absolute difference between the rates is almost similar in both cases.

Our main comment, however, relates to Frisoni and colleagues' concluding comments. Although we agree that prospective studies are needed, we do not agree that the epidemiological relevance of e4 in determining Alzheimer's disease may be lower than suggested by others. This is certainly plausible. Although we have no extensive clinical data on Alzheimer's disease available in our cohort, the proportion of men with the disease in our population based sample of elderly men was probably very low. Since despite this low proportion e4 predicts cognitive decline, the role of e4 in dementia and disorders related to dementia in general might instead be larger than expected.

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Referral of women with breast lumps

EDITOR,—I disagree with J M Dixon and R E Mansel's suggestion that general practitioners should not aspirate breast lumps.¹ Firstly, aspirating a cyst in the surgery provides instant relief for the patient and avoids an agonising wait before she is seen at hospital. Secondly, in my experience, the first thing that the surgeon will do is attempt to aspirate the cyst.

Breast cysts are seen fairly commonly in general practice, and I suspect that if all cysts were referred to hospital the consultants would experience a considerable increase in their workload.

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1 Dixon JM, Mansel RE. ABC of breast diseases: symptoms assessment and guidelines for referral. *BMJ* 1994;309:722-6. (17 September.)

Positive predictive value of tests for breast disease

EDITOR,—J M Dixon and R E Mansell attempt to clarify the utility of various diagnostic tests for symptomatic breast diseases.¹ Unfortunately, their use of the positive predictive value in this context is misleading since it can refer only to the situation in a specialist breast clinic and is not applicable to other settings.

The positive predictive value is a function not only of a test but also of the prevalence of the disorder in the group of patients subjected to the test. Back calculation from the figures for sensitivity, specificity, and positive predictive value presented shows that the prevalence of malignant disease was 69% in the patients subjected to clinical examination and mammography, 62% in those subjected to ultrasonography, and 96% in those subjected to fine needle aspiration cytology. Such high prevalences would be unlikely in a non-specialist setting such as general practice.

A useful illustration of the effect of prevalence on the positive predictive value can be derived from data presented in another article by Dixon and Mansel.² Consider a woman aged 31-40 with a breast lump. According to the graph in the article, the prevalence of malignant disease in such women is about 10%; if this woman were subjected to fine needle aspiration the positive predictive value of

the test would be less than 68%. In other words, if the test suggested the presence of malignant cells the woman would have a one in three chance of having benign disease.

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1 Dixon JM, Mansel RE. ABC of breast diseases: symptoms, assessment, and guidelines for referral. *BMJ* 1994;309:722-6. (17 September.)

2 Dixon JM, Mansel RE. ABC of breast diseases: congenital problems and aberrations of normal breast development and involution. *BMJ* 1994;309:797-800. (24 September.)

Psychotic illness in ethnic groups

Data on Surinamese patients in the Netherlands support study results

EDITOR,—Michael King and colleagues reported increased incidences of psychosis, including schizophrenia, in all ethnic minority groups and not just African Caribbeans.¹ Interestingly, study of the Dutch psychiatric register shows a high incidence of schizophrenia in Surinamese and Antillean immigrants to the Netherlands.

The 1980 census in Surinam distinguished Afro-Surinamese (44%), Hindustanis (whose ancestors emigrated in the 19th century from British India to become contract labourers on Surinamese estates; 34%), and others (Indonesians, Chinese, etc; 22%).² Large scale migration of all ethnic groups from Surinam to the Netherlands occurred between 1974 and 1981. The percentages of Hindustanis and Afro-Surinamese in the Netherlands are estimated to be about 43% and 37%, respectively.³ The Dutch psychiatric register records data on country of birth but not ethnic group, so I collected data on the ethnic background of Surinamese patients admitted to this hospital, one of three psychiatric hospitals in the Hague. It is a teaching hospital and diseases are carefully diagnosed. The municipality of the Hague estimated the numbers of Hindustanis and Afro-Surinamese to be 19 059 and 6944 respectively, a ratio of about 2.7 to 1. This ratio is unlikely to have changed significantly over recent years, and the age structure of both ethnic groups is similar. The number of patients who had been born in Surinam and were treated for schizophrenia (according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders, third edition, revised*) from January 1991 to December 1994 was 105. Almost all had schizophrenia for the first time. Seventy six were Hindustani and 25 Afro-Surinamese, with four others. Thus, the ratio of Hindustanis to Afro-Surinamese in the hospital (about 3 to 1) was similar to that in the city.

These findings support the conclusion of King and colleagues that the current focus on black people is misleading. I suggest that the race and ethnic background of the immigrants are not causally related to the high incidence of schizophrenia and that some other factor is of critical importance.

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

2 Europa Publications. *South America, Central America and the Caribbean*. 3rd ed. London: Europa Publications, 1991.

3 Roeland T, Royen J, Veenman J. *Minderheden in Nederland: Statistisch Vademecum 1992* [Ethnic minorities in the Netherlands. A statistical guide 1992]. Rotterdam: Erasmus University Rotterdam, 1992.

Numbers are small

EDITOR,—We were not surprised that Michael King and colleagues found that the rates of psychosis were higher among the African Caribbean population than among the white population¹—a finding well established by previous research. We would take issue with their assertion that rates are higher among all minority ethnic groups when they found only a limited number of cases. To conclude from seven Asian cases that rates are high among the Asian community is perilous. In a comparable study in Ealing conducted over a similar period we found 31 cases of first onset psychosis among Asians and that the rate of broad schizophrenia did not differ significantly from that of the white population of the same catchment area. Research into ethnic group and mental illness is beset with complexities, and generalisations on the basis of small numbers are not likely to clarify our understanding of this difficult subject.

A second issue that raises our concern is the inclusion of European patients of Turkish-Cypriot origin in the white group. We would anticipate that their experiences of racism and cultural conflict would be different from those of the indigenous population. Therefore it is more appropriate to treat them as a separate minority ethnic group for the purpose of calculating incidence rates.

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

Study did not deal with "category fallacy"

EDITOR,—The paper by Michael King and colleagues¹ should be seen in the context of three important issues studied and explored in several publications.²⁻⁴

(1) Concepts inherent in the model of mental illness used in Western psychiatry are unlikely to be meaningful in a crosscultural setting.

(2) Neither schizophrenia nor psychosis as illnesses have been validated for use in crosscultural study.

(3) The race of a person as perceived by the psychiatrist making a diagnosis seems to play an important part in assigning the category of schizophrenia, irrespective of the race of the psychiatrist.

King and his colleagues refer to the influence of racism in determining the diagnosis of schizophrenia but ignore the issue in their methodology. They seem to assume that the problem of using Western categories of illness is avoided by using a Western structured interview schedule (the present state examination) and a computer program. However, the main criticism of this study is its failure to deal with "category fallacy," which is the imposition of one culture's diagnostic categories on to patients of another culture and was described by Kleinman as "the most basic and certainly the most crucial error one can make in cross-cultural research."⁵ The authors deal with this problem by a slippage of language. They start by referring in the introduction to people from one ethnic group who "receive a diagnosis of schizophrenia more often than do members of other ethnic groups," then write in the results about the "incidence of psychotic illness," and end in the conclusions section with the remarkable statement, "Members of all ethnic minority groups are more likely to develop a psychosis...."

I suggest that the title of their paper should have been: "Psychiatric diagnostic practice in London.