colleagues' study among the total migrant population of 54 was black (n=38); this group included Caribbean (n=19) and black African (n=14) subjects. Countries with a majority black population do not feature at all in the study most quoted when similar worldwide prevalences of schizophrenia are claimed.² Limited data exist on prevalence in some African and Caribbean countries, but these studies do not use standardised criteria. Because the provision of services is different in the developing world underreporting may well occur.^{3,4}

As the incidence of schizophrenia in Britain is thought to be declining⁵ it is important that studies of migrant populations relate to the countries of origin as well as the host countries. While I am not trying to suggest that biological factors can fully explain the increased incidence of psychosis in migrants, I do not think that they can be ignored.

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- 1 King M, Coker E, Leavey G, Hoare A, Johnson-Sabine E. Incidence of psychotic illness in London: a comparison of ethnic groups. *BMJ* 1994;309:1115-9. (29 October.)
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Conclusions of study are unwarranted

EDITOR,—Michael King and colleagues draw some unwarranted conclusions from their study on psychosis in ethnic groups.¹ On the basis of their finding of high rates of both schizophrenia and affective psychoses in black and Asian patients they suggest that "the current focus on African Caribbeans and schizophrenia [is] misleading." High rates of serious mental illness in British African Caribbean people have been noted in studies over three decades, and this has often included affective illness.^{2,3} In contrast, no consistent picture has emerged for Asians. The authors rightly avoid multiple statistical comparisons of small numbers but then extrapolate from their results specific conclusions about African Caribbeans with schizophrenia, of whom there were just nine in their sample.

In discussing the limitations of their work King and colleagues imply that knowledge of the predictive validity of psychiatric diagnosis in ethnic minorities awaits the completion of their planned follow up study. They may not be aware that, for African Caribbean patients with schizophrenia, the predictive validity has already been established.⁴

The phrase "all ethnic minority groups are vulnerable" is offered as a clinical implication; worst of all, the paper concludes that the "personal and social pressures of belonging to any minority group in Britain are important determinants of the excess of psychotic disorders." These views may be attractive to many commentators, but the latter in particular remains without foundation. While some widespread environmental factor seems to precipitate extra cases of schizophrenia in African Caribbean families at risk,⁵ circumstantial evidence points to prenatal viral infection.⁶ At present no empirical data or plausible mechanism exist to relate racial prejudice and disadvantage to population rates of psychosis.

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Social observations on childhood

EDITOR,—As the producer of Clifford Yorke's talks on BBC Radio 3, *Childhood and Social Truth*, I wish to respond to Mark Berelowitz's review.¹ Berelowitz says that Yorke does not explain why the children of stable families have become unstable parents. In fact, his talks concentrate on answering this question. The reason is that parents often fall victim to fashionable ideas and social pressures and therefore act in ways that are contrary to their good understanding of children's needs. Berelowitz is disappointed that the talks do not offer new theories of childhood. This shows that he has missed the point, which is that we should pay much more attention to what we know.

Berelowitz misrepresents the contents of the talks. Yorke does not say that it hardly matters whether a child suffers from divorce or marital disharmony. He makes it clear that divorce is likely to be much worse. He certainly does not say that the whole of parenting consists of teaching the child to manage frustration. He mentions frustration to show how regressive "doing your own thing" is. Yorke gives a vivid picture of the harmony with oneself and others to which most parents aspire.

Many criticisms in the review are of the brief for the series rather than its contents. Berelowitz thinks that the talks should have been commissioned to "encourage parents"; to give a blueprint for reversing poverty, illness, and poor schooling in Britain and pestilence, war, and famine abroad. He wanted more treatment of the role of fathers within a stable household. But there are already plenty of manuals for parents and politicians. I commissioned a set of social observations by an authority on normal child development. The purpose of the broadcasts was to stimulate thought among listeners, and that thought was to be about what individuals can do to mitigate the weaknesses of society.

It is not easy to understand why a doctor should be less able than some dozen newspaper journalists to digest and summarise Yorke's arguments correctly.

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- 1 Berelowitz M. Everybody's doing it wrong. *BMJ* 1994;309:1309. (12 November.)

Circumcision

EDITOR,—Disappointingly, the discussion concerning the personal view¹ and book² on the joy of uncircumcising failed to emphasise the central issue with a clear statement that the practice of social circumcision is unacceptable in a civilised society. It is unacceptable not because of the increased surgical risks,² surgical complications,³ harmful long term outcome,⁴ difficulty in reversing the process,¹ or increased sexual dysfunction⁵ but

primarily because systematic ritual genital mutilation is both unnecessary and unjust.

Parents pursuing personal, social, and religious beliefs may request such an operation, and surgeons may then carry it out seemingly without question and sometimes for not entirely altruistic reasons. When such a permanently mutilating procedure is proposed and performed without clinical need there seems to be no individual culpability; surely a systematic deformation on any other part of the body would have been deemed to be a form of ritual child abuse. Furthermore, society has traditionally turned a blind eye to this problem, and seldom is any comment or criticism made by politicians and parliamentarians; social pundits and religious gurus; organisations entrusted with the welfare of children and the prevention of cruelty; or medical mandarins in the higher echelons of the General Medical Council, Royal Colleges of Surgeons and Physicians, and BMA.

Is it not time for all members of our society to reflect on this issue and to give a considered judgment on whether social circumcision could be deemed justifiable? While the jury is out—and it could be out for a long time—the least we can do is to stop performing such operations on children until they are old and mature enough to give informed consent.

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Triglyceride concentration and coronary heart disease

EDITOR,—We wish to respond to two letters concerning our paper.^{1,2} Despite the intuitive appeal of lowering triglyceride concentrations along with cholesterol concentrations when both are raised, there is no evidence that this strategy is more effective than targeting treatment at cholesterol alone. Even treatments that raise triglyceride concentrations reduce the risk of coronary heart disease in hypercholesterolaemic subjects. In the Lipid Research Clinics coronary primary prevention trial, treatment with diet and cholestyramine resulted in a 19% reduction in the risk of coronary heart disease despite an increase in serum triglyceride concentrations averaging 2.5%.³ Oestrogen treatment is also associated with increased triglyceride concentrations and a reduced risk of coronary heart disease.⁴ Clinical trials have not established which subgroups of hypercholesterolaemic patients, if any, benefit from a reduction in triglyceride concentrations.

A M Cruickshank notes that the rare patient with severe hypertriglyceridaemia is at risk of pancreatitis⁵; this association, however, is insufficient justification for universal screening of triglyceride concentrations. Certainly, screening would detect some hypertriglyceridaemic subjects who would otherwise be overlooked. But severe hypertriglyceridaemia, in the range associated with pancreatitis, is usually obvious from its physical manifestations and visual inspection of the lipaemic blood specimen. Seldom will the result of a screening test be the sole clue to a very high triglyceride concentration.

The varied results in the literature make it possible to select studies that show an independent association between hypertriglyceridaemia and coronary heart disease, like the three that Peter H Winocour cites.² But many studies support the opposite conclusion.³⁻⁷ Triglycerides may have a role in risk prediction when well standardised measurements of high density lipoprotein cholesterol are not available, as Winocour suggests. The negative correlation between the two measurements means that the triglyceride concentration can serve as a surrogate for the high density lipoprotein cholesterol concentration, albeit a relatively imprecise one. For any lipoprotein test, and especially for triglycerides, its accuracy in predicting risk depends on the quality of the measurement in the specific laboratory, so clinicians should learn about the accuracy of lipid tests available in the laboratory they use.

Whether to measure triglycerides is a moot issue once hypercholesterolaemia is found and a decision made to measure low density lipoprotein cholesterol. Many laboratories use an indirect measurement of low density lipoprotein cholesterol which requires knowledge of the triglyceride concentration. Consistent evidence that triglycerides have an important independent role in preventing coronary heart disease, however, remains elusive; calls for triglyceride testing must appeal to faith rather than established fact.

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- 1 Cruickshank AM. Triglyceride concentration and coronary heart disease. *BMJ* 1994;309:668. (10 September.)
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Child and adolescent mental health services

EDITOR,—I wish to correct an error that Michel Vanstraelen and I made in our article on purchasers' knowledge of, and plans for, child and adolescent mental health services.¹ When we first contacted Camden and Islington Health Authority in April 1993 it was able to provide little information about child and adolescent mental health services. I have since been informed by the medical director and director of contracting, however, that later in the year the health authority spent considerable time thinking about its purchasing plans for child and adolescent psychiatry. Our statement that the information in our article was correct as of December 1993 was therefore incorrect.

I am aware of the richness of services available within the area served by Camden and Islington Health Authority and am pleased that the health authority has started to address the purchasing of child mental health services. However, the authority has been able to provide me with only a description of services written by the provider and some general quality standards for child and adult

mental health, which have little relevance for child mental health services. This is similar to the level of information provided by other health authorities in our survey.

Substantial numbers of children have psychiatric disorders and need services. A recent report sponsored by the Department of Health shows that provision of services across Britain is patchy and often inadequate.² Purchasers must start to pay more attention to this small but important area of the health service.

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- 1 Vanstraelen M, Cottrell D. Child and adolescent mental health services: purchasers' knowledge and plans. *BMJ* 1994;309:259-61. (23 July.)
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Hepatitis C in asymptomatic blood donors

Did ethics committee approve study?

EDITOR,—In their short paper on hepatitis C in asymptomatic British blood donors D J Mutimer and colleagues do not say whether their study was approved by an ethics committee.¹ In the paper's comment they state that their patients would not have undergone biopsy outside the context of the study.

This point may have been omitted because of lack of space. I would like to be reassured, however, that the project had approval from a research ethics committee. If this was not the case the paper should not have been accepted for publication.

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- 1 Mutimer DJ, Harrison RF, O'Donnell KB, Shaw J, Martin BAB, Atrah H, et al. Hepatitis C in asymptomatic British blood donors with indeterminate seropositivity. *BMJ* 1994;309:847-8. (1 October.)

Authors' reply

EDITOR,—Screening of British blood donors for antibodies to hepatitis C virus started in September 1991. Donors who are positive for the antibody (with positive or indeterminate results in the confirmatory assay) are excluded from further donation and advised that use of their blood may be unsafe. Guidelines on counselling and investigating these donors do not exist. Experience in areas of high prevalence suggested that donors with indeterminate results are frequently viraemic and may have clinically important liver disease. Results of liver biochemical tests are frequently normal in patients with liver disease related to hepatitis C virus.

All patients who are positive for antibody to the virus (including asymptomatic blood donors) who are referred to Birmingham Liver Unit have been managed according to a protocol. In line with this protocol, liver biopsy has been recommended for all patients. Blood donors were advised that the clinical importance of their seropositivity was unknown and that liver biopsy could exclude important liver disease. Informed consent was obtained from all patients before biopsy. The management protocol was not submitted for approval by the ethics committee.

During the first 12 months of screening more than 100 donors who were positive for the antibody

were referred for counselling and investigation. The results of investigation according to this protocol were analysed for each group of patients, including those with indeterminate seropositivity; these were the patients reported on in our paper. Because of the results of this audit we have modified our clinical practice. When results of liver biochemical tests are normal we now reassure donors with indeterminate seropositivity that they do not have important liver disease and that liver biopsy is not required.

Management according to the protocol and audit have also permitted appropriate (and locally relevant) recommendations to be made for managing donors in whom confirmatory assays give positive results.¹ We have also established protocols that determine which patients should be given antiviral treatment.

We recommend management that follows a protocol, audit, and modification of the protocol according to results. This is particularly important in the management of conditions for which guidelines have yet to be established.

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Intrahepatic cholestasis of pregnancy

EDITOR,—As in many liver diseases, in intrahepatic cholestasis of pregnancy¹ appropriate monitoring and treatment are often not instituted because the problem is not recognised and accurate diagnosis not reached. In addition, we know of cases in which warning signs, such as raised results of liver function tests, have been ignored.

It has been suggested that half of unexplained stillbirths in Britain may be caused by intrahepatic cholestasis of pregnancy. Once the condition has been diagnosed the combination of monitoring and early delivery seems to be effective in ensuring a good outcome for mother and baby. Babies' lives can be saved—without the huge costs associated with some procedures—simply by obstetricians and all those caring for pregnant women, including general practitioners, being aware that severe generalised itching is a classic symptom of the disease. We know of women who have been advised to apply camomile lotion for itching so severe that their only relief is to plunge their feet and legs into buckets of ice. Such symptoms should sound warning bells for physicians or obstetricians. Simple measures can be taken to avoid the agony of a needless stillbirth.

Given the likelihood that better education of those caring for pregnant mothers could save lives, we are anxious to ensure that this happens. As a relatively new charity, the British Liver Trust does not have sufficient resources to initiate a campaign to educate medical practitioners. Surely, though, this is precisely the sort of sensible improvement in health care—with identifiable results—that the government is keen to promote.

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- 1 Fagan EA. Intrahepatic cholestasis of pregnancy. *BMJ* 1994;309:1243-4. (12 November.)