Characteristic	Did not respond (n=34)	Responded (n=217)
Age range (average) (years)	52-65 (57)	50-65 (57)
Non-response for cervical screening	20**	16**
Not known personally to general practitioner	22*	77*
Marital status:		
Married	24	176
Widowed	5	29
Divorced	4	5
Single	1	7

*P=0.01, **P=0.001.

ascertained whether the following factors were associated with non-attendance: non-response for cervical screening, marital status, and whether the patient had personal knowledge of the general practitioner. The only factors that reached significance (table) were non-attendance for cervical screening ($P < 0.001$) and no personal knowledge of the general practitioner ($P < 0.01$).

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1 Rudiman R, Gilbert FJ, Ritchie LD. Comparison of uptake of breast screening, cervical screening, and childhood immunisation. *BMJ* 1995;310:229. (28 January.)

Acyclovir and post-herpetic neuralgia

Two other participating study centres report different results

EDITOR,—J I McGill and J E White report follow up data¹ on 57 of 74 patients from Southampton originally treated as part of a three centre study of acyclovir versus placebo in herpes zoster in elderly patients.^{2,3} The original protocol required patients (mean age 71.7 years) to be followed up for six months or until pain free for one month. We are not clear about some of McGill and White's data. They state that 10 (37%) of the placebo group had pain "at each follow up" (at six months and five years by implication), compared with two (7%) of those receiving acyclovir. The original data indicate, however, that 20 patients who received placebo in Southampton were followed up to six months and only two had pain. Clarification of this point is essential: have the authors included patients who still had pain at an earlier visit even though the protocol was violated and follow up was stopped? They surely cannot rely on the five year memory of patients for accurate assessment of when "the patient was finally pain free."

We have completed a late follow up (nine to 10 years) of 298 patients enrolled in the same study from Sheffield and Birmingham. A detailed search was performed for all patients. Of the 298 patients, 138 were lost to follow up as 99 had died, 35 were not traceable, and four were unable to participate (M W McKendrick *et al*, second international conference on varicella zoster virus, Paris, 1994). Altogether 160 patients (all over 60 when they acquired shingles) were visited and examined and had a structured questionnaire completed. Thirty four had experienced pain within the year before review; 33 of these had had moderate or severe pain at entry into the study, and 25 had prodromal symptoms lasting longer than 72 hours. Of 132 patients who reported absence of pain for at least one month when discharged from the original study, 16 reported pain "within the past year," which suggests that recurrence of pain may be more common than previously realised. Our analysis has shown no association between the

presence or recurrence of longer term pain and the use of acyclovir and does not agree with the conclusions of McGill and White.

Although some studies^{4,5} (but not the large British study⁶) have shown acyclovir to reduce pain in the first few months after herpes zoster, we believe that any conclusion regarding longer term benefits must be based on firm criteria. We await clarification of the above points.

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The balance of available evidence supports its use

EDITOR,—J I McGill and J E White's paper adds further to the debate on the efficacy of oral acyclovir in herpes zoster ophthalmicus.¹ It reports the long term follow up of a small sample of patients with ophthalmic complications from a study of 205 patients with herpes zoster in any dermatome.² Pain and ocular complications were significantly less frequent at six months and five years. The original paper failed to find a beneficial effect of acyclovir on pain between one and six months or on pain in the 53 patients with ophthalmic zoster.² McGill and White report on 74 original patients with ophthalmic zoster rather than 53, now with a significant difference at six months and five years, so it would be useful to know whether the two populations are the same and the source of the additional 21 patients.

McGill and White's paper agrees with a previous paper not referenced by them, which reported pain and ocular involvement after herpes zoster ophthalmicus in 46 patients randomly treated with either placebo or 800 mg acyclovir five times daily for 10 days, starting within 72 hours of the onset of the rash.³ Active ocular disease was significantly less common in the acyclovir group ($P=0.01$). Pain was significantly less severe between two and six months and less common between two and three months. In this paper the rate of ocular involvement was 53% in the patients receiving placebo, which is similar to the figure reported by McGill and White; this suggests that the two study populations are similar and the results might be consistent. Two other papers have been published on the subject: one showed a beneficial effect on early ocular signs and pain⁴ and the other detected no treatment effect in the eye.⁵

With conflicting results from several papers it is difficult for clinicians to make a clear judgment, but the balance of evidence currently favours the use of oral acyclovir in all patients with herpes zoster ophthalmicus.

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Authors' reply

EDITOR,—In the part of the trial in Southampton independent analysis showed a significant difference in the duration of post-herpetic neuralgia between 38 patients treated with acyclovir (mean (median) duration 2.44 (2) months) and 36 patients treated with placebo (3.59 (4); P (two tailed)=0.01; Kaplan-Meier product limit method used to estimate duration of pain). The significance was lost, however, when the three centres' results were amalgamated.¹ This difference could have been due to the high number of patients from Southampton with trigeminal herpes zoster, which can be more severe and prolonged than other dermatome involvement²; thus the favourable effects of acyclovir would have been more pronounced in these cases.

M W McKendrick and M J Wood ask whether we relied on the patients' recollection of five years previously to determine when the post-herpetic neuralgia stopped. As we prophylactically followed up the patients monthly to six months and then at five years we avoided this pitfall and were able to detect late recurrences of pain, which occurred at five years in three patients who had not any such pain at six months.

We agree with Harding and Porter, whose study population was similar to ours, with a 53% rate of ocular involvement in placebo treated patients, that acyclovir lessens the risk of active ocular disease.³ Our results also agree with those of others.⁴ The failure of Aylward *et al* to find any such beneficial effect of acyclovir may have been because their analysis was retrospective on a selected group of patients.⁵

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United Kingdom prospective diabetes study

Compliance with diet will affect results

EDITOR,—As a result of its comparison of the relative efficacy of diet and various drug treatments in patients with newly diagnosed diabetes the United Kingdom Prospective Diabetes Study Group concludes that chlorpropamide, glibenclamide, insulin, and metformin are more effective than diet alone.¹ The group does not present any evidence on what diets the subjects were given, what baseline diets were being consumed, whether diets changed during the study, or whether the subjects complied with the given dietary regimen. The authors did not consider whether there was any change in the dietary prescriptions over the 10 years of the study which might also have influenced the results. From figure 2 it is apparent that body weight did not change in any group, which suggests that, at least in obese subjects, those taking diet alone did not achieve the dietary