early months of marketing, 42% of all these prescriptions were written by only 10% of prescribers. Some doctors had prescribed a new drug for more than 100 patients, far more than could possibly be monitored. We concluded that "no differences in medical need can account for such variations in prescribing practice. Heavy prescribing by a minority of doctors during the period immediately following licensing for marketing may be placing patients at unnecessary risk."

New guidelines on sponsored safety assessments of marketed medicines include one major improvement in that they now confirm that it is unethical to change patients' treatments deliberately in order to include them in a postmarketing surveillance study.⁴ They do not, however, state that patients must give informed consent. They are guidelines and not laws and are likely to be ignored, as they have been in the past.

The best advice to colleagues is to have nothing to do with promotional studies solicited by a company or a contract organisation or by a drug representative. Patients have a right to choose whether to be included in a study of a new treatment. If something goes wrong and the patient was not a volunteer or the doctor was paid to prescribe the new treatment the potential consequences are obvious.

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Audit of management of induced abortion

Primary care component is ignored

EDITOR,—Gillian C Penney and colleagues' audit of the management of induced abortion in Scotland was very restricted, being concerned only with the hospital component of care, and those aspects considered important by medical staff.¹ Care should be taken in interpreting the quality of care without considering the contributions of other health professionals, users' views, and particularly the input of primary care. For example, from the patient's point of view waiting time starts at presentation to the general practitioner or family planning services. It would be imprudent to assume that a patient with a brief waiting time after referral experienced high quality care if her general practitioner delayed referral for two weeks. Audit criteria should reflect the overall experience of patients with health services as much as possible.

All improvements quoted after the second audit round refer to measures of process, whose relation to patient outcome may vary. For example, there is a difference in relation to quality of a criterion such as grade of surgeon and the recording of an agreed contraceptive plan. In the latter case the agreed plan may simply be to temporise ("await follow up," for example), which is unlikely to change the chances of a further unwanted pregnancy despite fulfilling audit criteria. It is important to be aware that measures of process have different validities and may be open to interpretation or even manipulation in different ways.

The overall tenor of the article was to stress improvements; indeed, the outcome measure given in the abstract was "improvement." While pointing out that there was no overall deterioration across the 10 hospitals, the authors do not discuss the fact that neither were there any overall improvements in any of the criteria related to

organisation of services. Indeed, three hospitals showed a significant reduction in the proportion of patients seen within five days of referral. From a patient's point of view the wait for appointment and abortion may be of greater importance given the anxiety and other emotions associated with unwanted pregnancy than the recording of cervical smear history and issues of follow up.

A more interesting investigation of the effects of audit might have included more focused, qualitative description—for example, of what ensued in Hospital 10 after the second audit round, where the proportion of patients meeting the waiting time criterion had fallen by 90%.

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Chlamydial infection is ignored

EDITOR,—One of the criteria for good quality care agreed by the Scottish gynaecologists in Gillian C Penney and colleagues' audit study was that "women undergoing abortion should be screened for genital tract infection and treated if indicated" (criterion 7).¹ Surprisingly, the authors did not discuss the findings relating to this criterion. We are concerned that in the first audit only two of the 10 centres screened routinely (>85% patients); the rest screened <16% did not screen at all. In the second audit, after the recommendations for change had been made, only one centre had increased screening to the higher level.

With regard to infection with chlamydia, several studies, including that by Qvigstad *et al.*,² have shown that young women undergoing termination of pregnancy have a high incidence of infection with *Chlamydia trachomatis* (serovars D-K). Our pilot study showed that 9.2% of 420 patients requesting termination of pregnancy were infected with chlamydia.³ Treatment and follow up were not consistent, so in January 1991 a protocol covering screening, treatment, counselling, and contact tracing was introduced for all patients in the gynaecology units who had a chlamydial infection.⁴ Over the three years 1991-3, 325 of the 5229 patients requesting termination of pregnancy were found to be positive for chlamydia; all were treated.

The consequences of untreated chlamydial infection of the lower genital tract being present at termination of pregnancy have been recognised, and the potential health care costs have been summarised by Blackwell *et al.*⁵ Penny and colleagues refer to a workload of around 11 000 induced abortions a year (1991 statistics) in Scotland. Their audit data, covering 10 centres with 2004 patient episodes over two rounds of audit, indicate that some 60% of women were not screened for genital tract infection, giving overall a possible 5500 not screened out of 11 000. If 6% is taken as a fair estimate of the proportion likely to be infected in this group then around 330 women would have had undetected chlamydial infection. We do not know whether prophylactic treatment to cover chlamydial infection is given in centres where screening is not carried out.

Cameron and Blakely reported that contact tracing in cases of chlamydial infection yielded additional cases requiring treatment amounting to 62% of the contacts who attended a genitourinary medicine clinic.⁴ This means that an appreciable number of the contacts of the 330 women might be sources of reinfection and would also require treatment.

We believe that the Scottish gynaecologists were correct in including criterion 7 among the 16 criteria chosen for good quality care of women undergoing induced abortion. We hope that for the future health of the women concerned screening and treatment for chlamydial infection will be generally available.

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Urinary tract infection in children

How vigorous should investigation be?

EDITOR,—J M Smellie and colleagues concluded that it is essential to identify vesicoureteric reflux early by cystography in infants with antenatal dilatation of the urinary tract, infants and young children after a first urinary tract infection, and siblings and offspring of patients with renal scarring.¹ They reiterated that ultrasonographic imaging is inadequate to exclude renal scarring. A paper from Gothenburg confirms that even experienced radiologists frequently fail to find renal scars.²

In general radiological practice plain radiography and ultrasound examination of the renal tract seem to be a practical means of identifying children who need surgical intervention to correct obstruction, calculus, severe anomaly, or gross reflux.³ If the remaining children are treated with antibiotics until the infection has stopped is there a need to investigate and monitor them with such vigour?

Before we devote so much of our limited radiological resources and so much radiation to this cause can we be assured that the results of this massive radiological programme will affect the clinical management of these children in such a way as to result in a predictable benefit? If so it should be possible to calculate the cost and decide whether we can afford it.

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