisions on changes in skill mix should be driven by needs and not costs.¹ At a time when demand for services is outstripping supply, however, an eye to costs is wise. The rapid development of the role of practice nurses was spurred by the availability of finance (reimbursement of 70% of the salary costs; the nurses perform fee for service tasks; and reimbursement for health promotion work) at least as much as by patients' needs. Practice nurses have been shown to be effective and popular with patients. Whether they are cost effective, however, is another matter.

Heath mentions that nurse practitioners in Burlington, Canada, saw only half as many patients as doctors and that Stillwell saw patients at 20 minute intervals. In a study by Fallon *et al* in Glasgow,² where walk in clinics were held by nurses, the consultation time available was 15 minutes per patient in the mornings and 21 minutes per patient in the afternoon (4.1 consultations per hour in the morning and 2.9