problem of stratification and selection for admission to those units.

Finally, it is worth emphasising that not all investigations are of unproved value and that effective strategies for managing high risk patients do exist. We can avoid surgery altogether, and, indeed, quantification of risk may be particularly important in those operations, such as carotid endarterectomy, in which the benefit of surgery disappears at a given (and low) rate of perioperative complications.⁵

As we stated in our last paragraph, further studies are urgently needed; these should not only assess methods of stratifying risk but also evaluate their effectiveness in reducing morbidity. Until such evidence is forthcoming, our article summarises the best methods available.

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Treatment of acute mountain sickness

EDITOR,—Hans-Rudolf Keller and colleagues recommend descent as the treatment of choice for acute mountain sickness but show that both treatment in a portable hyperbaric chamber and administration of dexamethasone (which was the superior treatment) may facilitate descent by improving symptoms.¹ Pressurisation produced only short term benefit. A previous controlled trial of treatment in a portable hyperbaric chamber by the same group also failed to show any long term benefit of pressurisation in people with acute mountain sickness.² Spending longer in the pressure bag has not been shown to confer additional benefit.³

Despite the lack of long term efficacy the use of portable hyperbaric chambers has become widespread, and much has been made in the lay press⁴ of the anecdotal reports of symptomatic relief to which Keller and colleagues refer.¹ In Britain this popularisation of "the life saving pressure bag" has resulted in trekking agencies feeling under pressure to make sure that these portable hyperbaric chambers are available on package holiday treks and to state that they are in their advertising to potential clients. Unfortunately, there is confusion among the public about the therapeutic role of these portable hyperbaric chambers. At least one potentially avoidable death has occurred. In 1991 a European trekker died at 5100 m on the Mera La in eastern Nepal after three days of intermittent treatment in a portable hyperbaric chamber without an attempt at descent (personal observation). Descent might have been life saving.

Some 20 000 people travel from Britain to Nepal each year on trekking holidays, and many more go to India, Pakistan, South America, and east Africa, where they may trek to a considerable altitude. General practitioners, who provide travel immunisation for their patients, should familiarise themselves with the recommended treatments for altitude illness and ensure that their patients are informed about mountain sickness and its manage-

ment. Trekking groups that carry portable hyperbaric chambers should use them only to facilitate descent and not as an alternative to descent.

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Management of genital candidiasis

Review omitted issues on recurrent thrush

EDITOR,—The British Society for Medical Mycology's review on the management of genital candidiasis fails to bring out some important points.¹

Firstly, the vulval vestibulitis syndrome is not included in the section on differential diagnosis. This, however, is the commonest misdiagnosis in our clinic for patients with recurrent thrush and must be considered in any patient who complains of superficial dyspareunia.²

Secondly, the authors suggest that "recommended regimens are not clearly related to difference between drugs." Neither are they clearly related to differences between patients. Unfortunately, almost all comparative treatment studies have been in unselected women. In the section on management of recurrent disease the authors mention that recurrence may be due to sequestration of fungal hyphae and spores in the deeper layers of the vaginal epithelium, which then regrow when conditions are favourable. This "vaginal relapse" hypothesis implies that it may be possible to prevent further attacks by intensive antifungal treatment. This needs to be tested in prospective comparative studies specifically in women with recurrent disease.

Evidence suggests that changing the contraceptive method to medroxyprogesterone acetate may be beneficial in recurrent disease.³ In our experience, medroxyprogesterone acetate is better than suppressive antifungal treatment in selected women. This is currently the subject of prospective study in our department. Requests for support from the pharmaceutical industry for both this and other studies of hormonal treatments for recurrent vaginal candidiasis have been successful.

The controversy over whether sexual transmission causes relapse in recurrent disease is discussed at some length in the article. The authors do not mention that sexual intercourse may predispose to the development of symptoms by causing epithelial damage. This is indicated by the common clinical entity of "honeymoon thrush" and the association between frequency of intercourse and symptomatic attacks of vaginal candidiasis.⁴ In women with recurrent vaginal candidiasis it is important to emphasise that intercourse should be slow and unhurried, with extra lubrication being applied to the penis. The possibility of sexual transmission should be "de-emphasised" so that further damage does not occur in an already strained relationship.

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Chlamydial and gonococcal infections are rare causes of vaginal discharge

EDITOR,—It is unfortunate that the British Society for Medical Mycology lists chlamydial and gonococcal infections as part of the differential diagnosis to be considered in the management of vaginal discharge. While both may rarely cause frank cervicitis and thus be a direct cause of discharge, patients are much more likely to have associated bacterial vaginosis (or, less commonly, trichomoniasis). It is frustrating that this list, with the implication that gonorrhoea or chlamydial infection is a common direct cause of vaginal discharge, constantly appears in articles and textbooks. This misconception leads to requests for investigations that may be unnecessary and to inappropriate antimicrobial treatment.

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Role of viral infections in exacerbations of asthma

Study supports results of audit by General Practitioners in Asthma Group

EDITOR,—Sebastian L Johnston and colleagues¹ highlight what patients with asthma have been saying for years: that asthma gets worse with colds. The General Practitioners in Asthma Group carried out its second national audit of attacks of asthma and looked at 2332 attacks in patients of all ages. Factors that precipitated or preceded an attack were upper respiratory tract infection (1511 attacks), non-compliance with preventive treatment (151), "stress" (113), and allergy (103). This supports the view that upper respiratory tract infection is the dominant precipitating factor in asthma and deserves more attention.

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Allergy must also be a factor

EDITOR,—Sebastian L Johnston and colleagues from Southampton report impressive data supporting an association between viral infections (predominantly rhinoviruses) and exacerbations of asthma among children of school age.¹ The association they observed was so strong that it is